The construction of the active, involved patient
A discourse analysis of the patient role in Danish publications 2014–2015

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Abstract
The patient role has been discussed in western health systems literature for decades. In this discourse analysis, based on the work of the French philosopher Michel Foucault, we analyzed a broad selection of Danish materials in the field of healthcare. We found that patient involvement is a discursive ideal. The ideal is anchored in implicit assumptions about the characteristics and capacities that the patient is expected to acquire and display: the patient must be active, knowledgeable, a competent decision-maker, obtain insight into own disease, and have supportive relatives. To achieve the ideal of patient participation we suggest that there is a need for a certain type of active patient; otherwise patient involvement plans cannot succeed. We identified a single discursive strategy in which the patient was attributed the role of being actively involved by addressing the patient’s characteristics, skills, desires, actions and expectations. Finally, we discussed how this patient role could actually increase health inequality despite intentions to the contrary.

Keywords
Denmark, Foucault, governmentality, health inequality, health system, patient involvement, patient participation

Introduction
According to Riiskjær, Mainz and Rhode (1), a goal within contemporary Western health systems is to involve patients in their own care and treatment (1). Hence, in 2011, the Danish patient organisation established the Danish Knowledge Center for User Involvement in Health Care (ViBIS), with the purpose of gathering knowledge on research into user involvement and to advice on involvement in practice (2). Kjaer and Reff (3) argue that, in the attempt to become patient-oriented, services are constantly involved in a process of defining the patient role. From our social constructivist position and based on a reading of the work of Michel Foucault we understand the “role of the patient” as a social construct, which is constantly produced and reproduced in social processes where language plays an important role. We draw on Foucault’s texts as we assess them to hold a critical potential
that allows the researcher to scrutinize commonly shared perceptions of a phenomenon, in our study of patient roles, without having decided in advanced what it is or what it should be, and without adding values to the phenomenon. We follow the viewpoint in social constructivism that, instead of understanding language as a passive tool to express inner meaning, truth or thinking, language should be understood as a social practice that is doing something to that or those about which it speaks (4–5). Hence, discourses in which citizens are articulated, regardless of it being in the public media, information material or in scientific journals, contribute to the construction of both the role of the citizen on becoming a patient and the reality in which citizens must act as patients.

The aim of this Foucault-inspired discourse analysis was therefore to identify and describe discourses in different Danish materials between 2014 and 2015 that contribute to construction of the patient role; moreover, to discuss what space the discursive landscape offer citizens to navigate within when they become patients.

A shift of paradigm in the description of the patient role
Several scholars have illustrated that, in the 1970s and beginning of the 1980s, we witnessed a paradigm shift in the health sector, in relation to how the role of the patient had been previously articulated (1,3,6–10). In the literature before 1970, the meeting between the patient and the professional was commonly described as a relationship in which the professional was knowledgeable, active and decisive and the patient passive and trusting, adapting him/herself to the professional’s instructions (6–7,10,11–12). Since 1970, the idea of the socio-economic, involved patients, who are responsible for taking care of their own health, has been articulated (9).

An EU Commission report from 2012 (13), articulates that involvement of the patient are ambiguous and that there are only a small number of concrete ideas and activities in place to actually realise this in practice (13). The same conclusion is put forward in international research articles (14–16). It is also problematized that the use of a large concept apparatus entails the risk that we all believe we know what we are talking about; whereas, in reality, it seems that many different, individual interpretations exist, which translate into various different actions in practice (7,13,17–20).

Holen (21) concluded that patient involvement cannot be achieved within the contemporary organization of the health system. Ravn, Frederiksen and Beedholm (22) suggested in a discourse analysis of Danish chronic care policies that chronic care policy discourses consider chronically ill patients to have the potential to become active, despite the challenges presented by their chronic diseases.

A further discourse analysis concluded that, despite the contemporary aim to involve patients in their own treatment and care, descriptions of patient education lacked a patient perspective (23). Knutsen (24) concluded in a discourse analysis that, in creating programmes to empower patients to deal with their health, it seems vital that health professionals examine the presence of power. However, while the above-mentioned studies have dealt with the role of the patient, they have not addressed “the patient role” as a construct.

The aim of our analysis was therefore to explore how the patient role was constructed in a broadly selected text corpus in a contemporary period and to identify the discursive landscape citizens have to navigate when they become patients and to discuss what significance the patient role construct could have for the individual patient.
Method
Data collection and material
Foucault’s work in “the Archeology of Knowledge” (25) guided us to uncover a contemporary view of the role of the patient. This work supported the forming of questions to enable us to challenge our truisms, as suggested by Beedhom, Lomborg and Frederiksen (26). Foucault used the term “archive” to describe the set of implicit rules and laws, in a practice, which determines the appearance and disappearance of statements. Foucault describes the archive in this way:

(…) we have in the density of discursive practices, systems that establish statements as events (with their own conditions and domain of appearance) and things (with their own possibility and field of use). They are all the systems of statements (whether events or things) that I propose to call archive (25, p. 145).

Hence, we included a wide collection of material that addressed the patient role. We set out to identify both the writing concerning the patient role, as well as who wrote about the role. We limited our analysis to texts from the years 2014–15, published in Danish. With this timerestriction, we could include material from many different positions. We included some policies dated before 2014–15 that we judged was still in use.

The material used for the analysis was identified on central Danish internet and intranet sites, and the search was supplemented with citation searches.

The following material was included in the archive: articles in journals, articles in magazines, materials from the Danish newspapers, opinion articles, videos, strategies, government plans, dialogue papers, standards for practice, major studies and reports, plans, recommendations, websites and diverse material from hospitals – including policies, pamphlets and images. In total, we identified 39 different materials.

The complete archive is presented in Table 1. English translation in parentheses.

Table 1. Archive

<table>
<thead>
<tr>
<th>Articles from the press</th>
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</thead>
<tbody>
<tr>
<td>• Christiansen, F. (2015a). Læge til patient: &gt; det skal du ikke bryde dit kænne lille hoved med &lt; [Doctor to the patient: &gt; Don’t worry your little head about it &lt;]</td>
</tr>
<tr>
<td>• Christiansen, F. (2015b), Patienter skal have (mere) magt over egen sygdom [Patients must have (more) power to make decisions regarding their own illness].</td>
</tr>
<tr>
<td>• Kofoed B. (2014). Patienter skal være mere aktive i egen behandling [Patients must be more active in their own treatment].</td>
</tr>
<tr>
<td>• Lauridsen J. B., Sand, T. (2014). Læger og patienter savner tid til at inddrage patienter [Doctors and nurses lack the time to involve patients].</td>
</tr>
<tr>
<td>• Articles from trade magazines</td>
</tr>
<tr>
<td>• Graversen, H. P. (2014). Patienten er vågnet – og vil nu være medproducent på sit behandlingsforløb [The patient is awakened – and will now want to be co-producer in his own treatment].</td>
</tr>
<tr>
<td>• Højgaard, J (2014). Diabetes: patienten definerer selv mål for behandling [Diabetes: the patient defines his own treatment goals].</td>
</tr>
<tr>
<td>• Kjeldsen S. B. (2014). Personalet skal turde slippe kontrollen [The staff have to dare to let go of control].</td>
</tr>
<tr>
<td>• Lilja, B. (2014). Sæt dig selv i spil [Take an active role].</td>
</tr>
</tbody>
</table>

1. Infomedia, Sum.dk, Sundhedsplatformen, Google, Bibliotek.dk, Danskeregioner.dk, Åldresagen, Danskeklinikken, VIBIS.dk, Kliniskegydepleje.dk, Sst.dk, dsr.dk, Ugeskriftet.dk, Region Hovedstadens intranet, Regionh.dk, E-dok, VIP-portalen, Mails til afdelinger på landets sygehuse, kk.dk, KORA.dk, og patientsikkerhed.dk.
• Nielsen, J (2014). Patienten skal have rum til at kunne og ville selv [The patient needs room to be able and willing to do it themselves].
• Pedersen L & Kirk, K. (2014). Nye roller og magtfordeling mellem patienter og sundhedsprofessionelle [New roles and division of power between patients and health professionals].
• Steenberger, A. (2014). Er patienten blevet borger [Has the patient become a citizen].
• Danish Regions. (2015b). Make the Danish hospitals even better [Gør de danske sygehuse endnu bedre].
• Danish Regions (2015c). The citizenship health sector – opinions [Borgerens sundhedsvæsen – udtalelser].
• Neurological unit. Bispebjerg hospital (2015). The participatory ward round [Den inddragende stuegang].


• Material from patient and health unions
• The Danish Society for Patient Safety. (2015). It’s good that you ask [Godt du spør’]
• Danish patients, the Danish Medical Association, the Danish Nurses’ Organization. (2014). Four recommendations for enhanced patient involvement [Fire anbefalinger til styrket patientinddragelse].
• The Danish Society for Patient Safety. (2015). Guidance and rights related to hospitalization [Råd og rettigheder i forbindelse med hospitalsindlæggelse].
• Material from the Danish Government and the Health Ministry
• The Ministry of Health and Preventive. (2014a). Dialogue paper about the increased involvement of patients and their relatives [Dialogpapir om øges inddragelse af patienter og pårørende].
• The Ministry of Health and Preventive. (2014b). Presentation of the Danish Health Act [Bekendtgørelse af sundhedsloven].
• The Danish Government. (2014a). The sooner the better, early diagnosis, better treatment and more quality of life for all [Jo før – jo bedre. Tidlig diagnose, bedre behandling og flere gode leveår for alle].
• The Danish Government. (2014b). Healthier life for all. National targets for the Danish population’s health over the next 10 years [Sundere liv for alle. Nationale mål for danskernes sundhed de næste 10 år].
• Danish Health Authority et al., (2014). The citizen’s health service [Borgerens sundhedsvæsen].
• Material from quality and knowledge development units
• IKAS. (2012). 2.1.2 – Patientens og pårørendes inddragelse som partnere (2/3) [Patient involvement 2.1.1 The patient and relatives as partners].
• IKAS. (2014). 2.1.1 – Borgeren som partner (1/3) [2.1.1 – The citizen as a partner].
Methodological framework – discourse analysis

Foucault considered himself a writer for users not for readers and described his books as 'a kind of tool-box which others can rummage through to find a tool which they can use however they wish in their own area' (27). We will therefore explain our application of the term discourse analysis in this study.

In line with Foucault, we understand discourse as a collection of statements that utters something about a specific field/area/practice/topic (25,28). Moreover, we consider discourse to be both the concept for the general domain of all statements and an anonymous regulatory practice for a number of statements (25,28). We find that a discourse both expresses and takes part in constructing our understanding of the world in a particular historical, cultural or institutional context. Therefore, all statements that emerge about the role of the patient – spoken as well as written, constitute a discourse. To describe and identify some discursive facts and statements in a given field, Foucault (25) points out that some statements belong to the same discursive formation and are therefore judged to be a discourse. Foucault (28) delimits the discursive formation into four directions:

(... the four directions in which it is analysed (formation of objects, formation of the subjective positions, formation of concepts, formation of strategic choices) correspond to four directions in which the enunciative function operates (28, p. 116).

In our study, we adopted these four directions as the foundation of the discourse analysis.

*Discursive objects* is the term that covers a text's key constructs (25). The formation of the discursive objects in a discourse occurs in a complex network of relations, which, again, is framed by some conditions and rules (25). According to Foucault, the objects to which they relate combine discourses. Therefore, a statement is merely a statement if it produces objects through the articulation (25).

*The subjective positions* refers to the positions from which truth is spoken meaningfully about key objects (25). Foucault (25) suggests that one must find the law for the recitations and the place they come from. We therefore understand subjective positions as positions from which statements about the patient role are enunciated.

*The concepts* is an expression used for the descriptive words associated with the discursive object and should not be seen as isolated but rather as a “network of concepts” in which the concepts are related to each other (25). Hence, in the construction of the patient role, we seek to identify discursive objects, which are defined in a “network” of concepts through various systematics.
Foucault describes how discursive strategies are established in the discursive practices and organizes a discursive field in a special way. Foucault (25) describes the strategy as a discursive constellation at a higher level than that of the discourses. We therefore understand the discursive strategies as a direction or overriding movement that can be derived from the discursive objects, discursive subjects and the formations of concepts. This picture of an overriding movement in the network of discourses emphasizes the point that discourses within a network are not passive utterances, but play an active role in the network of discursive practices which, taken together, construct something real, in the present study, the role a citizen must take when s/he becomes a patient.

In our analysis of the archive material, we made a preliminary reading of the texts from the archive, due to Foucault’s suggestion that statements should be grasped in their neutral appearance and should not be interpreted but analysed in their relation to other statements (25, p.106,120)). After this initial reading, we condensed the analysis with the aim of identifying patterns in the statements and succeedingly to identify discourses, in relation to four directions namely the discursive objects, subject positions, discursive concepts and discursive strategies.

We therefore asked the following questions:

**Table 2. Questions to the archive**

<table>
<thead>
<tr>
<th>From which (subjective) position was the material written?</th>
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<tbody>
<tr>
<td>How is the patient role constructed and which truths seem obvious?</td>
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<tr>
<td>Which discursive objects are constructed, and which concepts are related?</td>
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<tr>
<td>Which discursive strategies, patterns and discourses can be identified from the subjective positions, objects and concepts?</td>
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<tr>
<td>Which actions and competencies are described as necessary in order for the patient to be able to fulfil his or her role?</td>
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**Findings**

We identified a discursive strategy aiming fulfilling the constructed ideal of patient involvement. The strategy attributed to the patient the condition of being actively involved in his/her own treatment and care. The condition was assigned through descriptions of legitimate actions and, thereby, expectations of the patient. The subjectification of the patient took place in a discursive condition of possibility, where the discourses altogether mould the patient to take on an active role through statements concerning the patient’s characteristics, skills, own desires, actions and, thereby expectations that are attached to the role of an “ideal patient”. We argue that the strong active and involved patient with strong relatives is constructed as an “ideal patient” and a discursive truth that may define possibilities and legitimations of the patient role.

In the following sections, we illustrate the main results of the analysis.

**Who speaks? – A discursive network without the voice of the patient and the health professionals**

We identified five different subjective positions: the press, trade magazines, regions, patient and health unions, the Danish government and the ministry, and quality and knowledge development units. Across the different positions, a constructed reality about an “ideal patient” is implicitly constructed through normative statements about how the patient should be or behave.
The patient – an active and involved partner
The patient role is constructed as a discursive object through discursive regularities that appear as legitimate actions, expectations, capabilities, competencies and activities, which, in combination, construct the role that the patient is expected to adopt.

A pattern that appears across the statements and subjective positions is the formation of some capabilities that the discursive object, the patient, should possess. This is reflected in the concepts attached to the patient as an object. The patient is described as an active partner who expresses demands, is knowledge bearing and competent, the centre of action, awake, information seeking and expectant. This can for example be seen in materials from the press and the regions:

"... a new patient is under development: the competent or active patient" (29) and "We see patients, relatives and volunteers as active partners when it comes to the individuals health and disease – and when it comes to developing the health care system" (30, p. 7). The construct of the patient as being active is also seen in images from the regions. In the catalogue: Elderly in Copenhagen from Copenhagen Municipality (31), there is a picture of an apparently happy elderly lady who is cleaning her house while receiving oxygen through a nasal breathing aid. Another picture shows an elderly lady wearing sweatbands, a tracksuit and using small dumbbells (30, p. 8).

The characteristics attributed to the patent role are supported by some desires that are ascribed to the patient across the subjective positions. For example, it is written, that "Patients and families also have a desire to be more involved in the treatment of their disease and the decisions to be taken along the way" (32, p. 30) and "The patient is awakened – and now wishes to be co-producer of his own treatment" (33).

Another consistent pattern across the material and subjective positions concerns the formulated, specific expectations connected to the patient role. The patients are expected to be involved in the dialogue as decision-makers capable of taking care of their own health and perform self-care, while also taking part in developing the health care sector. E.g. the Danish Government and Health ministry state: “As a patient or relative you are expected to be actively involved in the treatment and care … based on the principle of “my treatment – my decision” (32, p. 30). The Danish Government (32, p. 32) additionally states, that: “The patient role as an active partner in the treatment and the ability to be the master of one’s own disease ...”

The properties, activities, actions and expectations that are entailed in the construction of the role of the patient are created simultaneously within a premise of a given framework. Region Zealand (30, p. 5) write in their recent vision, The patient as a partner, that: “Citizens who wish to plan their own collaboration with the health care system have the opportunity to do so, within the established framework”.

We also see a pattern in the way the patients are expected to assume responsibility, not only for their own treatment and care, but also for demographic challenges. This becomes apparent when, across the subjective positions, a discursive truth appears that emphasizes the demographic challenges faced by Denmark. The constructed solution to this is that the individual patient becomes involved and takes responsibility. For example The Danish Government (34, p. 21) writes “If we are to increase life expectancy and secure better years of life for all, it is also required that the individual take responsibility and pay attention to their own health and have the desire and willingness to change their habits”.

Thus, it becomes a discursive truth that the patient role holds a responsibility toward the community and that the solutions on societal problems are placed on the patient.

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2. Regions, Regional authority. Denmark is divided into five regions, each controlled by a regional council consisting of 41 elected members. The region’s main task is the provision of health care.
Hence, we suggest that, a normative discourse occurs that describes how the patient should act and behave, and a reality is constructed where the patient is active, involved, and responsible, has relatives, is healthy, resourceful, and capable of developing the health care system. Thus, the patient is offered a role as an active team player who complies with the expectations to his/her behaviour as a patient. We thus argue, that the role of the patient must be performed within a certain framework of possibilities.

In the construction of the patient role, we identified an alternative, weaker discourse in which the patient is verbalised as a person with few resources and skills (31,35–37). This alternative and weaker discourse is only based on two subjective positions from: The Regions and The health Ministry. We identify this weaker discourse in the following: “Everyone has resources that should be put into play. But not everyone has the same resources” and “Citizens with few resources have an equal right to self-determination” (35, p. 9). The Capital Region of Denmark (37, p. 6) states that their policy will, “help and coach users, patients and relatives that do not have the necessary resources to know and understand their possibilities”. However, this discourse follows the same pattern as the main discourse, namely the pattern to mould the patient into being actively involved and thereby it follows the movement towards an “ideal patient”. Regardless of the quantity of personal resources, the patient is expected to be active. This secondary discourse is identified in only a small amount of material.

The health professionals – supportive but not performing well
Another discursive object within the network is the health professionals. Health professionals are described as being supportive, providing guidance and encouraging of patient involvement in a normative discourse, where it is described how the health professionals, relatives and patient should act:

But it is not just doctors and nurses that need to take a different approach. So do patients and relatives …
We need to apply some structural changes, but the culture among the patients and relatives also needs to be different. They need to ask about things (38).

Moreover, Region Zealand (30, p. 11) states that: “Based on the citizens’ knowledge and experience, the staff advise and guide citizens, with a view to deciding which choices suit the citizens’ needs and wishes”. This is accompanied by a discursive truth, across the subject positions and material that the health professionals are not doing well enough. An example is the following quote: “… as a minimum, the health professionals have to respect and apply the patient’s knowledge, preferences and resources in the treatment” (39, p. 4) and from patient and health unions the same distrust appears: “When will I receive the results of the tests, and in case I do not receive the results who do I then need to call ?” (40)

Involvement – a discursive truth
Across the material and subject positions expectations to the patient are voiced in connection with involvement. It is a prerequisite that the patient is active, knowledge-bearing, a competent decision-maker, obtains insight into their disease and has relatives.

In the material, a discursive pattern was that involvement is considered to be beneficial to the patient, the health professional, relatives, the health care system and society. This is taken to be a universal truism, a discursive truth that transcends all subjective positions represented in the archive: “It is absurd not to be positive about patient involvement” (41).
and “There are therefore good and forceful reasons to improve the involvement of the patient ...” (35, p. 4).

The health care system – a rethink
Another discursive object attached to the patient is the health care system. As an example, the Danish Government writes “... The health care system has to be organised so the patient involvement in decisions and their own treatment” (32, p.10). The need for the health care system to make a shift appears as a discursive truth across the subjective positions as does the iteration that a culture in which health professionals, patients and relatives prioritize the focus on active involvement does not currently exist. By discursive truth we mean a collection of statements or discourses that no one questions and therefore they become dominant and appear to be true, a discursive truth. Therefore, this construct of the health care sector as something to be rethought is made in conjunction with the truism that the health care sector needs to change in collaboration with the so-called new patient role. This interconnection is showcased when Weekly Report Monday morning (42) writes that; “It is a process of change that requires active participation from all key personnel in the health care system (...) But, without the citizen’s participation we will never cross the finish line ...” and the trade magazines writes that: ”(...) it is part of the development toward an increase in patient involvement” (43). Participation in the health care sector is thus constructed as a new and growing tendency that is established with a new patient role.

Relatives – a necessity
A fifth discursive object that can be identified across the material is the patient’s relatives, voiced as a truth that the patient and the relatives have to carry out the same activities. However, this truth is predominately present in the Regions, the Danish Government and the ministry (30,32,35–37,42,44). An example stems from one of the above quotes, in which patients and relatives are addressed in the same sentence: “The parties behind the joint statement have agreed to work for a health care system, where the citizens, patient and relatives experience that their knowledge, needs and preferences are the starting point in the entire treatment, care and rehabilitation process” (44, p. 2).

Hence, the patient role is constructed within a discursive network, in which the relatives are articulated as a significant object. Thereby an implicit truth is that “the ideal patient” not only needs to have relatives, but also needs to have relatives who, in line with the patient, assume the role of a partner that is involved, responsible, active, and develops the quality of the health care system in collaboration with the patient. As it is voiced how the patient and the relative should behave, we identify the discourse as a normative discourse.

Discursive strategy – The ideal patient is active and involved through decision making
After having identified subjective positions and discursive objects, together with the discursive network in which they are embedded, we have identified some overriding movements that can be understood as discursive strategies that affect the individual to whom they are applied. Foucault (25) describes discursive strategies as discursive constellations, a movement in the network of discourses which is not passive, but which constructs something. This means that the discursive strategy affects the reality that the citizen must take on when s/he becomes a patient. In the construction of the patient role, the strategy is to mould the patient into a position as active and involved.
The subjectification of the citizen to become a patient thereby takes place within discursive conditions of possibility, where the discursive network offers the patient a role through statements on the patient’s capabilities, competencies, own desires, actions, activities and, hereby, expectations that different positions have of the patient. In this way, a constructed reality in terms of an “ideal patient” is created. This “ideal patient” is constructed by all subjective positions through normative discourses, where the patients, along with the relatives, emerge as active, involved and decision-making discursive objects. Therefore, we argue that the strong active and involved patient with strong relatives is constructed as an “ideal patient” and a discursive truth that may define possibilities and legitimize the patient role.

With the collective discursive strategy, the patient role is constructed in a one-sided reality, in which it appears as a truth that behaving as an active patient is the best for the patient. This might be part of a larger social movement and social processes that are likely to have significant consequences for the patient.

Discussion

We argue that the “active and involved patient” is as a constructed reality, a discursive truth that the patient should strive to achieve. This construction is anchored in implicit assumptions about which characteristics the patient should display. We found that: the patient must be active, knowledge-bearing, a competent decision-maker, obtain insight into own disease, and have supportive relatives.

With reference to Foucault (25), we suggest that it is useful to understand the construction of the patient as a contemporary product of major social processes embedded in a historical and social context. Foucault writes (45, p. 782): "We can say that all types of subjectivation are derived phenomena, that they are merely the consequences of other economic and social processes: forces of production, class struggle, and ideological structures which determine the form of subjectivity".

Our analysis is in line with Mik-Meyer and Villadsen (46), who argued that the increasingly rampant individualization process, experienced in today’s Western society, has several implications. One of them is that the citizen is made responsible for their own situation, when it comes to their healing, learning, treatment or integration. The ideal citizen is therefore a person who acts responsibly and recognizes him/herself as playing a leading role in solving his or her own problems (46).

Governmentality

The process through which citizens are governed to become the sought-after individual is termed “governmentality” by Foucault (25) and elaborated by Dean (47), who uses the governmentality concept in a broad diagnosis of the Western world’s management principles, rationalities and trends. Dean argues that the concept is constituted by more or less organized ways in which, at a given point in time and place, we think, practice and perform activities such as care (47). According to Foucault (45), the individual is objectified and individualized at the same time, in a complex process.

This objectification occurs at the same time as the patient is subjectified through self-technologies performed by the patients themselves. With reference to Mik-Meyer and Villadsen (46), we suggest that the individual is constantly being constructed in the role as a patient.

In the construction of the role of the patient, the starting point is that the patient can freely choose and act as a subject. Foucault (45, p. 790) writes that
Power is exercised only over free subjects, and only insofar as they are free. By this we mean individual or collective subjects who are faced with a field of possibilities in which several ways of behaving, several reactions and diverse comportments, may be realized (45, p. 790).

Governmentality is therefore about how we are created as actors with specific capabilities and options for actions (45,47).

Dean describes how we control ourselves and others in accordance with different truths concerning our existence and characteristics as humans. Therefore, the goal of the disciplining power is to install the purpose of management in the individual’s self-management (47). In an example from the archive, The Danish Government (32) states that: “The patients can hereby themselves monitor how their health develop. This creates a larger degree of security in their daily life and they are able to avoid unnecessary contacts to and/or admissions to the hospital”. In this extracts of the text, we see how the patient are governed into taking an active part in monitoring their own health situation. Thus, we suggest that patients are governed into taking an active part in monitoring their own health situation. And this goal is reached through complex management techniques, resulting in the patients themselves assuming responsibility.

Many patients benefit from the movement towards activity and decision-making. However, those who are defined as disadvantaged in the discourse must come to terms with being unable to fulfil the discursive expectations that are attached to the role of “the ideal patient”.

Dean (47) writes that a significant divide can be identified between active citizens (who are capable of managing their own risks) and target groups (underprivileged people, risk groups, and high risk groups) that need interventions in order to handle risks and to be self-governing. Through management techniques and discipline, the patient can be helped to make him/herself an “ideal patient”.

No provision is made in the discourse for the position as a passive patient. Based on the premise that language is a practice that is doing something to that or those about which is speaks, it might be more correct to change the discourse from “patient participation”, “patient involvement” and “shared decision making” to “the patient should involve him/herself through an active patient role”. Dean (47) argues that it is easier to defend the management when the indirect reasoning is of benefit to the patients themselves. There is a risk that, through the discourse/speech of “the patient role”, health inequalities could, in fact, potentially be increased because the “disadvantaged” patients feel that they are inadequate, if they cannot live up to the role they are expected to perform.

According to Lehn-Christiansen et al. (48), despite a long-standing focus from the political position, health inequality in Denmark continues to increase.

Various researchers suggest that our welfare institutions are structured to create patients whose health problems correspond to the institution’s categories, rules and cultures and that this contributes to inequality in health in an invisible way (49–51). Dybbroe and Steenberg (51) and Beedholm and Frederiksen (52) argue that, nowadays, the effort to ensure one’s health is based far more on the characteristics of the person him/herself, one’s ability and willingness to live healthily and one’s economic and social resources. Health is very much the individual’s own responsibility.

We see a risk that, through the discourse or speech of the patient role, there is a potential for an increase in health inequality. On the other hand, several researchers and reports argue that involvement of the patient reduces health inequality (2,18–19,32,39,53–54).
Professor in nursing Marit Kirkevold advices nurses to challenge the existing discourse in nursing practice with reference to Foucault (55). Several researchers suggest that health professionals should critically reflect on the discursive truths that are implicit in the categories and discourses used by welfare institutions and to point out the effects on patients and the general population (46,52) Our article contributes a critical perspective and reflection on what emerge as obvious facts in social practices about the patient role.

Limitations
We identified recurring positions and discourses in the material, which derives from a wide range of different sources. However, we addressed only the published, written discourses, and not the discursive interplay with other discourses in contacts between patients and health professionals.

According to Foucault (56), power systems that have a tendency to prioritize some academic statements and neglect others are inlaid in the discourse. It would only be possible to access the patients’ and health professionals’ directly subjective, spoken positions through interviews. We suggest these positions are explored in future studies.

Conclusion
The patient, as an active and decision-making subject, appears in the archive as a constructed reality in terms of an “ideal patient”, a discursive truth and an indisputable good. The patient is expected to agree with this construction and strive to achieve it. Inherent in the construction are some implicit expectations of the patient, if s/he is to fulfil the ideal and become involved: the patient must be active, knowledge-bearing, a competent decision-maker, obtain insight into own disease, and have supportive relatives.

In line with Foucault, we suggest that, in today’s norm-oriented society, the patient is classified and that a specific subjection is imposed on the patient. We are aware that many patients benefit from adopting the role of the “ideal patient”. However, we also consider that, when the notion of the ideal patient is embedded in a discourse that contains certain assumed valid and true concepts, some patients might feel that they are inadequate, if they are unable to meet the expectations. We suggest that the discourse about the patient as active and decision-making might force a role upon the patient that s/he cannot fulfil. This might increase the level of inequality in health, despite intentions and arguments to the contrary.

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