CHAPTER 3

POWER AND THE CLINICAL SETTING

In 1970, the Boston Women's Health Book Collective published the forerunner to *Our Bodies, Ourselves.* With sales now exceeding 4 million, *Our Bodies, Ourselves* has become a classic, having been revised numerous times and now published in almost 20 foreign languages. The impetus for this empowering book came from a workshop discussion of women and health. The women in the workshop discovered a commonality: Each had a doctor story to tell, filled with frustration toward "doctors who were condescending, paternalistic, judgmental, and uninformative" (Norsigian et al. 1999:35).

At that time, feeling anger toward the medical profession came easily. Doctors behaved like authoritarian father figures and were trained to make unilateral decisions for their patients. In medical school, they were taught to be disrespectful, even contemptuous, of women. One example of this was the widespread practice of teaching medical students how to do pelvic examinations by using anesthetized women (Kapsalis 1997:65), hardly a situation that would teach doctors-to-be to respect a woman's body or her wishes. The medical textbooks furthered the denigration of women by showing images of ashamed women and speaking of the naturalness of male power and female submission. Thus the cover of one 1970 textbook in its eighth edition shows a naked woman attempting to cover her pubic area and breasts with her hands, as she cried out in agony. The source is a famous painting of Eve trying to conceal her shame upon her expulsion from paradise (Fisher 1988:154–156 has photos of each). Another text asserts that the "traits that compose the core of the female personality are feminine narcissism, masochism, and passivity," and that a woman should acquiesce to a man, as in a wife allowing "her husband's sex drive to set their pace" by attempting "to gear hers satisfactorily to his" (quoted in Scully and Bart 1973:1048). In yet another textbook, the author goes so far as to claim divine qualities for the gynecologist: "If he is kind, then his kindness and concern for his patient may provide her with a glimpse of God's image" (quoted in Scully and Bart 1973:1048).

Though clinician–patient relations have changed as our health care system has evolved, many women are still dissatisfied with the process of talking with their doctors. Current comments sound much like those of the 1970s. A national survey reports that women feel "talked down to" by doctors (quoted in Elderkin-Thompson and Waitzkin 1999). A witness from the inside, a female doctor, notes the anger women feel at their doctors' arrogance (Legato 1992). Another female doctor writes about the pelvic examinations her patients had experienced with other doctors: They complained that these procedures were "insensitive, embarrassing, uncommunicative, and performed in a demeaning and patronizing fashion" (Wallis 1998:xxxvii). Even reports of unauthorized pelvic examinations on anesthetized women have not ended (Kapsalis 1997:65).

A major reason for this continued dissatisfaction is the entrenched power differences in the patient–clinician relationship. This chapter explores the bases on which these power differences rest, how such power differences affect the interaction between doctor and patient, how women have resisted the dominance of doctors, and what organizational changes have supported the evolution of a more egalitarian relationship.

In this discussion, the patient will be referred to as a woman, and the doctor as a man. Despite the growing number of female doctors and the importance of other types of caregivers, such a designation still reflects the majority of health care interactions, including those that are regarded by women as least satisfying.

DOCTORS' POWER ADVANTAGE

Doctors have enormous power in their interactions with patients. Their income, education, professional status in society, and often their social class and gender, are all valued social assets that confer an advantage over the typical female patient. The doctor's power also comes from his "turf" advantage. Patients come to see doctors in a setting that is completely familiar to the doctor, but often confusing and unsettling to the patient. The doctor's interactional edge grows because he is comfortable in his street clothes covered perhaps by a white lab coat, or surgical scrubs, while the patient is often awkwardly naked with a skimpy gown, or in a passive or supine position.

Power is also about who controls resources. A primary resource in the doctor–patient interaction is information. The patient comes in a time of need, seeking access to information held by the doctor, who serves as a gatekeeper regarding the dissemination of this information. If significant health problems exist, the attendant fear and anxiety on the part of the patient make the need for information greater, but even more difficult to obtain. The personal account of a medical encounter by one sociological expert on medical interactions and gynecology is telling. Stunned that she first met the doctor as she lay disrobed on the examining table, she found herself accepting the limited information offered. Diagnosed with an ovarian mass, she was told by the doctor that she needed immediate hospitalization for testing and surgery. She did not ask for a discussion of alternatives. She left the office feeling

> *a lot less confident about my ability to cope during medical interactions. I knew from my previous research that the institutional authority of the doctor's role provided an interactional edge for the physician that placed the patient at a disadvantage. But I had been totally unprepared for how great that disadvantage would be for me—a well-informed professional woman.* (Fisher 1988:2)

A woman could gain power in this situation if she had alternative strategies to choose from. Or, as a last resort, she could simply leave the interaction if no improvement in the discourse was forthcoming. Yet few women do so. Insurance coverage and managed care arrangements that specify access to particular doctors increasingly limit options. Time, too, may constrain the individual. Getting a second opinion and perhaps making a transfer to a new doctor requires time to research the availability of doctors with similar specialities, and then wait for an open appointment, which may be several weeks away. Work schedules and other commitments may make such shopping around burdensome at best.

When a woman enters the medical office and meets the doctor, his greater power translates into the likelihood that he will set the agenda for the interaction, determine what kind of information is exchanged on what time schedule, and make the decisions. Although his power would allow him to facilitate a shared agenda, to promote symmetry (an equal exchange) in conversation, and to encourage collaborative decision-making, these outcomes are unlikely for several reasons.

Barriers to Interactional Symmetry

The male-doctor/female-patient interaction persists as an interaction among unequal parties because it replicates the gender inequalities of our society. Although medical students no longer learn from textbooks with explicitly outrageous comments about women, medical education still embraces gendered concepts. Thus, as we saw in Chapter 2, research reports may contain subtle, sexually stereotypical images, such as those of the egg and the sperm. Or medical textbooks may present information implying that the man is the norm and the woman is "the other." Moreover, the gendered division of labor in society is duplicated

in the medical setting, with men in the more powerful and prestigious positions. And doctors are trained in settings that are not exempt from sexual harassment. (See Chapter 15.) All of these factors lend support to the establishment and maintenance of an unequal playing field, one that encourages the preeminence of the doctor when interacting with women.

In addition, medical training and the culture of medicine have been physician-centered, teaching doctors that, regardless of the gender of their patients, they should be in control. Doctors spend years learning highly technical information and do so in a context that often silences the patient and treats her as an object. When doctors take medical students on rounds to make bedside visits to patients, they talk about the patients in the third person, as though the patient were not there (Mizrahi 1984). The medical model has them focus on the disease to the point where doctors may even refer to patients by their diseases, rather than by their names. They may refer to the "gall bladder in room 4," rather than to Mrs. Rhodes.

When doctors talk to patients, they also retain control by holding information back from the patient. A long-standing tradition in medicine supports the idea that the patient should not know everything; just as a doctor should not give a patient all medications in his bag, he should not give her all the information. Although doctors now share information with their patients about the diagnosis (a major change since 1960, when 90 percent of doctors did not even tell their patients of a cancer diagnosis), other information is often withheld, and doctors are of the mind-set that they should be the ones to make life and death decisions (Laine and Davidoff 1996).

Furthermore, it takes a skilled clinician to make an interaction between people of dissimilar power into a more symmetrical exchange. Yet medical school education and subsequent training as an intern and resident poorly prepare doctors in the art of medical communication. The people who plan the curriculum see time in short supply, necessitating the setting of priorities. They value biology, anatomy, and physiology courses over time spent learning bedside manners or how to interview a patient to gather maximally useful information. The emphasis on medicine as a science and on objective information as defining disease has meant that interpersonal skills are seen as so much fluff in the curriculum, with the result that the art of the interview is often neglected. As discussed later in this chapter, it was not until the 1980s that the training of medical school students in interviewing became even a small part of curricula at more progressive medical schools.

Upon leaving medical school, the doctor-in-training continues to be in situations that value and reward the learning of technical procedures. At each stage, the doctors who supervise the training of interns and residents judge them based on their technical expertise, not based on their interactional abilities. Medical students and interns become skilled in *minimizing* time with the patient so that they will have time to develop technical skills (Mizrahi 1986). They spend so much time with the technology and so little time with the patient that they learn to devalue the information they can get from a patient.

For some doctors, talking with patients is less about communicating with them than about finding opportunities to use and develop technical skills. Thus on a gynecological rotation, a resident may use his privileged position during intake to surreptitiously note which women patients are potential surgical candidates. Weeks or months later, when that resident has rotated to the surgical phase of the training, he can call up these women in order to try to convince them to have a hysterectomy (Scully 1994).

The Doctor–Patient Interaction

The powerful position of doctors, their training to focus on technical matters, and their lack of training in interviewing skills produce particular patterns of clinician–patient interactions. The doctor's goal is to discover a problem that he can diagnose and treat. He typically begins the conversation and controls it by asking closed-ended questions to elicit a yes or no answer, or a limited

description. Doctors have mastered symptom lists that script much of the interaction with patients and serve the narrow goal of eliciting objective information that can either rule out or suggest particular diagnoses (Lazare, Putnam, and Lipkin 1995:3). Patients ask few questions and are often nervous when they do (West 1993:150–151).

If the patient speaks too long, the doctor quickly interrupts her. Said one doctor, "I used to get frustrated with people because patients rambled. Now I just don't give them a chance to ramble" (Mizrahi 1984:160). Estimates are that on average, the doctor jumps in after 18 to 23 seconds (Beckman and Frankel 1984; Marvel et al. 1999). Although most patients do not have time-consuming responses to an opening question, and if allowed to talk freely, most finish in 6 to 90 seconds (Beckman and Frankel 1984; Carlson and Skochelak 1998:36; Marvel et al. 1999), the doctor cuts them off. The quick interruption means that much is missed that the patient finds important. By interrupting, the doctor may not even elicit the real reason for the visit, nor find out how much information the woman wants, or what topics she wants to cover (Putnam and Lipkin 1995).

In one study, doctors underestimated patients' desire for information in 65 percent of their interactions (Waitzkin 1984). In another, 58 percent of genetic counselors (primarily doctors) were unaware of what patients wanted to discuss (Wertz noted in Todd 1989:20). In visits with menopausal women, doctors often do not learn that women are interested in hearing about the long-term consequences of low estrogen, not the short-term effects (Randall 1993). Sixty percent of women over the course of their pregnancy report they did not discuss all the topics concerning their babies or impending labors that they had wanted to (Shapiro et al. 1983).

Some patterns of doctor–patient interaction are clearly shaped by the gender of the patient. Doctors are more dismissive of women and more likely to doubt the authenticity of their health complaints. They are more likely to underestimate a woman's understanding of medical information than a man's (Carlson and Skochelak 1998:36) and more likely to give a woman an answer that is less technical. Although women ask more questions and get more answers, they do not get more time for those answers, which turn out to be more superficial than answers given to male patients (Wallen, Waitzkin, and Stoeckle 1979:145).

Doctors seeing women and men with similar symptoms appear suspicious of the women's reports of their symptoms. They are less likely to give women a physical diagnosis based on those symptoms, and are more likely to diagnose women as having psychosomatic problems (Robbins and Kirmayer 1991). Doctors of female patients are thus less aggressive in their pursuit of the typical treatment for the given symptoms. Heart disease, discussed in Chapter 10, is an excellent example. A research and clinical tradition has led doctors to see women who complain of chest pains as "moaning and groaning" about nothing. Thus doctors are unlikely to follow up on a woman's cardiac symptoms by pursuing further diagnostic procedures and treatment options.

Doctors' training to be gatherers of objective information ill prepares them for the feeling dimension that patients bring to the interaction. Since women are more expressive than men in their presentation of symptoms, the emphasis on finding the cold, hard, physical facts disadvantages them. Doctors miss many windows of opportunity for responding with empathy to a patient's fears and concerns (Suchman et al. 1997). The expression of emotion by female patients seems instead to confuse the doctor. A study of doctors' responses to patients with cardiac symptoms demonstrated the effect that a woman's expressiveness has on her doctor. The researchers used videotapes of a female actor portraying two types of patients: an unemotive, controlled, businesslike woman, and an emotive woman who used considerable voice inflection and gesticulation. The scripts used by the actress were identical, as were the positive lab results that accompanied each tape. Only half (53 percent) of the doctors who viewed the expressive woman recommended a cardiac workup, compared to nearly all (93 per-

cent) of the doctors who viewed the woman with a more "professional" demeanor (Birdwell, Herbers, and Kroenke 1993). These differences in recommendations, based solely on presentation style, are dramatic.

Doctors' power has allowed them to encourage women to make health decisions based on only limited information. With pregnant patients, doctors suggest prenatal tests for fetal abnormalities as though they were routine procedures, without explaining the dangers of the tests and the implications of the findings. (See Chapter 14.) If an abnormality is detected, the doctor might use his position to suggest fetal surgery, appealing to the woman's "motherly duty" to do all she can for her child. The extent of risk for the mother is little discussed (Casper 1998). The duty to risk one's own health for the health of the fetus is left as an unexamined, presumptive expectation of appropriate maternal behavior.

At times doctors' recommendations move beyond powerful persuasion, and the relationship with the patient may become adversarial. Doctors have decided in some situations that women were not behaving in the best interests of their fetuses and turned to the court system to intervene on behalf of the fetuses. On the basis of such requests, courts have ordered women to have medical procedures, such as forcing pregnant women to have cesarean sections. This coercive power over women has been invoked primarily with women of low income or minority status. (See Chapter 14.)

Doctors have also used their power over patients and their views of women to perform unnecessary operations. For instance, hysterectomy, the removal of a woman's uterus and sometimes her ovaries, is the most common nonpregnancy operation for women. By age 65, about one-third of all women will have had a hysterectomy. Eleven percent of hysterectomies are performed as a lifesaving treatment for uterine, ovarian, or advanced cervical cancer (Dorin 1998). Most hysterectomies are elective. Some provide great symptom relief from benign problems such as fibroid tumors, excessive bleeding, or pain. But many hysterectomies are unnecessary and invasive operations that doctors persuade women to have. Doctors have had a very cavalier attitude toward hysterectomies:

> *I remember a common quip that I heard in medical school from the mouths of my esteemed professors.... "There seems to be no testicle bad enough to come out and no ovary good enough to stay in!" Although said with a twinkle and a smile, it captures the mind-set that makes this major procedure so overperformed. And indeed, it may well underlie the view of both women and their doctors that a hysterectomy is somehow a trivial procedure rather than the serious medical encounter that it is. (Healy 1995:186)*

Fisher's study of decision-making in hysterectomies found doctors quite willing to recommend a hysterectomy for the "benign diseases" of the nuisance of menstruation and the possibility of pregnancy. A doctor might say, "What you should do if you don't want any more children is have a hysterectomy. No more uterus, no more cancer, no more babies, no more birth control, and no more periods" (Fisher 1988:48). Influenced by the persuasive sell of the doctor and uninformed of the risks of surgery or the long-term impact, most women in her study accepted the treatment recommendations unquestioningly (Fisher 1988:44). Social class differences were apparent. Doctors were more likely to recommend hysterectomies to lower-class patients.

A doctor's power also means that any prejudices he has, whatever lack of empathy he may have for particular kinds of people, may be consequential for his patients. Women with devalued characteristics—elderly women, lesbians, women with disabilities, and minority women, among others—do not get the same kind of care and respect as other women, whose only devalued characteristic is their gender. Thus, a doctor may continue to relate to a lesbian patient as though she were heterosexual, asking inappropriate questions about sexuality and contraception (Stevens 1996), or otherwise display homophobic attitudes (Solarz 1999). A woman with physical disabilities may find the examination table incompatible with her mobility and postural restrictions (Welner

1998). An elderly woman may find that doctors' dislike of older women leads to inferior care. A woman of color may find herself excluded from decision making if her doctor is not of the same ethnic background (Cooper-Patrick et al. 1999). And a poor woman may discover that although she typically wants more information from the doctor than a middle-class woman does, she is given less (Shapiro et al. 1983) and may be forced to assume the role of "teaching material"—literally used to train future doctors rather than having her own health care be the central aspect of her visit (Fisher 1988:57). Clinic patients are routinely seen by doctors in training who are in need of experience on patients. The patients who must use clinics for medical care have little power to protest.

WOMEN RESISTING DOMINATING DOCTORS

Some women grant doctors considerable power in their interactions, acceding to a "paternalism with permission" (Allman et al. 1993), perhaps because they do not want responsibility for difficult decisions, or perhaps due to discomfort with the situation. Thus, a study of college women having pelvic examinations suggested that many decided that a passive role with no questions asked was a reasonable way to speed up an unpleasant procedure (Griffith 1997).

But many women show resistance to doctors' domination of the interaction (Todd 1993). Some women reject what the doctor says because their own relevant experiences contradict the advice (Abel and Browner 1998). If a doctor recommends exercise and limiting weight gain during pregnancy to a woman pregnant with a second child, that woman may use her experience with her first pregnancy to decide not to comply with the doctor.

Moving out of a passive interactional role with a doctor may require that women become more informed. Such was the philosophy of the Boston women who produced *Our Bodies, Ourselves.* They felt that knowledge was power, and that women should go to their doctors with a greater understanding of their bodies. Women do tend to be more active than men in the health care setting, perhaps because they are more informed, and also because they see doctors more often. They ask more questions than men do, which begins to challenge the doctors' power and may dramatically change the outcomes of the medical encounter. In a study of gynecological surgery, simply asking "Is it necessary?" generated a discussion in which a surgical solution changed from being the only option considered to one of several possibilities (Fisher 1988).

Women are increasingly armed with information. In addition to publications such as *Our Bodies, Ourselves* and newsletters from the National Women's Health Network and other groups, the Internet provides health information from medical encyclopedias, government health sites, and various organizations (see Chapter 17). Having the information is, however, not enough. To be effective with such information, women need to enter the doctor's office with specific questions in mind and resolve to get them answered. It takes hard work with one's doctor to have questions heard and answered. Active patients are still not the status quo, and doctors sometimes resist their approach, viewing them as inappropriately demanding (Carlson and Skochelak 1998; Ainsworth-Vaughn 1998).

STRUCTURAL AND LEGAL CHANGES

Important though the empowerment and resistance of individual women is in making the interaction with doctors more symmetrical and satisfying, doctors' power endures because of structural supports. Changes in medical education and culture, in organizational arrangements, and in laws are critical in facilitating a more egalitarian relationship. Fortunately, some of those changes have occurred and have established a solid foundation for more.

A 1972 case (*Canterbury v. Spence*) was an important first step, changing the doctor–patient relationship by redefining informed consent. Prior to 1972, a *physician-centered* perspective defined informed consent as what a reasonable physician

was expected to tell a patient, and was often interpreted as requiring the physician to provide little or no information. The 1972 case changed the definition of informed consent to a *patient-centered* perspective of what a reasonable patient had the right to know (Laine and Davidoff 1996). This and subsequent court rulings affirmed the duty of physicians to share information. In 1991, patients were further empowered when the federal government passed the Patient Self-Determination Act, which requires institutions to provide written information to patients on treatment options and advance directives, thus enabling their greater participation in health care decisions. (See Chapter 10.)

Impressive though these legal and administrative edicts were on paper, huge gaps continued to exist between the law and the real world of patient care. The change they asked of doctors was dramatic. Some doctors, skeptical of a patient's ability to participate in decision making in a meaningful way or uncomfortable with talking about terminal illness, complied only with the letter of the law (Macklin 1993). Yet these regulations and proclamations had important effects: They defined a more egalitarian ideal in the doctor–patient relationship and opened up discussion of a more patient-centered model of care.

The medical establishment has reinforced these ideals, albeit slowly, with pronouncements from committees of esteemed professionals, and changes in the medical education curriculum: An international panel of experts convened in Canada in 1991 to discuss the doctor–patient relationship; in 1993, the American College of Obstetricians and Gynecologists agreed to rethink its relationships with patients; articles in the *Journal of the American Medical Association (JAMA)* spoke of a "professional evolution" toward patient-centered care (Laine and Davidoff 1996); and prominent doctors wrote books for clinicians committed to forming more effective relationships with patients (Lipkin, Putnum, and Lazare 1995).

There are two messages from such efforts. One is pessimistic—it laments how far the profession still needs to go. Thus, although experts did get together in 1991 to discuss the doctor–patient relationship, the panel ended up with a consensus report making rather pedestrian suggestions: Avoid interrupting patients, allow patients to speak about their feelings and expectations, and listen to them to develop a clear understanding of the nature of the patient's problem (Carlson and Skochelak 1998). Part of the problem is that established doctors were trained in the old physician-centered model, and find altering their habits to be very difficult. They need to be told not to interrupt and not to impose their judgment of the situation.

The other message is optimistic. A major philosophical shift has occurred: Doctors are talking constructively about doctor–patient relationships (Carlson and Skochelak 1998). Moreover, new models of medical education that incorporate the ideas of patient-centered care move us beyond mere talk. At several medical schools, such as Wayne State (Frankel and Beckman 1993), and at Harvard's "New Pathways" program, there is training in humanistic medicine, in basic clinical interviewing skills, and in how to establish a supportive relationship with patients. This training gives medical students much earlier and more extensive contact with patients, as well as a mechanism to receive feedback on their interactional skills.

Given the importance of the pelvic examination to women's health, it is notable that improved methods of teaching pelvic examinations were an early focus of curriculum innovators (Bell 1979). The once-radical model employing gynecological teaching associates (GTAs) is now in use at most medical schools. A GTA is a woman who works as a simulated patient at the same time that she instructs medical students on the manual and communication skills essential for a proper pelvic examination (Kapsalis 1997). The GTA may tell the medical student that his technique hurts or that she is uncomfortable with the interaction. The student not only learns better techniques, but may also learn that patients have a voice.

Some of the receptivity both in medical schools and among practicing doctors to the new patient-centered model has come from a growing

body of research findings attesting to the importance of physician–patient relationships. Patients who ask more questions have better medical outcomes and greater satisfaction with care, and those patients who are able to communicate about their feelings have better medical outcomes. (See review in Carlson and Skochelak 1998.) Those who have more support and information are likely to have reduced hospital stays and recovery time (Mumford, Schlesinger, and Glass 1982). Overall, the conclusion is that more egalitarian decision making leads to better functional outcomes, greater satisfaction, and fewer malpractice suits.

Such collaboration of the doctor and the patient is not easy. Both parties to the interaction must participate, and old habits must be changed. The doctor must agree to having the patient participate, inform her sufficiently to make that participation real, and relinquish whatever remaining allegiance he has to concentrating solely on the objective, physical disease. The woman's "life world" needs to be part of the discussion. The woman must agree to become informed about her body and her health, be assertive in asking questions, and be willing to participate in making decisions about her health care.

The current health care system does not make such collaboration easy. Managed care, the relatively new third party to the doctor–patient interaction, has changed the rules of engagement. Certainly some of the early effects have been negative, with bottom line considerations causing doctors to spend less time with patients, and restricting the options they are able to offer to patients. One must hope that recent changes in the financial structure of the American health care system will not undo thirty years of improving the treatment of women in clinical settings. More doctors have now been trained in patient-centered care, which at least establishes a ground. It will be up to a new generation of activists—both doctors and patients—to see that a healthy doctor–patient relationship is part of the evolution of managed care.