Measuring power relationships with the social science yardstick—again

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Claiming Power in Doctor-Patient Talk
By Nancy Ainsworth-Vaughn
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Here is a seemingly incomprehensible fragment of a conversation between a doctor and a patient. *"You stay here, okay. . . .* Oh I'm ashamed of the people, already, that I'm not home." *Why? Wh—ashamed for—.* I don't know. *—What reason? You're in a hospital, you're not—you're not goolin' off. That's ridiculous.*[1]

The patient's initial phrase would usually be taken to mean that the speaker is ashamed of what the people are (or did, or seem, etc). But the physician, who interrupted before she had a chance to finish the phrase, processed the utterance in milliseconds and understood that she was ashamed of what the people would think of her because she was staying in the hospital. How could the doctor know what she meant? It is the miracle of spoken communication. The whole interaction between these two, in a hospital room while the patient was being examined, took six minutes. Like most conversation it was filled with information and clarifying redundancies which, by the time the patient says the problematic phrase, remove the mystery.

From telephone calls to operating rooms, virtually nothing happens in medicine in the absence of the spoken language. The major complaint that patients have about their doctors is that they don't listen to them and they don't explain things. It has been known for a long time that when doctors spend more time talking with their patients, patient cooperation is increased. Starting in the 1970s, doctor-patient communication became a subject of interest to linguists (primarily sociolinguists). Since then many papers and books have been published on the subject, and there have been endless seminars and lectures on similar themes—how to talk to patients, how not to talk to patients, and how important the subject is. The result of all this effort in improvement in physician performance is decidedly underwhelming. Twenty years ago Frederick Platt wrote about "hypocompetence" in the clinical interview and recently he checked again and found virtually no improvement.[2]

On to this scene comes Nancy Ainsworth-Vaughn's book—another attempt to analyze communication in the medical encounter and teach physicians how to speak to

patients. It is written from within her discipline, sociolinguistics, and employs discourse analysis and ethnography. She was led to this work by the experience of her mother's malignancy and her own cancer of the breast. Her particular interest is how patients "claim power" in the doctor-patient interaction. That is new, she points out, as others have been interested in doctors' exercise of power, but not that of patients. She expresses her satisfaction that she has as subjects experienced physicians and patients (most with cancer) in a private setting rather than the inexperienced doctors in clinic settings often studied by others. She wants her work to be accessible to more than a linguistics audience, but points with some pride to her technical innovations such as "new definitions for major speech activities"—topic transitions, rhetorical questions, and diagnosis. The method of transcription of the conversations is not too technical, which makes reading it comfortable. The chapter on methodology adequately explains her decision to employ both quantitative and qualitative methodologies to study these conversations. The patients are interesting and the doctors seem to be good, so that if you are interested in the subject this book may contribute to your knowledge. The problem with the book is not the intrusiveness of the author, although that takes a little getting use to; it is the general approach to the topic of communication within a special relationship and the specific issue of power.

To return to the interaction with which I opened this essay, the miracle of the physician's understanding what the patient meant is not adequately explained just by the interaction itself. The patient has a malignancy and is being treated (as with Ainsworth-Vaughn's patients) in order that she might live. Her doctor's course of treatment has made her sick and she needs help with her distressing symptoms. The patient accepts that the doctor did not intend to do her harm. She acknowledges his expertise, but she is, like so many modern patients, very knowledgeable about her disease and its treatment. The patient also has a life and family outside of her medical care and her physician is knowledgeable about such things. Theirs is a relationship of two individuals that has a past and a future; they know each other from within the relationship, but also share common cultural and social traditions. They need each other—the patient's need may be more vital, and immediate—but the doctor knows himself as a doctor in part specifically because of her. He, like all clinicians, is more aware than anyone what is riding on his decisions and the constant possibility of dangerous error. In other words, this doctor-patient relationship is both fraught with dangers and complex. In fact, in all but the most trivial human relationships, the mutual understanding and knowledge that is demonstrated, and the obedience to social rules is not easy to comprehend—the more so because it is all so taken for granted. See how little we know of relationships in general and the doctor-patient relationship specifically at this late date in a century filled with social science research.

One of the mysteries is the phenomenon of power. It is characteristic of humans that they all have and exercise varying degrees of power. There are powerful children, women, and men. This power may show itself differently in one group than in another, but it is none the less power. Some persons are intrinsically more powerful than others; some inhabit roles that exhibit power; some persons' power may fluctuate with circumstances

and life experiences; some exhibit their power quietly and others more demonstratively. Many realize their power as they mature. Others are constrained to exhibit their power by unconscious psychological determinants. Power has been labeled by Howard Brody as charismatic power (personal), the Aesculapian power to heal, and social power.[3] But, although we recognize the categories, they do not help us understand them. That Ainsworth-Vaughn considers conversational questioning as an important exercise of power suggests a relatively superficial understanding of human power. In the doctor-patient interaction, it has been my experience that some people ask loads of questions to make up for a felt lack of power, while the very parsimony of others demonstrates their power. One group of physicians—psychiatrists—shows the power of their role by remaining silent while others demonstrate it by not bothering to answer questions at all. Yet, powerlessness is a dangerous state, and physicians may cause it to happen, or conversely, as Ainsworth-Vaughn demonstrates, they may empower their patients as an important aspect of their care.

If doctors have both the capacity to cause death and save lives, they must be powerful people. . . .

Think how little we know about our own exercise of power, or the power of others. If doctors have both the capacity to cause death and save lives, they must be powerful people—whatever they may think of their own powers. Does their education train them for a life of power? When I raise the subject, they and their teachers become uncomfortable at the mere use of the word. Why, if these things are so important, do we know so little about both relationships and power? One reason is that there are ideological differences in the way relationships are viewed and power is understood. Some, for example, see virtually all relationships as defined in part by the struggle for power, the oppression of the weak by the powerful, or the struggle of the oppressed to regain power. Despite the limited usefulness of such a viewpoint, one gets that sense from this book. A more important reason, however, is the general failure of some social science methodologies to plumb the human state beyond shallow soundings. This has been commented on repeatedly throughout this century, but little changes. "The favoring of cognitive objects and their characteristics at the expense of traits that excite desire, command action, and produce passion . . . ," as John Dewey said, distorts the reality of these relationships.[4] These patients, after all, have cancer, they can die, and they need these physicians to be correct and to help save their lives! Emulation of the physical sciences—what Susanne Langer called Idols of the Laboratory—seems to continue undaunted by repeated failures to understand collective and individual human behavior.[5] When Ainsworth-Vaughn writes at length to justify her use of "qualitative" methods, it tells us that in her discipline at this late date it is still necessary to make excuses for trained subjectivity or phenomenological tools.

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Auguste Comte believed that the social sciences would help provide the basis for a world reformed and rationally guided by science; this has been their century and rational world is not yet here. Instead we have the full harvest of Comte's positivism—a world of mechanistic science and atomistic individuals that worship objective facts and are punished by their failures in the domains of subjectivity. Power? Think you presidents and moguls? Think again to the power of the dead—e.g., Descarte, Comte, Marx, Wittgenstein—to hold back inquiry into the human condition.

Notes

1. Eric J. Cassell, *Talking with Patients: Vol. 1 The Theory of Doctor-Patient Communication* (Cambridge, MA: MIT Press, 1985), 142ff.
2. Frederic W. Platt, "Clinical Hypocompetence: The Interview," *Annals of Internal Medicine* 91 (1979): 898-902.
3. Howard Brody, *The Healer's Power* (New Haven, CT: Yale University Press, 1992).
4. John Dewey, *Experience and Nature*, 2nd ed. (La Salle, IL: Open Court, 1929).
5. Susanne K. Langer, *Mind: An Essay on Human Feeling*. Vol 1 (Baltimore, MD: Johns Hopkins University Press, 1967), 33ff.