'Work', It's Good for Your Health: Power, Morality and Individuals' Subjective Perceptions of Health Status

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ABSTRACT

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This thesis examines the impact of socio-culturally conditioned doctor-patient interaction, on individual's subjective perceptions of health status. The medical encounter is a complex social situation, marked by an unequal distribution of power and control, poor patient-practitioner communication, and imperfect medical knowledge on the part of both doctors and patients. Doctors are socio-culturally endowed with a greater share of the power to impose interpretations of the situation than patients. Individuals in health crises are more vulnerable to and less likely to resist others' impressions. Qualitative analysis of eight face to face, semi-structured interviews has been used in an effort to grasp patients' subjective perceptions. This study shows that these eight respondents' perceptions of health status changed subsequent to medical encounters.

DEDICATIONS

This thesis is dedicated to several groups of people without whom I would not have been able to complete my degree. I would like to begin by thanking my committee: Dr. Susan Hoecker-Drysdale (supervisor), Dr. Deena Artzy-White (Universite de Montreal), and Dr. Vered Amit-Talai whose guidance, expertise, support, and unflagging patience were invaluable to me. I would also like to thank Dr. Dorothy Pawluch of McMaster University who read this thesis in many of its incarnations and never failed to offer emotional and intellectual support.

Heartfelt thanks to my father Douglas Low, my mother Jeanette Low, and my brother Douglas Low who encouraged and supported me through six years of higher education and suffered through countless long-distance phone calls. This thesis is also dedicated in loving memory of my Grandmother Florence Elizabeth Low (1898 - 1992).

I also wish to thank my friends, classmates and workmates who have talked me through some difficult times over the last three years. Special thanks to Val Morrison, Belinda Lee, Carol Hughes, Kelly Warren, Janice Clarini, Ellen Burton, and Sandra & Michael for their kindness and concern. This thesis is also dedicated in memory of Lucy Horne (1929 - 1992).

Finally I wish to express my gratitude to all the respondents who participated and graciously allowed me into

EPIGRAM

"Every profession is a derogation of the laity"

Bernard Shaw

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INTRODUCTION

When I wrote my original thesis proposal my research focused on small scale interaction within the medical encounter. I was specifically interested in how the process of communication, between doctors and patients, affected individual's subjective perceptions of their recovery from illness. As with many theses or research proposals, my current interests have deviated somewhat from my initial concerns. While I am still occupied with small scale interaction within the medical encounter, my attention has shifted to include how health status is constructed and made meaningful for the individual. This change was partly due to a gap discovered in the literature while researching the concepts of health and illness. I found reams of journal paper devoted to what happens to individuals once they interact with medical practitioners, but less space is allotted to the process which brings people to 'the doctor' or the process through which individuals construct health status.

This is important as the way in which patients subjectively perceive the statuses of their health can greatly affect how they use medical services and "can affect their emotional state, ... self treatment and presentation of symptoms" (Helman 1985, p.924). In turn, all of these

processes can greatly affect the individual's future evaluation and reconstruction of his/her health status.

My personal interest in the concept of health status derives not only from my academic pursuits, over the years, my family and I have spent considerable time within medical institutions and in interaction with medical professionals. On one particular occasion I was scheduled to have minor surgery and was sent for a pre-operative examination which took approximately five minutes. On the basis of what I can only describe as a superficial examination, the doctor pronounced me 'healthy', one word, presumably all inclusive. [1] Needless to say I wasn't precisely healthy as I was going to have corrective surgery for what was medically defined as a problem of ill health. I understand that what was meant in that particular context was 'healthy enough to withstand surgery' but taken out of context, it made me question assumptions I held about what 'healthy' means.

A perfunctory review of studies in medical sociology reveals that living in society requires a minimum level of social, psychological, and *physiological* competency from individuals. Before an individual seeks medical treatment, his/her health status can be both enhanced and diminished by structural and cultural conditions. An individual's lifestyle may put him or her at risk and at the same time, the health of

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[1] The doctor took my blood pressure, heart rate and asked me if I smoked.

the individual patient may be affected by his/her socio-economic status, changing economic cycles, and other structural variables. When a patient interacts with medical personnel, he/she, may receive inappropriate medication and/or suffer serious side effects, which may include developing additional health problem as a result of medical treatment (Davis 1984, Illich 1975). Most often cited as problematic and as the source of much patient dissatisfaction is miscommunication between doctors and patients. West (1984) goes further and suggests that loss of life may be the result when doctors and patients fail to communicate adequately with each other.

The medical encounter is a complex social situation, marked by an unequal distribution of power and control, poor patient/practitioner communication, and imperfect medical knowledge (Waitzkin 1989). Despite these potential obstacles to health, there is a degree of consensus in society that the ill do recover and 'health' is within the realm of possible achievements.

What interests me is the impact of structurally and culturally conditioned doctor-patient interaction on individuals' subjective perceptions of health status. The research question for this study becomes:

> What is the effect of interaction between patients and health professionals, on individual patients' perceptions of health status?

The hypothesis ensuing from this question is that individual perceptions of health status involve a complex process, in which subjective perceptions are structurally and culturally conditioned through power relations manifest in social interaction. Specifically, interaction with medical professionals leads to changes in subjective perceptions of health for individual patients. This question and hypothesis are important as exploration of these concerns will help to cover an area neglected in the literature, namely how individuals perceive the *process* of the socio-cultural construction of health status.

This research is of theoretical importance for several reasons. A better understanding of the socio-cultural construction of health status will lead to a better theoretical model of the process of the socio-cultural construction of heath status. Health status is a complex concept with both subjective and objective dimensions. On a general theoretical level, I argue that a focus on individual health status allows us an instance through which to map the interplay of structure, culture and agency. Holistic approaches are necessary as health is a complex concept including structural, cultural, and individual values. At the micro level there are both the subjective and objective dimensions of the individual experience of health status and at the macro level health status is manifest as a potent cultural symbol, structurally institutionalized as a powerful

means of social control. An individual's health status can be threatened by a lack of material resources. The economy of a society is also effected by the financial costs of treating those in health crises. A society's particular cultural beliefs about health status condition how we think about, experience and treat such crises. In turn alternative ideas about health status and the treatment of crises can change the way we think about and treat crises in health status in the future.

This research can be of practical importance as well. A better understanding of how people perceive health status and select and use health services contributes information about how to better organize services which can help to provide better care for individuals as well as helping people to better understand and cope with crises in health status.

I have chosen a case study approach to my research questions including a qualitative research design, and face to face, open-ended interviews. The interviews were used as a method of getting at individual's interpretations of their subjective perceptions of health status.

My ultimate intent then, is to move towards a multi-level theoretical framework for the study of the socio-cultural construction of health status.

CHAPTER I

LITERATURE REVIEW

Conceptual Definitions of Health and Illness

In 1968 The World Health Organization defined health as "a state of complete physical, mental and social well-being ... not merely the absence of disease" (Mechanic 1968, p.49). While this appears to be a relatively inclusive definition, it is not particularly useful for sociological purposes. An immediate question is how to operationally define 'social well-being', among other things. Mechanic (1968) argues that this definition is problematic as it fails to distinguish between healthy and "sick in an operational sense" (Mechanic 1968, p.49). Another problem, is that by this definition, 'health' becomes an utter impossibility, as it is rare to encounter a person who meets the 'completeness' criterion.

Medical sociology has tended to define ill-health through the distinct concepts of disease and illness. Coe (1978) describes disease as "an objective phenomena characterized by altered functioning of the body as a biological organism" (Coe 1978, p. 98). The concept of illness, refers to the subjective dimensions of ill-health (Helman 1985, Idler 1979). According

to Idler (1979) this "includes both behaviour changes and feelings of being sick, each ... related to the person's social context" (Idler 1979, p.723, Helman 1985).

In Medical Nemesis, Ivan Illich (1975) describes how the ideology emerged in the late 1800's which endorsed the use of medical technologies to engineer healthy societies. Its legacy can be felt in such practices as genetic screening or ultra-sound tests for birth defects. In speaking about psychiatry and the C.I.A. brainwashing experiments, Gillmor (1987) characterizes the 1950's as the "romantic-heroic era of psychiatry." out to engineer healthy psyches through the use of technologies running from lithium to lobotomies (Gillmor 1987, p.159). An unintended consequence of this ideology has been the medical objectification of health as normal and illness as abnormal, where health becomes the absence of medically defined, clinical symptoms. Idler (1979) argues that an individual's "experience of disease is ... (a) social phenomena with both ... objective and subjective dimensions" (Idler 1979 p. 723).

The individual's experience of health status is structurally conditioned by his/her relative access to material and organizational resources including time, money and social support networks. Research has shown a statistical relationship between the degree to which the individual is marginalized and vulnerability to illness and disease (Bolaria & Dickinson 1988). Their experience is also

conditioned culturally by differing lay and professional interpretations of the symbolic meaning of health. Imposition of the medical model in medical encounters can have grave implications for individuals seeking medical help.

In a critique of the bio-medical model, Taussig (1980) claims that medical objectivity is illusionary and Waitzkin (1979, 1989) argues that medical knowledge is rarely absolute. For example, Mechanic (1968) reported that doctors often disagree over different therapy options, citing his finding that in the United States between 1946 and 1950, there were "over three hundred ... (different) methods of treatment" for peptic ulcers (Mechanic 1968, p.20). Adoption of the pathology model of disease has effectively limited sociological investigations to those issues given priority by the medical community. Mechanic (1968) claims that "biological theories of bodily functioning" ignore the psycho-social aspects of individual well-being (Mechanic 1968 p.50, Helman 1985). Helman (1985) also finds the biomedical model problematic as it ignores the fact that "how patients ... label their ill-health ... can affect their emotional state, ... self treatment and presentation of symptoms" (Helman 1985, p.924).

An alternate concept to those contained within the bio-medical model, "health status", is offered by Frankel (1984). This definitional approach sees "health status ... (as) emergent products and productions of individuals in social interaction" (Frankel 1984, p.161). According to Davis (1984)

an individual's perception of ill-health is confirmed by their social networks and Mechanic (1968) states that how individuals behave while experiencing ill-health is "a culturally and socially learned response" (Mechanic 1968, p.117, Speedling & Rose 1985). For my purposes, the concept of health status refers to health and illness as a socio-cultural process constructed by individuals in interaction.

This brief discussion of the concepts of health, illness, and health status indicates that a holistic approach to their definitions is lacking. The following discussion of theoretical models of health and illness further exemplifies this lack of theoretical holism.

Theoretical Models of Health and Illness

Studies in medical sociology can be classified within one of four traditional theoretical orientations; the structural functionalist, symbolic Interactionist, ethnomethodological & phenomenological, and conflict theory perspectives.

The distinctive foci of each of these paradigms have lead in general to reductionist theory. Micro theories, such as symbolic interactionist, ethnomethodological and phenomenological approaches, fail to account for the structural and cultural conditioning of interaction. Macro

theories, such as structural functionalist and conflict theory present the individual as a product of socio-cultural conditioning and fail to account for individuals experience and symbolic meaning (Waitzkin 1989, Pappas 1990, Gold 1977, Gerhardt 1989).

The following is a critical review of the structural functionalist, symbolic interactionist, ethnomethodological & phenomenological, and conflict theory models of health and illness.

The Structural Functionalist Model

According to Gerhardt (1989), Talcott Parsons' theory of health and illness ascribes deviance to the experience of illness. His sick role equates illness with the failure of the individual to keep well, where well means the successful carrying out of role-related activities. Gerhardt (1989) argues that subsequent structural functionalist accounts of the sick role failed to recognize that Parsons intended two models of illness; the capacity and deviance models. Adoption of the sick role within the capacity model is a negative achievement, while under the deviance model it is a positive achievement.

The capacity model refers to individual incapacity where the aetiology of illness is realized in the individual's

inability to perform his/her social role(s). Therapy consists of successful adoption of the sick role through which the individual may be returned to health and society to order. Implicit in this formulation is that the medical profession determines who may legitimately adopt the sick role. According to Cockerham (1981), Parsons' sick role is distinguished by the following four factors:

1. The ick role relieves the individual of his/her social obligations.

2. Individuals are not held responsible for their illnesses.

3. The individual is expected to make an effort to recover and should not linger in the sick role.

4. The individual is expected to rely on and collaborate with medical experts.

Central to the deviance model is that in succumbing to illness, patients derive secondary gain in the form of reduced social obligations and responsibility for their condition. This prospect of secondary gain is seen to motivate the individual towards illness or deviance. Adopting a psychoanalytical approach, Parsons linked vulnerability to illness with needs left unaddressed in primary socialization. Alternatively, deviance may result from the unconscious, uncontrollable reactions of individuals to the stresses of society; including activity and autonomy where individuals are seen to be eschewing social responsibilities and obligations

(Gerhardt 1989). Implicit in both models is the assumption that healthy is normal and that deviations in health are to be controlled within the doctor patient system of the sick role. The symbolic interactionist perspective challenges several assumptions of structural functionalist theory.

The Symbolic Interactionist Model

In reaction to structural functionalism and building on grounded theory and Lemert's labelling theory, symbolic interactionists see illness as a state of deviance produced through the perceptions and reactions of others in society. The most common reaction towards those experiencing a crisis in health status is social control in the form of medical intervention. That the 'sick' label is legitimated through the professional authority of medical professionals makes illness a political issue. The symbolic interactionist perspective also contains two models of the aetiology and treatment of illness the crisis and negotiation paradigms.

The crisis model characterizes ill health as a medical, professional construction. A definition of illness is formed by the medical community. The patient then surrenders to the expertise of the medical practitioner, where medical therapy is a punitive reaction within the total institution of the hospital (in Goffman's (1961) sense of the term). Submission

to medical authority enters the patient into a sick role which differs from the Parsonian model found in structural functionalism. One, the sick role is adopted permanently. Once the individual has internalized a label of ill health, it has a life long effect on the self of the individual. Two, the sick role is learned through interaction, not adopted through unconscious motivation or imposed by the role.

In further contrast, the crisis model does not see treatment as a necessarily restorative process. Therapy can have the effect of internalizing illness behaviours in patients and encourages deviant behaviour by isolating individuals, encouraging dependence, and associating all behaviour with illness. While this model does not posit a straightforward causal link between therapy and recovery, there is no doubt that the individual and others in the situation can see recovery to have taken place through medical treatment. According to Freidson (1970), this is due to a "placebo effect" which arises from a shared belief between patients and others that the therapeutic process works (Freidson 1970a, cited in Gerhardt 1989, p.119).

The negotiation paradigm also sees sickness as a medical, professional construction. It differs from the crisis paradigm in its notions of aetiology and therapy. The negotiation model implies that "doctors ... may bargain with patients over the meaning of symptoms ... (and) ... therapy ... consists of occasional or unavoidable use of medical services" (Gerhardt

1989, p.159). Doctors may diagnose an illness and suggest treatment but the patient makes choices as to compliance or noncompliance and is actively involved in the production of the situational definition, although doctors hold an unequal share of power in imposing definitions of the situation (Gerhardt 1989). Closely aligned with the symbolic interactionist perspective are the phenomenological and ethnomethodological approaches which also focus on the every-day interactions of individuals.

The Ethnomethodological & Phenomenological Model

The ethnomethodological and phenomenological approaches see "illness as ... intersubjectively constituted reality" (Gerhardt 1989, p.179). Illness is conceived of as trouble which arises when there is a rupture in the routine of everyday life. Efforts are then made to eliminate or reduce troublesome situations, usually in the form of "more or less punitive measures", though these measures are only brought to bear when the individual or those around him or her solicit help (Gerhardt 1989, p.190). Illness only becomes a social issue if it is perceived and reacted to by others, therefore, the aetiology of illness is the perception by others that an individuals' behaviour is problematic. The same behaviour is not defined as illness when "no intervention from ... (others)

occurs to assist in defining and/or solving the problem" (Gerhardt 1989, p.200). Therapy takes the form of intervention by others (usually medical practitioners) and may be more or less punitive in nature, depending on the moral assessment of the trouble. For example, people react differently to the victim of a car accident than to the victim of a sexually transmitted disease.

Within the perspectives of ethnomethodology & phenomenology, treatment is seen as part of the everyday world of clinical medicine where communication between doctors and patients is of paramount importance (Gerhardt 1989).

The Conflict Theory Model

Conflict theory in medical sociology sees above all else a connection between an unequal class structure, class conflict and health and illness. Doctors belong to a dominant class, and therefore have an interested role in perpetuating dominant ideologies and existing class relations, which in turn result in differential health statuses in society (Waitzkin 1989).

Contrary to the structural functionalist model, conflict theorists view illness as the statistical norm and health as a deviation from that norm. A lack of total health is seen as the aggregate sum of all obstacles faced by individuals in

society. This includes the individual's place in the social structure which greatly determines his/her vulnerability to illness and his/her ability to resist illness. In other words, resources to resist crises in health status (financial, social, emotional support) are unevenly distributed in society leaving marginalized groups more vulnerable to illness. Under conflict theory two paradigms emerge: the loss and deprivation models (Gerhardt 1989).

The loss model sees social loss (unemployment, loss of relationships, loss of home etc.) as the catalyst for ill health. Therapy in the loss model is concerned with the ability of individuals to endure forces harmful to health, where this ability is affected by differentials in personal resources such as access to medical care and standards of living. Conflict theorists argue for "patient self-help" and preventative measures over cure-oriented ideologies and practices (Gerhardt 1989, p.295).

Under the deprivation/domination model, the aetiology of disease is seen as a collective rather than individual process. Collective "inequalities in society ... result in deprivation, ... a major antecedent to morbidity" (Gerhardt 1989, p.322). The concept of domination addresses aetiology in the form of iatrogenetic disease. Iatrogenetic illnesses include such things as "therapeutic side effects, ... dependence on ... (medical) care ... (and) the medicalization of all aspects of life" (Illich 1975, ps.22-44). In this model

clinical therapy is seen as harmful to health as it discourages self reliance and fosters domination by medical professionals (Illich 1975).

The following tables summarize the structural functionalist, symbolic interactionist, ethnomethodological & phenomenological, and conflict theory models of health and illness found in Gerhardt's (1989) intellectual and political history of medical sociology.

Figure 1

STRUCTURAL FUNCTIONALIST MODEL

	CAPACITY MODEL	**DEVIANCE MODEL**
AETIOLOGY	Role failure or incapacity. The inability of an individual to perform his/her social roles.	The unconsciously motivated desire for secondary gain in the form of reduced obligations, stemming from faulty childhood socialization.
THERAPY	Sick role: the temporary relief of social obligations and responsibility for illness through compliance with medical experts	Medical social control in the form of psychotherapy.

Figure 2

SYMBOLIC INTERACTIONIST MODEL

	CRISIS MODEL	NEGOTIATION MODEL
AETIOLOGY	A medical professional construction, where the sick label is legitimated by medical professionals.	A socially constructed role, definitions of illness are a negotiated matter between doctors and patients.
THERAPY	Punitive social control in the form of medical intervention.	Medical intervention, options in therapy are negotiated between doctors and patients.

Figure 3

ETHNOMETHODOLOGICAL & PHENOMENOLOGICAL MODEL

AETIOLOGY	Illness exists when perceived by and reacted to by others in the individual's social situation.
THERAPY	Intervention by others which may be more or less punitive in nature and may or may not involve medical professionals.

Figure 4

CONFLICT THEORY MODEL

	LOSS MODEL	DEPRIVATION MODEL
AETIOLOGY	Social loss which leaves the individual more or less vulnerable to illness.	Social inequalities, domination, result in the unequal distribution of vulnerability and resistancy to illness.
THERAPY	Therapy is designed to build up the ability of individuals to resist disease, posits preventative medicine.	Medical intervention which is seen as health denying as it fosters dependency and reproduces domination through doctor/patient interaction.

Clearly all of these models are problematic or incomplete in some respect. Structural functionalist theory, has been criticised for its overly conservative bias which fails to take into account, class and sex differentials in "access to" and treatment by the medical profession (Stacy & Homans 1978, p. 286). Stacy & Homans (1978) further argue that Parsons' medical sociology is ahistorical and presents an overly optimistic representation of doctor-patient interaction. In particular, the Parsonian emphasis on the favourable aspects of illness (necessary for unconscious motivation) excludes the

undesirable aspects, including pain, "humiliation ... (and the) danger of impoverishment and deprivation" (Gerhardt 1989, p. 47). Further, while dependence can and often is a part of the experience of ill health, there may not be a causal link between illness and socialization. However therapeutic the intentions, social control has its punitive effects. Finally, defining illness as an individual's failure to keep well implies that 'healthy' is natural and normal (Gerhardt 1989, Statistics Canada 1985).

Stacy & Homans (1978) and Gold (1977) find problematic structural functionalism's lack of critical analysis of medical ideology and conceptualization of illness as a deviant role. The first two tenets of the Parsonian sick role (relief of social obligations and responsibility for illness) ignore that sick people are often not be relieved of all or any of their social duties. For example, individuals may not have not be able to afford the financial burden of taking sick time off work or may have to continue to care for their families while experiencing illness. People are also often held responsible for their illnesses, for example, in the characterization of AIDS as a 'gay plague' or retribution for an individual's decadent lifestyle. The third and fourth tenets, are problematic as it may not always be in the power of the individual to recover quickly nor in their best interest to comply with medical personnel, as in cases of inappropriate diagnoses and/or decisions about therapy.

It can be argued that illness as deviance is implicit in both of the Parsonian models. Whether or not a sick individual is formally labelled deviant, he/she may be treated as such. Adoption of any of the behaviours associated with the sick role can have the effect of classifying the individual as deviant and subjecting him or her to punitive measures varying from avoidance or isolation to formal incarceration of the sick individual in a medical institution (Goffman 1961, Conrad & Scnieder 1980, Gerhardt 1989).

Idler (1979) suggests that structural functionalism's concentration on the sick role effectively disregards the symbolic meaning of ill health which makes it more than just behaviours attached to a role. Individuals may well reject the sick role and the stigma attached to it and/or hold other roles outside of and in addition to the sick role.

Gerhardt (1989) charges that the definitional emphasis of the symbolic interactionist paradigm ignores the objective notion of biological pathology. Stacy & Homans (1978) argue that the symbolic interactionist approach is methodologically faulty and has yet to operationalize such variables as the structural forces and constraints which impinge on individual health status. The crisis paradigm sees the individual as passive in a model where illness is equated with the sick label. Conversely, the negotiation paradigm may assume an unrealistic degree of power on the part of the individual. Sick people are usually not in a position to negotiate for

their best interests or may not wish to have total decision making control (Davis 1984, Strull et al 1984, Taylor & Kelner 1987). It is also important to note that patients may only negotiate over what options have been put on the table, usually by the doctor or other medical professionals. For example, a therapy option is selected by the physician, the patient then usually has the option of non-compliance but the doctors is under no obligation to suggest alternatives.

The ethnomethodological & phenomenological paradigms may be ill-equipped to account for and explain such trouble as chronic illness which constitutes a permanent rupture in the everyday lives of individuals. Conflict theory's loss model may be criticised for assuming structural determinism. Concerning the deprivation model, it can be argued that doctors are members of a dominant class in society, but I'm not sure to what extent there exists a hegemonic class consciousness among the medical community. We can not forget that doctors are individuals who hold a multiplicity of social roles, values and loyalties. Further, the deprivation model's emphasis on self reliance may be dangerous as it can lead to a situation where the individual's lack of self control is blamed for his/her illness.

Most importantly, all of these models have been criticized for practising a reductionism which differs only in the direction it takes (Pappas 1990, Gold 1977, Gerhardt 1989). The structural functionalist and conflict theory

perspectives both reduce agency to structure when an individual's health is defined as role failure or alternatively by class position. For example, not every individual who loses their job or who lives below the poverty line is doomed to a life of ill health. Structural accounts neglect that individuals have the power to mobilize resources to enhance health status. In the other direction, symbolic interactionist and ethnomethodological or phenomenological models reduce structure to agency in failing to account for structural and cultural influences and constraints on health. Survey data has shown that vulnerability to illness is linked to material and organizational conditions. How individuals experience health status is also linked to differing interpretations of health as a cultural symbol.

Pappas (1990) and Gold (1977) argue that the reductionist tendency of theory in medical sociology is due to a failure to adequately account for the issue of power. According to Pappas, when power is introduced as a variable which is both a systemic as well as a relational aspect of social life, we see the need for a theory which accounts for patient power in relation to the power of the structural and cultural conditions which surround individual patients.

Chapter II discusses the structural and cultural conditions surrounding individual health status, how agents interact within these conditions, and a discussion of power as central to understanding system-interaction relations.

CHAPTER II

THEORETICAL FRAMEWORK

As outlined in the introduction, my intent is to develop a multi-level theoretical framework for study of the social construction of health. Once involved in a medical encounter, individual agency collides with a collection of structural and cultural conditions. Before an individual seeks medical treatment, his/her health status can be both enhanced and diminished by structural and cultural processes. An individual's lifestyle or cultural background may put him or her at risk or the health of the individual patient may be affected by his/her socio-economic status, changing economic cycles, and other structural variables.

The medical encounter is a complex social situation, marked by an unequal distribution of power and control, poor communication between patients and practitioners, and imperfect medical knowledge on the part of both doctors and patients. Despite the potential constraints on health, there is a degree of consensus in society that 'healthy' is natural and normal for individuals. I have developed the following research question from my initial observations and experiences:

What is the effect of interaction between patients and health professionals, on individual patient's perceptions of health status?

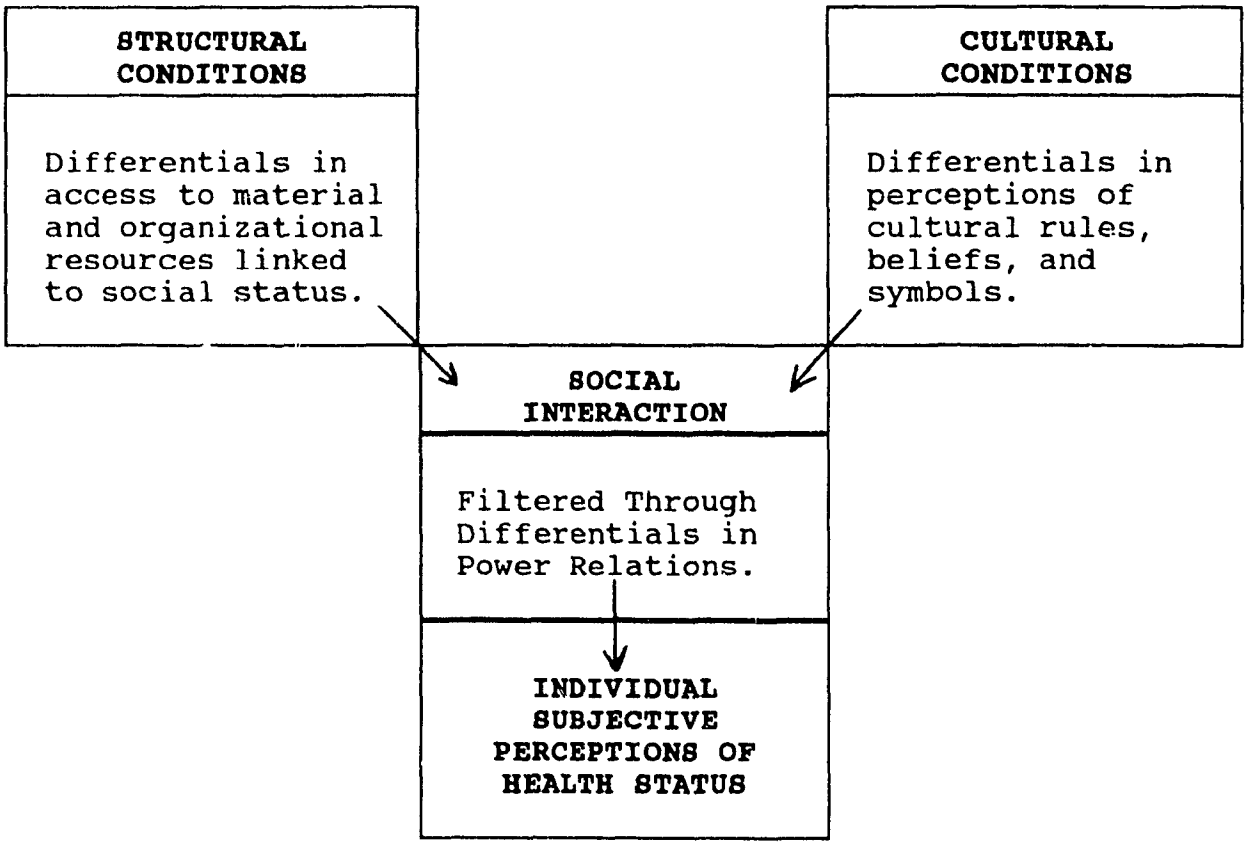
While chapter II deals with issues at the macro or systemic level (the impact of structural and cultural conditions on interaction), the focus of this research and analysis is at the micro level (that of individual's subjective perceptions of health status). This is a methodological necessity as one cannot consider both sides of the social coin at the same time (Archer 1988).

According to Berger & Luckman (1967), 'objective' reality is a social construction produced by individuals in social interaction. Social interaction is enmeshed in a complex arrangement of structural and cultural conditions. Whether acting routinely or purposefully, individuals do so with more or less awareness of past socio-cultural practices and anticipation of the future consequences of their actions. The consequences of social interaction may be intended or unintended. That individuals have the ability to reflect on both past and future action means that they are able, in Giddens' (1979) words, to act otherwise. All social interaction is filtered through power relations. When individuals interact, they routinely draw on unevenly distributed arrangements of material and organizational resources, and a framework of cultural symbols (Giddens 1979, Cohen 1985).

Despite the omnipresent and undeniable relations between structure, culture and interaction, for analytical clarity I will discuss each separately in relation to the concepts of health and individual subjectively perceived health status. This chapter will conclude with a discussion of power as a filter through which structure and culture condition interaction. The following diagram is an illustration of the theoretical framework employed in this study.

Figure 5

THE SOCIO-CULTURAL CONSTRUCTION OF INDIVIDUAL PERCEPTIONS OF HEALTH STATUS



Structural Conditions

According to Giddens (1979), the structural components of a social system include the differential arrangement and distribution of material and organizational resources, where access to these resources is affected by one's place in the social structure. Medical sociologists have likewise been interested in the relation between health and social status (Twaddle 1982, Freeman & Reeder 1957). For example, the aging process is associated with a greater vulnerability to illness and men and women suffer different illnesses (Bolaria & Dickinson, 1988). Mechanic (1972) points out the relationship between low socio-economic status and vulnerability to ill health. Gerhardt (1989) cites the negative relationship between a falling economy and the incidence of ill health in society. Ethnicity is tied to poor health status in relation to the extent to which the ethnic group is marginalized and/or lacking in social integration (Mechanic 1972).

Other studies have dealt with the structural asymmetry of doctor/patient relationships as potentially threatening to individual health status (Fisher 1984, Waitzkin 1989). The collective effects of poor health status for social structure has also been studied in terms of the financial costs of medical care and the relation between reduced production and absenteeism caused by illness (Bolaria & Dickinson 1988, Leaseman 1984).

In turn, how an individual subjectively perceives his/her health status is also affected by social status. For example, the 1981 *Health and Social Services Survey* shows that perceptions of poor health increase with age (after 44 years of age). There is only slight variation in how males and females perceive their health statuses. Socio-economic status also plays a role with respondents in the highest categories most likely to perceive their health as good. A related factor, education, was also positively linked with subjective perceptions of health. Those respondents with low levels of education are most likely to perceive their health status as poor (Statistics Canada, 1981).

The important point is that the health of individuals as well as individuals' subjective perceptions of health status are conditioned by differentials in power at the systemic level. The following section discusses how interactions within medical encounters affect social structure.

The Medical Encounter and Social Structure: Waitzkin's Micro-Political Theory

Waitzkin (1989) argues that interaction between patients and medical personnel are "micro-level processes ... (which) occur in a social context which is shaped by macro level structures in society" and that the issues of medical ideology and medical social control are intrinsically linked to the

production and reproduction of social structure (Waitzkin 1989, p. 221).

According to Waitzkin (1979, 1989), medical science, organized as an institution is closely related to prevailing structural arrangements. The medical institution functions as a purveyor of ideology, where ideology serves to both cajole and control individuals in society (Waitzkin 1979, p. 602). He maintains that in dialectical fashion, social structure is reproduced within the doctor/patient encounter. First, doctors control communication within and information given during the medical encounter. This effectively restricts the autonomy of the patient and in doing so replicates current structural patterns of domination and subordination. Second, the role of doctors as medical experts serves to keep the lay person and most aspects of his/her life under control (Illich 1975, Conrad & Schneider 1980). Social problems have also become medicalized. As a consequence, Waitzkin (1989) argues that "the societal roots of personal problems become ... depoliticized" (Waitzkin 1989, p.225). Rosenhan (1973), has pointed out that the labels of sane and insane, normal and abnormal are arbitrary yet a medically defined norm of 'healthy' behaviours and emotions has been established. Those who contravene the norm are subject to punitive measures.

Connections such as this lead Waitzkin (1989) to argue against theory which individualizes social problems as this directs attention away from patterns of "class ... oppression

in society" (Gerhardt 1989, p.266). The status quo is also protected is through "the exclusion of the social context (which) is a fundamental feature of medical language" and communication within the medical encounter (Waitzkin 1989, p.232). The very organizational structure of medical settings serves to obstruct productive communication between medical professionals and their clients. Most important of Waitzkin's (1989) observations is the notion of medicine's role in social control.

Medicine, Medical Professionals and Social Control

That medicine can function as an agent of social control has been well documented by studies in medical sociology (Conrad & Schneider 1980, In 1989, Helman 1985, Pappas 1990, Taussig 1980, Waitzkin 1989). According to Conrad & Schneider (1980), "medicine ... has replaced religion as the most powerful extralegal institution of social control" (Conrad & Schneider 1980, p.241). Even Parsons' rendering of the medical profession saw its capacity for social control, albeit, as a restorative device (Crawford 1984, Gerhardt 1979, 1989). The medical profession has cultivated an identity of *benevolent paternal judges* holding the authority to determine what is in the "best ... interests of society" (Macintyre 1973, p.129, Conrad 1987, Taussig 1980). The technical skills of medical

professionals have allowed them the authority to control through their position as medical experts.

Doctors hold the authority to determine who may legitimately adopt the sick role effectively controlling who may call themselves healthy or sick. According to Robins & Wolf (1988), Davis (1984), Idler (1979), Mechanic (1968), patients must prove to their doctors the moral legitimacy of their illness (Taussig 1980). According to Conrad & Schneider, "medical social control is the acceptance of a medical perspective as the dominant definition of certain phenomena" (Conrad & Schneider 1980, p. 242). What is problematic is that issues which are medically defined become the territory of the medical profession excluding discussion by the laity (Conrad & Schneider 1980).

According to Illich (1975), medicine has transcended biomedical bounds to claim control over almost all aspects of social life. The medicalization of deviance has been analyzed in detail by Conrad & Schneider (1980). Among other examples, they cite the replacement of criminal labels with sickness labels and the labelling of political dissidents as mentally ill as evidence of the increasing medicalization of deviance in society.

Waitzkin (1989) sees medicine as controlling individual emotions 'others' may find problematic through psychiatry and drug therapy. Illich (1975) asserts that today every stage of the life cycle requires medical management even when no

pathology is present in the individual, for instance, annual check-ups. He also argues that medical control has "expropriated the power of the individual to heal himself" or herself (Illich 1975, p.11).

The medical community has also gained control over human reproduction, medicalizing most aspects of childbirth (Illich 1975, Lorber 1975, Waitzkin 1989). Similarly, Pawluch (1985) describes how paediatrics defined childhood as a medical condition, subject to medical control, when the specialization was in danger of reduced capacity.[2] According to Conrad & Schneider (1980), medical social control is manifested in three ways: through "medical technology, medical collaboration and medical ideology" (Conrad & Schneider 1980, p.242). The following is a summary of Conrad & Schneider's three-fold thesis of medical social control.

1. Medical technology has facilitated social control through the development of pharmaceutical products, most notably the birth control pill, surgical intervention, and "genetic screening to eliminate deviant behaviour" (Conrad & Schneider 1980, p.243).

2. In their capacity as legitimators of the sick role, medical professionals collaborate with other agents and institutions of social control, most notably the criminal and judicial systems (Conrad & Schneider 1980).

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[2] The infant mortality rate had decreased through improved living conditions and the successful management of childhood diseases leaving pediatricians with fewer patients to treat. According to Pawluch (1985), "pediatricians sought a new mission in ministering to the psycho-social and behavioral needs of children. (Pawluch 1985, p.93)

3. According to Waitzkin (1989), the issues of medical ideology and medical social control are intrinsically linked. The prestige and status accorded to medical professionals does not encourage them to criticize the social structure or its dominant ideologies. In a more critical vein, Taussig (1980) states that medical social control is the manifestation of "political ideology in the guise of ... science" (Taussig 1980, p.3).

While medical social control gives doctors the capacity to exploit patients, Conrad (1987), Pappas (1990) and Wright & Morgan (1990), argue that a doctor's control over his/her patients is rarely total. Patients can exercise their autonomy is through noncompliance and by otherwise "violating the rules for good patient behaviour" (Wright & Morgan 1990, P.957).[3] Conrad (1987) concludes that non-compliance is representative of efforts on the part of patients to exert authority over management of their condition.

[3] For example, Conrad (1987) states that research has found that "one third of patients do not take medicine as prescribed ... (and) suggests that long-term compliance averages fifty percent" (Conrad 1987, p.17).

Cultural Conditions

According to Giddens (1979), culture exists as an ideological symbol system. Alternatively, in Archer's (1988), terms, the cultural system contains the sum total of all ideas that have holders. For the purposes of this study, the cultural system refers to the symbolic repertoire and rules of prescribed conduct of a society. As Mechanic (1968) points out, individuals' abilities to cope with the environment depend on the efficacy of the solutions that his ... (or her) ... culture provides" (Mechanic 1968, p.83). When individuals interact in society they do so by drawing on a common symbolic framework which they then interpret differentially (Cohen, 1985). Cultural conditions are no less important for perceptions of health status. Cultural beliefs about health and the prevention of illness can greatly affect how individuals experience the process of their health status.

Donna Davis' (1984) work underscored the cultural conditioning of subjective perceptions of individual health status. Her research focused on doctor/patient miscommunication which had arisen out of a clash of cultural interpretations of health. Her discussion dealt with how outport Newfoundland women perceived health in a cultural context very different from that of the mainland doctors. Davis found that the women she interviewed used the concept of 'nerves' as a metaphor for many symptoms of ill health. This

cultural metaphor was lost on the mainland doctor who took the complaint literally and prescribed tranquilizers not realizing that the woman was concerned about pains in her legs.

The work of Crawford (1984) examined the cultural meaning of the concept of health. In *A Cultural Account of Health*, Crawford (1984) argued that individuals perceive health as an issue of control and release. Respondents favouring the notion of control perceived health as an achievable status and defined lack of health in terms of a lack of control or "self discipline, self denial and will power" (Crawford 1984, p.66). Health for them is an achievable goal to be pursued through the realization of a healthy lifestyle, for example, exercising, adopting a healthy diet, and quitting smoking. Other respondents characterized health in terms of what Crawford (1984) called release. They saw stress as the component of life most destructive to health and argued that the key to health is "the psychological capacity for 'not worrying.'" (Crawford 1984, p.82) While these respondents emphasized that good health requires an absence of stress, they expressed disappointment about their lack of control over stress and did see aspects of their behaviours or lifestyle to be health threatening. Good health is still a valued status but those favouring the release model reject the constraints (controlling diet, giving up a habit) of the control model.

Crawford (1984) concluded that the concept of health as controlling has emerged out of the moral discourses of the

western middle class. He asserted that health has become the "perfect metaphor for values that structure our social and cultural life" including individualism, professionalism and self determination (Crawford 1984, p.77). The release notion of health is also a form of social control though not as overt. Crawford (1984) argued that the concept of "release has been appropriated to the requirements of consumption" (Crawford 1984, p.90).

Most important of Crawford's (1984) conclusions is the potency of the cultural symbol of health which figures greatly in individuals' subjective assessments of their health status. Of particular interest is the moral quality attached to the cultural symbol of health.

The Morality of Health

According to Macintyre (1973), doctors go beyond Parsons' notion of functional specificity and make decisions based "on political, moral and quasi-sociological grounds" (Macintyre 1973, p.132). In an increasingly secularized society medicine has adopted many of the functions formally served by religion (Conrad & Schneider 1980, Waitzkin 1989). Morality is reflected in the medical profession in the following three ways.

First, health is increasingly defined in moral terms. According to Mechanic (1968), "healthy is a social value" and Cockerham (1981) argues that "what makes people sick, ... (is) bound up in prevailing social norms and values" (Mechanic 1968, p.63, Cockerham 1981, p.247). Crawford (1984) found that individuals see health as an outcome of "self control, self discipline, self denial and will power" which implies that the individual is responsible for his/her health problems (Crawford 1984, p.66). In fact, the latest Statistics Canada general social survey's Health and Social Support section stressed the relationship between health problems and lifestyle (Statistics Canada 1985). Taussig (1980) argues that an emphasis on pathological models of disease "serve to adhere guilt to disease" (Taussig 1980, p.7, Crawford 1984).[4] Crawford (1984) concludes that "health is a moral discourse ... reflect(ive) of middle-class ethics" (Crawford 1984, pp.76-78).

Second, given their position as medical experts, doctors hold the authority to determine who may legitimately adopt the sick role. According to Robins & Wolf (1988), Davis (1984),

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[4] For example, Fisher (1984) describes a medical encounter where a female patient is effectively held responsible for her abnormal pap smear and seems to be blamed for "causing her medical problem by her inappropriate sexual behaviour". Her doctor told her "we don't see this (condition) in nuns", despite the fact that this particular condition is transmitted in many ways other than sexual contact (Fisher 1984, p.215). Similarly, Najman (1982) reports that older doctors tended to negatively stereotype patients with sexually transmitted diseases.

Idler (1979), Mechanic (1968), patients must prove to their doctors and others the moral legitimacy of their illness.[5]

Third, doctors have expanded their mandate and make moral judgements in areas outside of medical expertise (Conrad & Schneider 1980). Macintyre (1973) describes medical ideology as reflecting a kind of "benign paternalism" which allows doctors a moral opinion on almost any issue (Macintyre 1973, p.129).[6]

Social Interaction and Health Status

Berger & Luckman (1967) assert that individuals interact in everyday life drawing on stocks of knowledge as to how the world operates. Knowledge about the world is individually acquired through the process of socialization. It is through this interactive process that society is constructed as an objective reality. The outcome of differential power relations

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[5] A example is the need for a doctor's letter to legitimize absenteeism.

[6] An example, taken from a recent medical column in the Montreal Gazette, tells of a mother who wrote asking for advice on how to steer her son away from competitive swimming towards a sport with more lucrative career potential. While the doctor briefly discussed the physical fitness benefits of swimming, the main point of the column was to criticize the woman's value system. What is important here is not the validity of the opinions expressed in the column, but that both the doctor and the woman feel that child rearing, an issue of largely personal norms, morals and values, is a topic appropriate to a medical column. (Montreal Gazette, May 9, 1991).

determines whose version of reality will dominate.

Social interaction occurs in a present which contains both vestiges of the past and intimations of the future. In other words, the interactions of individuals are conditioned by a socio-cultural system which is antecedent to their interactions. In turn their interactions impact on future structural and cultural conditions (Berger & Luckman 1967, Giddens 1974).

According to Giddens (1974), agency refers to a specific type of action which results in "*causal interventions* ... in the on going process of events in the world" (Giddens 1974, p.55, emphasis mine).

Most contemporary studies in medical sociology have stressed the interactive quality of the socio-cultural construction of health status. Subjective perceptions of health status are constructed and made meaningful for individuals in interaction with others, especially medical others. Speedling & Rose (1985) conclude that being sick is a complex process in which individuals assess medical definitions "against their actual experiences ... the experiences of others in their social network, ... and then act accordingly" (Speedling & Rose 1985 p. 117). It is important to point out that individuals in crisis situations are particularly vulnerable to 'other' definitions of reality, especially those definitions legitimated by the authority of medical professionals (Idler 1979).

The process of communication is central to Giddens' (1974) notion of interaction. Berger & Luckman (1967) conclude that verbal communication is "the most important vehicle of reality maintenance" (Berger & Luckman 1967, p.152). Most often cited as problematic in encounters between patients and medical practitioners is the process of communication between doctors and patients. Doctors and patients come to the medical encounter with very different versions of reality. Specifically, conflict between lay and professional models of health serve to obstruct effective communication between patients and medical practitioners.

Doctor-Patient communication

Norton (1978) defines communicator style as "the way one verbally or paraverbally interacts to signal how literal meaning should be taken, interpreted, filtered or understood" (Norton 1978, cited in Buller & Buller 1987, p.375). Among other influences, the particular communicator styles adopted by doctors and patients have an impact on the effectiveness of communication, which in turn has an effect on the therapeutic process (Evans et al 1986, Pettigrew & Turkat 1986).

Buller & Buller (1987) found that, in general, doctors adopt one of two styles of communication in interaction with their patients, either "affiliation" or "control" oriented

styles (Buller & Buller 1987, p. 376). They argue that those doctors who convey the notion of affiliation in interaction with their patients were judged more favourably by patients.[7] Similarly, Robins & Wolf (1988) found that doctors who adopted "politeness strategies ... (and) asserted reciprocity" with their patients found this approach to be beneficial to the therapeutic process (Robins & Wolf 1988, p. 219).

Closely related to communicator style are personal characteristics which influence the usefulness of doctor-patient communication. (Helman 1985). According to Samora et al (1961) much of the research on doctor-patient communication has focused on the liabilities patients bring to these encounters. For example, patient's difficulties in understanding medical terminology and jargon have traditionally been seen as a constraint on effective doctor-patient communication (Evans et al 1987). In contrast, West (1984) argues that patients often understand more medical jargon than their doctors give them credit for. Freeman (1987) and Davis (1984) conclude that more problematic than the jargon, is "the role played by cultural beliefs and differing conversational styles and strategies" (Freeman 1987, p.10, Davis 1984). Helman (1985) points to differences in lay and

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[7] In a survey of 350 mothers in the United States, Mechanic (1968) found that 41% of respondents felt "a good doctor was one who takes a personal interest in patient(s)" and 37% stated that a good doctor was one who "behaves ... (in a) thoughtful, sympathetic, concerned ... (and) friendly" manner (Mechanic 1968, p.161).

professional conceptions of illness as a major impediment to productive doctor-patient communication. An associated issue is discussed in the work of Evans et al (1986) who studied the different frames of reference which doctors and patients use in understanding verbal exchanges. For example, a patient is likely to frame the word 'mammogram' within the larger concept of cancer while the doctor would be likely to reference it as a routine test (Evans et al 1986, ps.1028-1030).

The organizational structure of medical settings further serves to obstruct productive communication between medical professionals and their clients (Fisher 1984, Freeman 1987, Waitzkin 1989). Status differences between doctors and patients are also seen as barriers to effective communication (Davis 1984, Frankel 1984, Freeman 1987). Gender also has an effect. Weisman & Teitelbaum (1985) found that "on average, female physicians spend more time in face to face contact with each patient than do male physicians ... (and) male physicians may discourage communication ... with female patients" (Weisman & Teitelbaum 1985, p. 1124-1125).

Of all potential factors, *who* controls the flow of conversation has the most impact on the effectiveness of communication. According to Waitzkin (1989), Habermasian theory dictates that "domination creates distorted communication" (Waitzkin 1989, p.225). In general, when doctors and patients come together within medical institutions, the relationship is an unequal one with the

doctor in control of the communication process (Fisher 1984, Frankel 1984, Freeman 1987, Goffman 1961, Sankar 1986, Waitzkin 1989, Weiner et al 1980, West 1984). Doctors control communication in several ways. For instance, physicians gain and retain control of communication by asking the questions.[8] According to Waitzkin (1989), by questioning and interrupting patients, doctors control which subjects are to be discussed. Waitzkin (1989) asserts that the structure of the clinical encounter has traditionally included spaces for doctors to ask questions of patients, but "there is no prescribed format for doctors to give information to patients" or for patients to ask for information (Waitzkin 1989, p.231). In cases where doctors and patients begin speaking at the same time, Frankel (1984) found that it is the patients who more often stops speaking. Freeman (1987) found that doctors are likely to be unresponsive to questions asked by patients. According to Weiner et al (1980), patients may be reluctant to question their doctors as this behaviour may seem to be evidence of distrust or show the potential for non-compliance. According to Waitzkin (1989), doctor dominated communication results in gaps in the information doctors receive from their patients. Sankar (1986) found that when patients were treated at home, doctors lost the totality of control over the consultation. He argued that greater patient control of communication proved to

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[8] West (1984) found that "91% of questions ... (were) physician initiated" (West 1984, p.109).

be "a source of information concerning the patient's adaption ... to chronic illness" (Sankar 1986, p.974).

According to West (1984) and Freeman (1987), while patients may not ask many questions, doctor control of the communication process is rarely one-sided as patients can employ techniques for securing the doctor's attention by pausing, fidgeting or using facial expressions or gestures. Ineffective communication impacts on many areas of the doctor-patient relationship. Most often mentioned is that poor doctor-patient communication results in low levels of patient satisfaction (Buller & Buller 1987, Evans et al 1987, Mechanic 1968, Pfefferbaum 1982, Robins & Wolf 1988). In turn, patient satisfaction is seen as an important motive for compliance which is linked to successful therapy (Buller & Buller 1987, p.375, Evans et al 1987, Mechanic 1968, Pfefferbaum 1982, Robins & Wolf 1988). A latent effect of physician control of communication is the imposition of medical values on the problems at hand. Waitzkin (1989) argues that "the exclusion of the social context is a fundamental feature of medical language" (Waitzkin 1989, p.232). Miscommunication between doctors and patients has very real and serious implications for the therapeutic process (Evans et al 1987). West (1984) concludes that "in a medical dialogue, a life may be lost in the aftermath" of doctor-patient miscommunication (West 1984, p.107).

Power Relations

As stated at the onset of this chapter, social interaction is shaped by structural and cultural conditions which are filtered through power relations. According to Giddens (1974), material resources are "vehicles of power, comprising structures of domination, drawn upon by parties to interaction and reproduced through the duality of structure" (Giddens 1974, p.69). Power is manifest in institutional arrangements of autonomy and dependence and differential access to material and organizational resources. Power is also exhibited in the capability to define reality and to "enact or resist sanctioning processes" (Giddens 1974, p.83).

Pappas (1990) asserts that power is viewed differently by proponents of micro and macro theories. Action theory "locate(s) power in decision making ... (while) structural accounts ... examine bias ... the non-decision making constraint that determine(s) conditions" (Pappas 1990, p.200). According to Pappas (1990), the theoretical gap between structure and agency can only be reconciled with a better understanding of "power, control and domination" as well as exploitation (Pappas 1990, p.199). Pappas (1990) sees power as a variable aspect of relationships manifest in the deployment of resources.

From this perspective power is never a totally one-sided affair, and individuals, even in the most unequal

relationships are never completely powerless, though the nature of power held may not be the same. According to Pappas (1990) "domination ... is the structural asymmetry of resources drawn upon in interaction" and exploitation refers to domination linked to specific interests (Pappas 1990, p.200). In other words, power is both a structural resource and an aspect of individual action. As Archer (1988) argues, it is the interface of these powers which determines socio-cultural life.

While Pappas (1990) puts great store in the power of the autonomous individual, Strong (1979) argues that the power to choose or resist at the level of the individual may not have any connection to power relations on a structural or cultural level.

While it is popular to speak about the empowered patient as a challenge to medical authority in resisting or practising non-compliance, there are three problems with this notion. One, the patient who resists can be labelled a problem patient who is then subject to punitive measures of varying severity, from lectures to a reluctance to treat patients characterized as problematic (Najman et al 1982). Further, much non-compliant behaviour is practised covertly by patients presenting little challenge to prevailing structural arrangements. Two, the notion that the capacity to resist or choose is synonymous with power and freedom can serve as a particularly subtle form of social control. For example, that

patients are able to seek a second opinion or choose from a variety of forms of treatment can be seen as power of a sort, but it is not revolutionary power. The power that patients exercise when they make choices keeps them safely within the boundaries of traditional medical practice and does little to promote systematic change. Three, it has been documented that individuals facing a crisis in health status may neither feel powerful enough nor wish to have control over treatment decisions (Idler 1979, Strull et al 1984).

CHAPTER III

METHODOLOGY

Case Study Design

Archer (1988), Bourdieu (1990), and Giddens (1979) all advocate a methodology which somehow isolates in analysis, one or another aspect of socio-cultural life. For Archer (1988) the approach is analytical dualism, Bourdieu (1990) considers the two moments of social reality, and Giddens (1979) advocates methodological bracketing. This type of isolating out an area of study is epistemologically necessary as " 'parts' (structure and culture) ... and 'people'(agency) are *not* co-existent through time", though there are undeniable relationships between them (Archer 1988, p.xii). Therefore the research design for this study involves looking at only one aspect of the socio-cultural construction of health status individual's interpretations of his/her subjective perceptions, giving attention to how these perceptions are affected by structurally and culturally conditioned power relations within interaction.

The most appropriate approach to the research questions raised in this study are best approached by a qualitative

methodology as individuals' interpretations of subjective perceptions are being explored. I have not attempted to directly observe the phenomena of the socio-cultural construction of health status. Rather I 'ground' the theoretical framework in the meaning people attribute to their subjective perceptions. According to Glazer & Strauss (1967), qualitative data is as valid a source of evidence as quantitative data, especially when the choice is an exploratory or descriptive analysis.

According to Yin (1989), qualitative analysis of case studies are recommended when 'how' or 'why' questions are asked, when they concern contemporary phenomena, when they do not require control over behavioral events, and in cases where there are too many variables for effective quantitative analysis (Yin 1989, p.17). This is certainly the case for this design which looks at 'how' perceptions are affected by the complex inter-play of social structure, culture and interaction. Case studies are most amenable to and best served by a variety of sources evidence, including documentation, archival records, interviews, direct observation, participant observation, and physical artifacts (Yin 1889, p.85). One of the most important of these is the interview which represents an "essential source of case study information" (Yin 1989, p. 89). I have therefore chosen a case study approach which focuses on a content analysis, of taped and/or transcribed face-to-face, semi-structured interviews, where the unit of

analysis is the individual.

The semi-structured, open-ended, face to face interview is the most appropriate method of data collection for several reasons. This type of data gathering allows for analysis of respondent's interpretations of personal perceptions of their health statuses, as well as assessments of their relationships with their doctors. Face-to-face interviews can yield considerable insight into the motives and meanings behind the actions of individuals and the "assumptions according to which one ... construes the world" (McCraken 1988, p.17, Babbie 1986). This type of interview is a situation where the respondent does most of the talking (Babbie 1986, p.247). The interviewer's task is to guide this 'conversation' towards his/her research concerns (Babbie 1986, p.247). The hope in face to face, semi-structured interviews, is that additional information will emerge outside of questions asked during the interview and that these questions will generate further questions for subsequent interviews.

As well as establishing face validity, this design displays construct validity through the use of respondents as reviewers. External validity and reliability are sought through the use of multiple cases. A research design such as this need not establish internal validity as it does not attempt to make causal statements (Yin 1989, p.43).[9]

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[9] Face validity refers to "that quality of an indicator that makes it seem a reasonable measure of some variable " (Babbie 1986, p.555). Similar to face validity, construct

Among potential sources of error are interviewer effect, inaccurate memory on the part of the respondents, the desire of respondents to give the 'right' answers to questions asked, and the complexity and difficulty inherent in analyzing qualitative data. These sources of error are balanced by the potential in using this methodology to better understand the respondent's point of view.

Ethical concerns are addressed in this study. Respondents were all asked for their informed consent prior to the interviews and understood that their participation in the study was voluntary. They were assured that they need not answer any question that they were uncomfortable with and knew that they could end the interview at any time. Prior to the interviews, the respondents were assured of confidentiality, and were offered an opportunity to read the thesis upon its completion.

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validity refers to the development of the appropriate "operational measures for the concepts being studied" (Yin 1989, p.40). External validity refers to the degree to which the results of a study are generalizable (Yin 1989, p.41). Internal validity is concerned with the establishment of causal relationships between variables (Yin 1989, p.40). Reliability can be defined as "demonstrating that the operations of a study ...can be repeated, with the same results" (Yin 1989, p.41

Data Collection

Consistent with the case study method interviewing was the principal method of gathering data. Eight individuals were interviewed in total. A small sample size was not problematic as the intention was to generalize at the level of theory not populations (Yin 1989).

Due to the lack of a concrete sampling frame from which to select the respondents, a combination of convenience and snowball sampling were used and attempts were made to vary the sample in terms of age, gender and socio-economic status. The sample which resulted contained four women and four men with ages ranging from 20 to 62 years of age. Despite a variety of backgrounds on the part of the respondents I was less successful in varying the socio-economic statuses with the resulting sample made up of largely middle class individuals. The variation of this sample was not undertaken in an attempt to generalize to the population. It was attempted in order to validate certain of the theoretical assumptions employed in this study. Another criterion for choosing respondents concerned the particular statuses of their health. Individuals were selected on the basis of whether or not they had been to see a medical professional within a year prior to interviewing and if their illnesses were not of extreme natures, such as the common cold or terminal illnesses.

The interviews were conducted over the winter of 1992. I intentionally made the schedule flexible so questions could be added and deleted as the open-ended interviews required. The interviews lasted from an hour to an hour and a half. The interview schedule covered a year in the lives of the respondents beginning with a general description of their life at that time, covering a specific crisis in health and ending with their present assessments of their health status (A copy of this schedule appears in the appendix).

The research question and hypothesis[10] contained in this study required respondent accounts of perceptions of health status *before* as well as after the experience of a crisis in health. This was necessary as the focus of this research is the documentation of changes in subjective perceptions of health status resulting from doctor-patient interaction.

Analysis of data gained in the manner described above is notoriously difficult and requires the constant re-reading of transcribed interviews searching for patterns that may emerge.

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[10] Research Question: What is the effect of interaction between patients and health professionals, on individual patient's perceptions of health status?

Hypothesis: Individual perceptions of health status involve a complex process, in which subjective perceptions are structurally and culturally conditioned through power relations manifest in social interaction. Specifically, interaction with medical professionals leads to changes in perceptions of health for individual patients.

Data Analysis

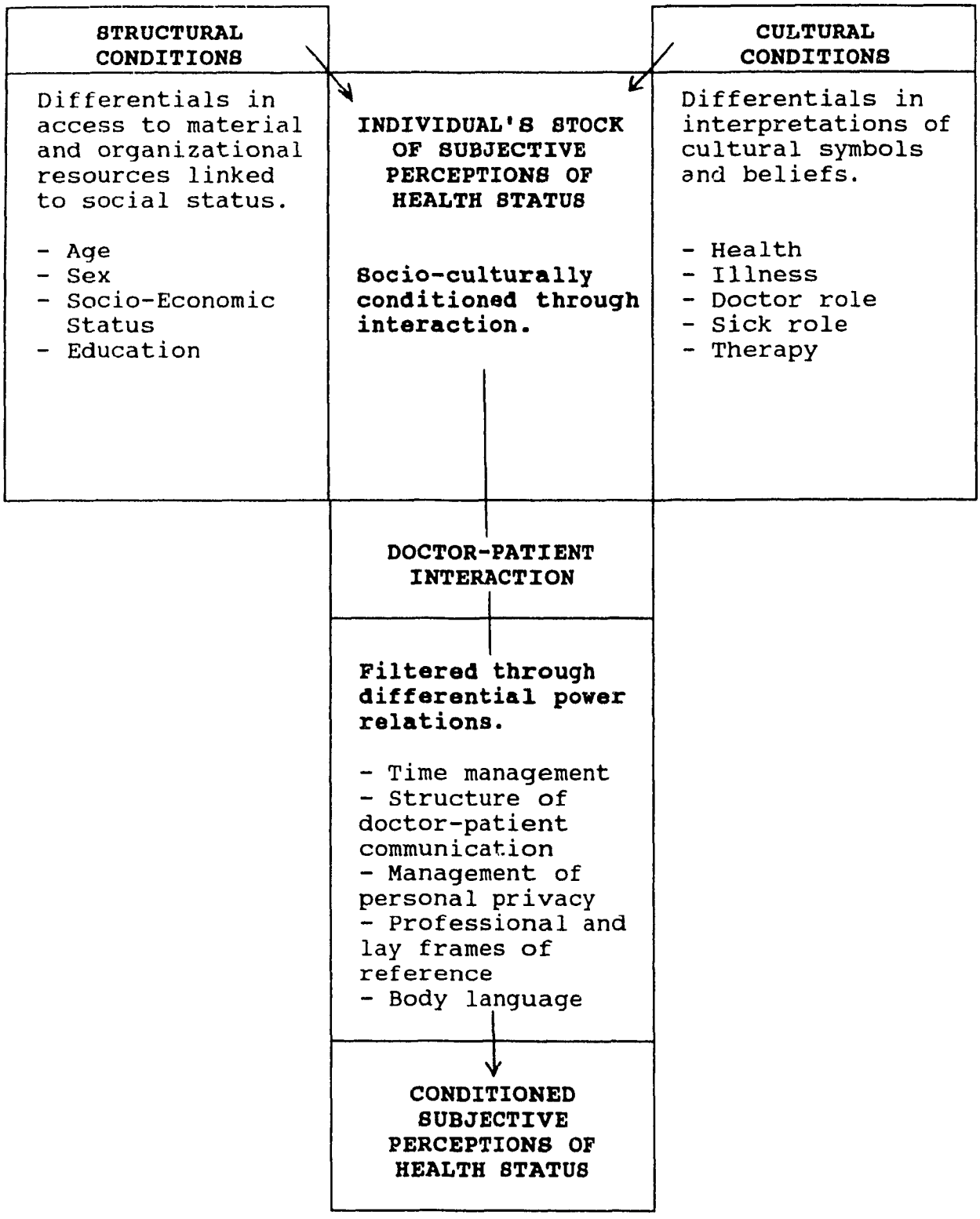
As previously stated, the method of analysis used in this study is content analysis of taped and/or transcribed open-ended semi-structured interviews. According to Holsti (1968), in its most general sense, content analysis refers to "any technique for making inferences by systematic and objective identifying special characteristics of messages" (Holsti 1968, cited in Berg 1989, p.106). More suitable to this study is a specified interpretation of content analysis as the systematic analysis of artifacts of social communication (Berg 1989). According to Berg (1989), these artifacts most often consist of written documents and/or transcriptions of audio-taped verbal communication. Berg (1989) states, one uses content analysis of the transcribed interviews looking for "similarities, dissimilarities -patterns- in the data. But one must look for these patterns systematically!" (Strauss 1990, Berg 1989, p.43) What makes content analysis systematic in application is the use of 'a recipe' of codes to organize and categorize the data under analysis. In this case the data is taped and/or transcribed verbal communication.

While not using a grounded theory approach I have adopted Strauss & Corbin's (1990) notion of open coding in the development of the 'analytic recipe' used in this study. Open coding refers to "the process of breaking down, examining, comparing, conceptualizing, and categorizing data" (Strauss &

Corbin 1990, p.61). By making comparisons within and asking questions about the data, the researchers is able to discern and label phenomena and in doing so create concepts. In turn, comparison between these concepts leads to the creation of categories and sub-categories of phenomena with discernable properties and sub-properties (Strauss & Corbin 1990). The following is a schematic representation of the analytic frame work used in this study.

Figure 6

ANALYTICAL FRAMEWORK



The framework begins with the category of the individual's stock perceptions of health status. By this I mean the stock of socio-culturally conditioned perceptions, held by individuals and carried into power relations in interaction. Ideally one would interview people before they became ill, at the onset of illness, and after they had recovered to get at their subjective interpretations of their perceptions of health status at these different times. However, this is a logistical impossibility. As a way around this methodological problem I asked respondents questions about past health-seeking behaviour as indicators of subjective perceptions of health status at that time. Questioning about past health-seeking behaviour is an indirect method of gaining information which avoids data contamination that can result from respondent's interpretation of memories of past perceptions.

As indicators of the structural conditioning of interaction, I am looking for respondents' subjective perceptions of power relations as manifest in differentials in status (including; the age, sex, socio-economic status and, level of education) and as linked to unequal access to material and organizational resources.

Similarly, cultural conditioning is indicated through power relations evident in the respondents subjective perceptions of their own and their doctor's different interpretations of cultural symbols, including health,

illness, therapy, the sick role (which includes both the role of the doctor and the role of the patient) and responsibility for illness.

Indicators of power relations within the medical encounter include control over time management, body language, lay versus professional cognitive frames of reference, the differential structure of doctor-patient communication, and control over privacy of the body within medical encounters. These variables are indicated through interpretation of respondents' accounts of conflict within encounters with medical professionals.

CHAPTER IV

FINDINGS

The Respondents

Respondent One

Respondent One was a female who was sixty-two years old at the time of interviewing. She reported that she had always lived in Montreal and spoke both English and French. She had reached a grade five level in the French school system in Quebec, a grade three level in the English system, and reported her occupation as a retired waitress. At the time of the interview she had been twice widowed and had two sons and a daughter who were over eighteen years of age. She lived with her youngest son (a schizophrenic) whom she took care of. She had recently stopped drinking after several years of heavy alcohol consumption and had reduced her cigarette smoking from sixty to thirty cigarettes a day. She did no specific exercise and her general level of activity was very low, consisting of minimal amounts of walking. Throughout the interview she expressed concern over the worry and stress she perceived in her life.

Respondent Two

My second respondent was also female and was thirty five years old when the interview was conducted. She reported that she had lived in Montreal since 1984 and spoke English and some French. She had been twice divorced and had one son over eighteen years of age from her first marriage. At the time of interviewing she was living with a sixty-two year old man as his companion/caretaker. Along with a very active life she reported that she also exercised regularly. She was a pack-a-day smoker at the time and was a moderate consumer of alcohol. Her everyday life is best described in her own words;

> *I'm a student in psychology, I'm overloaded with work, I take care of a sixty year old man who's had an aneurism and ... lacks motivation, can't read or write. He has business affairs and bills and things like that to be taken care of. He doesn't cook, he doesn't clean and it's stressful.*

Respondent Three

The third respondent was female and fifty-six years of age when interviewed. She had always lived in Montreal and reported that she speaks both English and French. She was a widow and was living with her son and daughter who were both over eighteen years of age. She had completed a bachelor of arts degree and was enroled as an independent master's student as well as working in an office as a clerk/analyst. She had recently quit a pack-a-day cigarette habit and drinks alcohol occasionally. She also described her life as stressful.

Respondent Four

The fourth respondent was male and was fifty-three years old at the time of the interview. He reported he had lived in Montreal for twenty-four years and speaks English, French and Portuguese. He was married, had three sons over the age of eighteen and was living with his wife and two youngest sons. He had completed his bachelor's degree and had begun a master's degree, as well as working full-time shift work as a telecommunications technician. He quit smoking in 1988 and said he rarely drinks alcohol. He reported his general level of activity as low and described himself as *overweight ... under exercised,* and under considerable stress.

Respondent Five

Respondent Five was a twenty-four year old male, who was unmarried with no children and was living in Montreal with a female roommate at the time. He was a full-time student who had completed his bachelor's degree and had begun a master of arts degree. In addition to his studies he worked as a teaching assistant and as a bank clerk during the summer months. He reported that he smoked half a pack a day and was a moderate consumer of alcohol. He reported his life as active although he did no specific exercise. He also perceived a great deal of stress in his life.

Respondent Six

The sixth respondent was a thirty-five year old male. He was living in Montreal at the time of the interview and reported that he spoke both English and French. He was married (common-law) and had two daughters (one a foster daughter), both under the age of eighteen years. At the time of the interview he was living with his wife and two daughters. He had undertaken independent studies towards a bachelor's degree and recently had changed careers from sales to self employment as a sports card collector and vendor. He described his life as very active and reported that he exercised regularly, including playing in a community baseball league. He reported that he rarely drinks and smokes minimally. He also described his life as very stressful.

Respondent Seven

Respondent Seven was female and was twenty-five years old at the time of the interview. She was living in Montreal and reported that she speaks both English and French. At the time the interview was conducted she was single, had had no children, and was living with her older sister. She had completed a bachelor's degree and was in the middle of a master's degree as well as working full-time as a Baptist youth pastor. She reported she does not smoke and rarely drinks. She described her life as active and reported that she exercised regularly. She described her life as stressful.

Respondent Eight

The eighth and final respondent was a male who was twenty-seven years old when the interview was conducted. He was living in Montreal and reported that he speaks English, French and dialect Italian. He was single, had no children and was living with his parents in the family home. He was a full-time student in the process of completing his bachelor's degree. At the time of the interview he reported that he drinks moderately, does not smoke, and described his life as moderately active, though he does no specific exercise. He too perceived a great deal of stress in his life.

Stock Perceptions of Health Status

When individuals come to interact in a medical setting, they do so drawing on a stock of subjective perceptions about the world including; the roles of doctors and patients, the meanings of health, illness, therapy, and recovery. This stock of perceptions arises out of past socio-culturally conditioned experiences which in turn greatly influence subsequent interaction (Berger & Luckman 1967).

By analyzing respondents' reports of past health seeking behaviour we can make inferences as to how their stocks of perceptions about health status are culturally and structurally conditioned through interaction.

The Structural Conditioning of Individual Stock Perceptions

Concerning the structural conditioning of perceptions, one female respondent perceived her health status as something she didn't have the time to maintain due to her status as a student who was also working and taking care of an elderly man. When I asked her to tell me how she knew she was ill Respondent Two answered:

> *I was just sick, I was just sick, sick, coughing, sneezing, and runny nose, it was awful, ... my nose just ran the whole week, I was too sick, I couldn't go to the doctor, I didn't have time.*

Her perception of health status maintenance as an issue of time and power was reinforced by her perception of the medical encounter as a situation where the institutionalized power of the doctor ensures that he/she legitimately holds the balance of control over time management within the encounter. It is status differentials between doctors and patients which allow for experiences such as the following, described by Respondent Two. She reported that she

> *... couldn't find the time to go and sit in an office for two hours, which is what it usually takes to see the doctor ...*

The position of the individual in the social structure also conditions his/her stock of perceptions of health status. For example, 62-year-old Respondent One incorporated into her stock perceptions the cultural belief that health status breaks down and vulnerability to ill health increases with age. She explained:

> *... it seems as I'm getting older I get more colds than I used to ...*

Gender also plays a role. As a woman with a history of uterine cancer Respondent One perceived herself as vulnerable to 'female' cancers. Subsequent to her cancer surgery, any abdominal pain she experienced was perceived as a potential cancer. She reported:

> *I had awful pains, doubled over and I thought well, me I had cancer one time maybe it was back, so of course I went to my gynaecologist.*

Her perception of her health status as vulnerable to cancer was reinforced by follow-up appointments with her doctor. Specifically, Respondent Two's perception of herself as healthy became tied to the legitimizing power of medical professionals. She has to see the doctor to know that she is healthy.

> *... I had cancer in the ... womb, but I'm healthy, no recurrence, I see the doctor twice ... twice a year, now it's twelve years.*

Structural differentials in education further condition stock perceptions of health status through differential access to information. For example, Respondent One's education was limited to the lower primary grades. She relied on folk or naive explanations of the cause of her ill-health and theorized that standing on her balcony had caused her illness. By Contrast Respondent Five, a master's level university student, who had access to information concerning sexually transmitted diseases, recognized that the burning he experienced during urination was an indication of the presence of an STD. He recounted:

> *She's a ... social work student ... she's worked in hospitals before and she's just one of these people who has every single pamphlet, from every single organization, about every single disease.*

The important point is that Respondent One was blocked by a lack of information and did not act while Respondent Five acted on information and sought medical attention.

The Cultural Conditioning of Individual Stock Perceptions

Cultural beliefs about the responsibility for crises in health status are also part of individual stock perceptions. For example, Respondent Five perceived treating his STD with antibiotics as an act of cleansing. He stated he

> *felt very dirty and ... was just glad to have something to put in my body to get rid ... of what it was.*

Stock perceptions about the respective roles of doctors and patients are also a product of cultural conditioning. Respondent Two's stock of perceptions included the culturally conditioned belief that doctors often serve in the capacity of moral judges. Her perception of her doctor's attitude towards smoking affected her perception of the worsening of her condition as well as her motivation to seek medical attention.

She stated that she

> *... had a bad feeling in the beginning of September 91 and I waited five weeks and then I went to my doctor. I waited five weeks because ... I'm a smoker and my doctor would never give me anything for my cough. So finally I was very, very sick and I had to go and she put me on ... antibiotics.*

When asked what they thought the qualities of a good doctor were, the respondents all described the role of the doctor through the cultural symbols of paternalism and professionalism. Their answers were similar to those Mechanic (1968) found in his 1968 survey of three-hundred and fifty mothers in mid-western America.[11] For example, Respondent Six stated that a good doctor is one who:

> *... listens to what you're saying ... makes me feel comfortable ... has had experience in the problems chat I am bringing to them and offers alternatives ... someone who cares about me as a human being not just a medicare card ... a doctor ... is warm, compassionate, ... talks to you as a friend ... is interested in your family and ... in things that are going on in your life.*

That our culture increasingly defines the role of the patient as responsible for knowledge about medicine in general and their health status in particular was exemplified by the following quote from Respondent Three. When asked what she

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[11] See pages 111, 112, and 113 in Appendix II for the results of three of the questions from Mechanic's (1968) survey.

thought the responsibilities of a good patient were, Respondent Three stated:

> *I am so ignorant of my body, I think I'm the worst patient. A good patient ... knows ... before entering that office what's wrong with them ... and ... I think that can only happen if you're a little in touch with yourself because ... your body gives out messages, I for one don't hear them.*

Finally, all the respondents held the culturally conditioned belief that healthy is normal and illness abnormal. All gave variations of the following quote from Respondent Two. She reported that for her, health means:

> *feeling good, being able to go through your day in a ... normal way ... by normal I mean just feeling well and moving along, not being tired, uncomfortable in any way.*

What 'normal' symbolized to these respondents is represented by the answer given by Respondent Three. She perceived healthy as normal though the attributes of health she listed seemed impossible to achieve.

> *Health to me is a state of mind, if you have a healthy mind, ... you're able to deal with other illness ... you head for the right people to make you well ... health is not necessarily just physical ... it's healthy to be dressed well ... to eat well ... to laugh ... to think good thoughts and it's healthy to have fun ... health incorporates ... your very being.*

Structure and Interaction

According to Fisher (1984), the medical encounter is marked by status differences between patients and physicians. The result of status differences, institutionalized within the structure of medical encounters, is that doctors hold the balance of power in the doctor patient-relationship (Waitzkin 1979, 1989). Within the encounter patients hold power of a different sort, the power to resist or comply rather than to control dominate or exploit (Pappas 1990, Conrad 1987).

For example, all of the respondents reported that they questioned what they had been told by their doctors; two did not comply with their doctor's recommendations. In general though, this of non-compliant behaviour was unknown to their doctors. Only one respondent related that she directly challenged her doctor and the rest have either kept their uneasiness to themselves or spoke about it with family and friends. Though Respondent Four followed his doctor's regime religiously and never challenged his doctor verbally, he did resist mentally.

> *Instead of getting any better I was getting worse. So there arises a degree of absolute, not suspicion, but mistrust that what the doctor prescribed wasn't right.*

One of the most discomfiting aspects of the medical encounter perceived by patients is the power doctors are legitimately able to exert over control of bodily privacy. Respondent One described her perceptions of fear during her doctor's explanation of a medical procedure which would invade her body.

> *... before he did the test, he told me that he was going to insert the probe into my bladder and ... I was a bit nervous because you see this big long thing, you see a monitor over there ... it's was a bit scary because you didn't know ...*

The gender of the patient is significant as a woman's body is invaded on a regular basis when she goes to the gynaecologist for a pap smear. Respondent Three perceived her pap smear as a yearly ordeal to be dreaded. She reported:

> *... you're lying on that little dwarfed table with your feet in the stirrups, with nothing on and ... the rooms are freezing ... you can ... hear the metal of the instruments and ... the garbage pail ... and then bang he's into the next ... it's such a terrible position.*

The gender of the doctor is also significant for doctor-patient interaction. Respondent Three felt that it was difficult for her to communicate (a component essential to productive interaction) with her male gynaecologist. She explained that

> *... as a female I feel it's the hardest thing, to go to a gyno. I can get around that I suppose by going to a female gyno but ... I've never had one. I don't know if there were any around when I was going to gynaecologists or having babies, but for me they were always male and while his hand is in your vagina up to his elbow, he's looking you in the eye and asking you how you're feeling, now that ... is the wrong time to ask you how you're feeling ... get your hand out and I'll be able to talk ... I'm shy, most women are.*

The very structural organization of the medical encounter serves to place doctors in control of the communication process (Waitzkin 1979, 1989). As West (1984) points out, one way doctors take control of communication within the encounter is by monopolizing questions asked, to the exclusion of questions asked by patients. When I asked Respondent Two how many questioned she had asked in a particular medical encounter she answered:

> *How many questions I asked? I didn't ask many, maybe one or two ... she asked me what my problem was ... I said that I was sick with the flu. She said that I had chronic bronchitis ... she took my blood pressure and said that I was borderline and that I should go back in two or thee weeks to get it checked ...*

One result of doctor control of communication is that patients most often give rather than receive information. For example, Respondent Three stated:

> *It was a question answer period, you know, he'd ask the questions and I'd try to answers them.*

Institutionalized procedures within medical encounters also disrupt patient initiated communication. For example, Respondent One described an encounter where she perceived that there was no point in trying to begin communication. She stated:

> *... there's no use in me talking, he's got the ear plugs ... (stethoscope) ... in and he couldn't hear ...*

Status differences between doctors and patients are manifested in who retains the power to decide what language will be used in the encounter. Respondent Eight felt that his doctor had inappropriately used his power over communication in insisting that he (Respondent Eight) speak in the language the doctor was most comfortable with.

> *My experience was negative ... he asked me to speak French, to explain in French ... after I spoke English to him.*

Differentials in education and access to knowledge are yet another of the structural conditions of the medical encounter which can effect productive communication between patients and practitioners. Respondent One, a 62-year-old

woman with a grade school education was embarrassed to disclose that she ... *couldn't say the words* ... when her doctor used technical medical jargon. Respondent Three perceived her lack of access to information as a product of the exclusionary power of the medical profession. She said:

> *It's buzzwords, ... it's a profession, it's like everything else, if you know the buzzwords you're in, but I'm not in because I don't know anything about it.*

Age is also linked to manifestations of structural power in the medical encounter. For example, Respondent Eight described an encounter where a nurse 'pulled rank' on the basis of her professional status as well as her age. He reported that he was angry when the nurse questioned the validity of his description of his symptoms. He stated:

> *It was the first time I actually talked back to somebody and she said 'young man don't raise your voice at me ... don't take that attitude with me'...*

Status differentials within the medical encounter are evident in the body language of doctors and patients. For example, Respondent Two asserted that her doctor rarely made eye contact with her and stated:

> *... she was looking at the chart ... I don't feel any doctor really pays that much attention to you ... most doctor's eyes glaze over when you're talking to them.*

Doctors hold the power to control time management within medical encounters. Respondent Two noted that it took three days to get an appointment which lasted fifteen minutes and Respondent Three stated:

> *he's trying to get to know as much about me in the fifteen minutes they allow you ... it's like a factory, in and out, in and out.*

Doctor control of time management is also manifest in the waiting patients associate with medical encounters. Respondent Three reported:

> *... my appointment was at nine o'clock, I didn't see him before ten, and I think that's because he started late, he came in late and his whole day has been late ... I think that's a chronic complaint with most doctors ... It can make you very angry, because you begin to think, who do they think they are, my time is worth as much as their's ...*

Culture and Interaction

One way the cultural conditioning of interaction is manifest is in the differing lay and professional perceptions of illness and therapy which doctors and patients bring to the medical encounter. While doctors rely on the medical model, patients employ different aetiological models of illness and

hold different assumptions about therapy. Respondent One perceived the cause of her health problem to be related to her environment. She stated:

> *I got plants in the summer galore out there ... (on a cement balcony) ... and I says ... maybe I just got a cold in my tummy, which sometimes happens ... standing out there without socks or something ....*

Her doctor diagnosed bowel trouble unrelated to environmental factors. In a subsequent conversation with her doctor, Respondent One perceived her doctor's interpretation of a particular therapy as different from her own. She reported:

> *I asked him how this fungus stuff ... (an antibiotic) ... would work ... and I says am I going to die? Is it dangerous? He says no ... the liquid antibiotics will help you, ...*

When lay and professional perceptions come into conflict it is often the case that the doctor is able to impose his/her definition of the situation. Respondent Four also saw cold floors as the cause of his symptoms and stated:

> *I wanted to blame the cold floors in the office and he ... (a company doctor) ... wouldn't back me up ...*

Respondent Three also came into conflict with her doctor over the nature of her symptoms and the appropriate means of treating them. After telling her doctor she was feeling run down and out of sorts, she reported that:

> *he said ... "are you depressed? What do you think about seeing a psychiatrist?" ... my response immediately was I'm not that depressed, because ... (seeing)... a psychiatrist has ... (the) ... connotation that you're crazy.*

Doctors' perceptions of female patients play a role here. It has been documented that women's complaints are often interpreted as psychological problems and female patients are far more likely than male patients to receive a prescription for tranquilizers (Weisman & Teitlebaum 1985).[12]

Much of the conflict reported in medical encounters results from differing lay and professional perceptions of the role of the doctor. The following quotes are examples of two respondents' idealized perceptions of the doctor's role.

> *Everyone wants someone to make them feel better like our mothers used to, I mean we all wish all doctors could be 'mom'* (Respondent Five).

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[12] A 1977 survey found that women were prescribed tranquilizers in 37% of visits to psychiatrists while men were given tranquilizers only 28% of the time. (Weisman & Teitelbaum 1985, ps.1121-1122)

> *... a good doctor ... (is) ... there when you need him ... you can depend and rely on him, and ... treats you like ... not a number, but a human being ...* (Respondent One).

These idealized perceptions are often in conflict with patients perceptions of actual encounters with medical professionals. For example, the following two respondents perceived that their doctor was not living up to their expectations.

> *... I got mad one time and I called him in his office and said look if you don't want to take care of me just tell me, I says, my cats get better treatment* (Respondent One).

> *... he didn't seem to have his shit together at all ... he never phoned me back so I decided to contact him again myself, was severely disappointed ... the shmuck!* (Respondent Six)

Cultural beliefs about the sick role also condition interaction. For example, all the respondents espoused the belief that the sick role implies compliance on the part of the patient. For example, Respondent One, Respondent Two, and Respondent Five all continued to take prescribed medication even after they began experiencing side effects. Respondent Two reported:

> *I thought I was having a stroke, so I called her up and I said, I'm acting really funny, I feel very funny, my speech is slow, I said ... I don't know what's wrong with me ...*

Yet she reported that after talking to her doctor she

> *finished off the antibiotics she had given me ... (and) ... I recovered.*

Further, doctors are culturally endowed with the power to determine who may legitimately take on the sick role. Respondent Four perceived the legitimating power doctors hold when his employer required a letter documenting his absence from work.

> *He knows I'm not the type of patient he can just tell 'stop and go home' ... I need to have all the dotted i's and crossed t's.*

Respondents Three and Eight likewise needed a doctor's letter to legitimize their absence from school. Respondent Three reported that her doctor

> *... gave me a letter and I was able to not go back ... the new semester was just starting.*

Doctors are also the designators of legitimate forms of therapy. Adherence to this cultural belief meant that none of the respondents had tried alternative forms of therapy. When I asked Respondent One if she had sought help from anyone other than a traditional medical doctor she replied:

> *... to me they're not doctors ... I've never had anything to do with them ... (a doctor) ... is someone who ... studies, knows what he's doing ...*

Closely aligned to their cultural mandate to legitimate is the role of doctors as cultural purveyors of moralistic norms for social behaviour. For example, Respondent Five perceived that going to the doctor for an AIDS test made him feel *dirty and guilty* and the following respondent resented the moral tone she perceived in her doctor's voice. According to Respondent Two,

> *She was my doctor for five years and she just looks at me and says stop smoking and she never gives me anything to help me with a cold except a lecture.*

Further, all the respondents believed that health is a matter of personal responsibility. Respondent One perceived health as an issue of personal vigilance and stated:

> *It's not as if I neglected myself, I never do, if I find there's something wrong, I don't wait around, I have it checked.*

Respondent Six also perceived that he had a responsibility to stay healthy by keeping fit and concluded that; *I find that when I work out, I get sick a lot less.*

People experiencing health crises come to the medical encounter with a stock of perceptions concerning health in general and perceptions of their health status in particular. These perceptions are subjectively interpreted by the individual and socio-culturally conditioned through power relations in interaction. Chapter V focuses on specific case examples of the effects of socio-cultural conditioning of medical encounters on individual subjective perceptions of health status.

CHAPTER V

DISCUSSION

Changes in Subjective Perceptions of Health Status

Before seeking medical attention, individuals interact with family, friends, and others concerning crises in health status. In so doing the individual constructs a definition of his/her heath status which he/she then brings to the medical encounter. As previously discussed, individuals also bring a stock of perceptions about the world including health, illness, medical professionals, and medical encounters. Once involved in the encounter the individual becomes engaged in power-ladened relationships with medical professionals. To reiterate, the research question for this study has been;

> What is the effect of interaction between patients and health professionals, on individual patient's perceptions of health status?

Whatever their perceptions of their health statuses prior to interaction, patients' subjective perceptions of health status are conditioned by interaction with medical professionals. According to Berger & Luckman (1967), doctors are culturally endowed with the structurally institutionalized

power to impose their perceptions on the medical encounter. Idler (1979) points out that individuals in crises of health status are more vulnerable to and therefore more likely to accept the medical profession's constructs of their difficulties. I propose that interaction with medical professionals leads to changes in subjective perceptions of health for individual patients. This hypothesis is examined through the following five case examples.

Case Example One

A relevant example is provided by the case of Respondent Five, a twenty-four year-old male university student, who at the beginning of the school year prior to the interview, perceived symptoms of a problem with his health status.

> *I was feeling run down ... I thought I had mono(nucleosis) ... I thought I'm too lethargic, too tired, no one else seems to feel the same way therefore I ... thought ... there was something wrong ... more than a cold, more than a flu, it just seemed to go on ... too long.*

Within his stock of perceptions, Respondent Five held specific views about mononucleosis, how it is contracted, what symptoms there are, and how the course of this illness would impact on his life. These perceptions were greatly influenced

by his interactions with a friend who had experienced a bout of mononucleosis. As Respondent Five described it

> *I was feeling under the weather and a bit drained ... a friend of mine had mono ... (I worried that) ... in my contacts with her ... (I had picked it up) ...*

He also perceived mononucleosis as something that would prevent him from *getting on with ... (his) ... life.*

> *I wanted to make sure that these weren't symptoms of something that would put me out of commission for a long time ... having to drop out of school ...*

In the period of time prior to the medical encounter he undertook no self treatment. While he discussed his condition with friends, he didn't talk about it to his parents as he wanted to avoid a moral lecture concerning his supposedly unhealthy lifestyle. He said he didn't want to hear

> *... the lecture ... about taking care of yourself and making sure you sleep and you know that you go out too much ... all the things ... you already know ...*

Worried over his possible loss of productivity, he discussed his symptoms with a friend (a social work student who had worked in a hospital) who told him he should seek medical attention. He perceived that he had a responsibility to seek medical confirmation of his perceived symptoms. He stated:

> *I ... went to ... (a university medical clinic) ... thinking I should ... just to find out for sure.*

Clearly, among his stock perceptions was the belief that medical professionals are the only ones to make legitimate diagnoses. The following is his description of his perceptions of the medical encounter. He reported:

> *They were very friendly ... I told ... (the nurse) ... what I thought was wrong and she asked questions, ... more than I necessarily thought she would. She asked why I felt this way ... we discussed other issues related to ... health and my life and lifestyle as a student and exterior to being a student ... then they did a mono spot ...*

Respondent Five's perception of the scientific legitimacy of blood tests (the mono spot) changed his perceptions of his symptoms. Despite the fact that prior to the medical encounter he thought he had contracted something worse than a cold or flu (symptoms which remained after the medical encounter), subsequent to the medical encounter he accepted the medical perception of the status of his health and stated:

> *... the mono spot was negative ... what came out of it was that there was nothing wrong with me ...*

Ironically, he also accepted the parental lecture he had earlier tried to avoid *when it came from a medical professional*. He reported that the nurse told him to

> *... just take care of myself, get plenty of rest ... and ... (that) ... I had too much calcium and ... protein in my diet ... she told me to cut down on calcium ... and that was it, I was fine.*

The relationship between interaction and perceptions was apparent to Respondent Five. He reported:

> *Of course you miraculously feel better once someone tells you there's nothing wrong with you.*

What is most important to note is that the respondent's perceptions of his health status changed after an encounter with medical professionals. Further, his perceptions that he had a moral duty to remain productive and that health status is something he is personally responsible for were reinforced within the medical encounter.

Case Example Two

Another example of changes in perceptions resulting from doctor-patient interaction concerns the case of Respondent Seven, a twenty-five year old woman who was a full-time student and a part-time youth pastor at the time the interview was conducted. Between January and March of the year prior to interviewing, Respondent Seven had detected physical symptoms of ill-health. She reported:

> *... I had been having a low-grade fever and I didn't know what was going on ... I'd get sore throats, ... headaches, I'd get ... all these ... vague symptoms that went on and on ...*

Through interaction with friends and others she described how she

> *... had heard from other people about all these syndromes ... and thought, I must have one.*

She also discussed her symptoms with her sister who

> *... said you might have mono. She ... (the sister) ... had had mono for several months ... I was really tired so I thought I had mono ...*

Within Respondent Seven's stock of perceptions was a belief in the preventative model. She believed that doctors are the legitimate authorities concerning problems of ill-health.

> *I'm very cautious about my health, if there's anything I usually call the doctor and check it out.*

After experiencing these symptoms for approximately two months, she

> *went to the doctor and ... (he found) ... nothing ... physical.*

Subsequent to that encounter she discussed her symptoms with her mother who suggested that they were related to stress.

> *I remember ... my mom ... suggested that maybe it was related to some of the emotional stuff ... (I) ... was dealing with. I said no ... it's not my emotions, I'm perfectly in control of things , it's just that I'm physically ill ...*

She reported that she returned to the doctor

> *sometime in the spring ... I went back ... and I told him again about all the symptoms and that I didn't know what it was ... I got the impression that he wasn't taking them ... (the symptoms) ... seriously ... and he said what else is going on in your life? ... He said, I'm not saying there's nothing physically wrong, I'm just saying that it's related to emotional needs.*

Respondent Seven's perception of her health status changed following this appointment.

> *Not that everything all of a sudden got better but that was a real turning point ... I still don't know really what I had but ... (now) ... I'm sure that it was related to the stress I was under.*

More specifically, she now saw her symptoms as indicators of emotional stress rather than illness or disease. Apparently she did not accept her mother's diagnosis of emotional stress until after the doctor had legitimized it.

Case Example Three

Respondent One's perceptions also underwent change subsequent to interaction with medical professionals. Prior to the medical encounter she perceived pain as an indicator that something was wrong with her. After talking to her doctor about forthcoming surgery she was prepared to see pain as part of the healing process.

> *... after the surgery you know there was pain but it was a different kind of pain it was a healing pain ... it was a different pain, it was a good pain.*

Case Example Four

The case of Respondent Two provides a further demonstration as to how patients perceptions are conditioned in interaction. Respondent Two initially perceived her condition as a cold. After seeing her doctor she received a prescription for antibiotics. Subsequently she began experiencing symptoms of, what she perceived to be, the onset of a stroke. She went to a hospital emergency ward where she was examined. When her perceptions were challenged by the medical experts in the emergency ward, she easily surrendered them. One can conclude that the scientific legitimacy of the neurological exam precipitated this change. She stated:

> *I asked them if ... (the symptoms) ... could have been from the antibiotic and they said no. I had a neurological exam ... they didn't ... find anything and ... after that ... I finished ... the antibiotics ... (and) ... I recovered.*

Case Example Five

A final example of perceptions conditioned through doctor-patient interaction concerns the case of Respondent Three, a fifty-five year old mother who worked full time at the time of the interview. During the year prior to the interview, Respondent Three experienced symptoms which she perceived as the onset of menopause. She reported:

> *My bones hurt, I thought what is happened to me ... I'd lie in bed at night and my thigh area would ache. I felt ... my personality is changing and I'm ... negative as hell and I thought there's got to be something that can help me ... so I thought ... menopause, you know the story ... we've all heard about it ... and I thought, ... it's true, it's happening to me. I really didn't want it ... to happen to me.*

She then made the decision to seek medical attention to ask about possible therapy options.

> *So I went up to see ... if anything could be done, to learn no, there's nothing really ... the gynaecologist that I was seeing at that time ... believes women should not take oestrogen.*

She left that encounter with the perception that oestrogen was not an appropriate therapy. Subsequent to that encounter she spoke to her sister who was also menopausal. Her sister felt her personality had been positively enhanced through oestrogen therapy. Respondent Three stated:

> *My sister's marvellous, she was so negative and then ended up so positive ... and I thought, that would have never happened before ... oestrogen.*

On her sister's advice and on the advice of other women Respondent Three decided to visit a menopausal clinic. According to Respondent Three,

> *I made the decision through ... talking to others ... I have a sister who swears by it, a cousin who lived with it for twenty years ... (and) ... wouldn't do without it ... a lady in a dress shop telling me ... when she's off her oestrogen, till she gets back on it she's nothing but a bitch and that's terrible. So I said O.K.*

This represents the first change in Respondent Three's perceptions. She now perceived oestrogen as a therapy which could help her. After her visit to the clinic where she was prescribed oestrogen, her views on hormonal therapy changed again. Subsequent to the second medical encounter she perceived that hormone therapy really didn't help her. She reported that having taken the oestrogen she felt

> *No different, my humour's still the same ... other than ... the supplement of calcium which ... has helped a little bit but I'm not ... (a) ... happy person ... it didn't happen for me ...*

She now does not perceive her unhappiness as necessarily linked to menopause. Further, she recognized that doctors do not always agree about therapy options and referred to the two doctors concerned as anti and pro oestrogen. Again, what is important to underscore is that each of the changes in Respondent Three's perceptions were linked to interactions with others. After receiving conflicting advice from two doctors Respondent Three's perceptiors were fundamentally influenced by those close to her.

The end result of socio-culturally conditioned medical encounters is that respondents' perceptions of 'healthy' as 'normal' and illness as a form of deviance were reinforced. According to Respondent Two, healthy is:

> *... feeling good, being able to go through your day in a relatively normal, ... way.*

and Respondent One said

> *Everything's back to normal, I don't like being sick, ... I feel pretty good ... pretty healthy.*

The most common concern expressed by the respondents concerning illness was the fear of being unable to continue working, going to school and/or other day-to-day activities. In other words, they feared being unproductive or inactive. Along side this concern was their belief in the prevention model's assumption that individuals are responsible for preventing ill health. What is common to all these perceptions is the moral tone they imply. Reworking Parsons' deviance model, it is not "the excessive demands of ... society for activity and independence" which determine individuals' perception of health, but rather it is the moral obligation to produce which is imposed by *others* on individuals through social interaction which determines perceptions (Gerhardt 1979, p.242).

Summary & Conclusion

In summation I propose that individual perception of health status is a complex process, in which subjective perceptions are structurally and culturally conditioned through power relations manifest in social interaction. Individuals assess subjective definitions of health status with medical definitions and with the definitions of others around them (Davis 1984). While both doctors and patients have the capacity to exercise power within the encounter, as Pappas (1990) points out, doctors are socio-culturally endowed with the institutionally legitimated power to control patients. Patients exercise power through resistance and non-compliance.

This study's research question asked: what is the effect of interaction between patients and health professionals, on individuals' subjective perceptions of health status? The answer found in the interviews conducted for this study supports the hypothesis that interaction with medical professionals leads to changes in subjective perceptions of health status for individual patients. The subjective perceptions of health status held by the respondents underwent changes subsequent to encounters with medical professionals. I conclude that these changes are accounted for by the socio-culturally legitimated authority of medical professionals to

impose their perceptions on patients. Individuals in crises of health status are particularly vulnerable to others', especially medical, perceptions of their health statuses. Further, the symbolic moral content of the current cultural model of health facilitates medical social control. It does so by extolling the virtues of psychological and physiological health by advocating control of one's lifestyle in order to remain active and productive.

A multi-level model of the social construction of health status takes into account all aspects of social life including the impact of 'others,' especially medical professionals as well as structural and cultural conditions which shape the actions of individuals. When individual health statuses are compromised, it can have an impact on all levels and in all orders of social life. Health is an individual as well as a socio-cultural issue (Waitzkin 1989, 1979, Illich 1975). Without adequate health status, the individual is vulnerable to impoverishment and/or other suffering. Society can also suffer in terms of the costs of health and illness, from the enormous financial burden of Canada's medicare system, to weakening of the labour force and reductions in production (Lesemann 1984). Once involved in a medical encounter, individual interaction is conditioned by structural and cultural circumstances which both enable and constrain (Giddens 1974).

This research focuses only on the impact of socio-cultural interaction on individuals' subjective perceptions of health status, one aspect of the theoretical model presented. Future research should focus on those aspects left unattended. For example, Waitzkin (1979, 1989) and Giddens (1974) conclude that social interaction necessarily reproduces prevailing systemic relations. According to Waitzkin (1979), interactions in medical settings reproduce existing relations of production in three ways; one, the doctor-patient relationship mirrors that of owners and workers, experts and lay people. Two, doctors are gatekeepers of "legitimate time off" regulating patient absenteeism in the labour force, and three, by reinforcing the work ethic by equation of health with a return to work (Waitzkin 1979, p.605). Yet Strong (1990) points out, it is possible that activity on the level of agency may not affect socio-cultural systemic relations. Individual patients can serve as medical revolutionaries if the action they take challenges prevailing structural and cultural relations though evidence from the respondents I interviewed would suggest that this is not the case. For example, the power to choose is often equated with individual autonomy and freedom. One might assume that when patients choose amongst different doctors it is because they are free to do so, yet this freedom is limited to the options made available within prevailing arrangements, neither challenging nor reinforcing socio-cultural arrangements. Future research should investigate the impact of

individual's subjective perceptions of health status (structurally and culturally conditioned through interaction) on structural and cultural relations of power.

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Appendix

INTERVIEW SCHEDULE

PART I

1. **I would like to ask you about your life and health over the last year.**

2. **Can you describe what your life was like last year?**

   work
   home
   family
   friends
   school
   daily routine
   stress
   any other activities

3. **When did you first feel sick?**

   How did you feel?
   What did you do?
   What was your illness?
   How did you find out about your illness?
   Did you self treat at all?
   What did you do?
   How did that make you feel?

4. **Did you have anyone to take care of you?**

   Who?
   What did they do?
   How did that make you feel?
   What did you do?

5. **Did your daily routine change because of illness?**

   What changed?
   How did this make you feel?
   What did you do?
   miss work
   miss school
   other responsibilities

6. **Who did you talk to about being sick?**

   Family
   Friends
   Health professionals
   Other
   How did they respond?
   How did that make you feel?

7. **When and how did you decide to go to the doctor?**

   How long was it before you went to the doctor?
   Did you try alternative or natural medicine?
   What kind of Doctor (G.P., specialist)?
   What kind of Medical practice?
   Male or female doctor(s)?

8. **What Happened at the doctors?**

   prognosis
   diagnosis
   prescription
   treatment
   options in treatment
   alternative treatment
   interaction with doctor
   communication with doctor

9. **What did You do?**

   Comply or not
   How did this make you feel?
   Was there anyone taking care of you now?
   What did they do?
   How did that make you feel?

10. **What was your life like after you went to the doctor?**

    What did you do?
    How did you feel?
    work
    school
    relationships
    family

11. **Did you have to go to the hospital?**
    What happened?
    What did you do?
    How did you feel?
    What did others do?
    How did that make you feel?

12. **How long were you ill?**

    What happened?
    What did you do?
    When did you feel better?
    Did you suffer financially?
    in relationships

13. **Has your life changed?**

    How?
    How does this make you feel?

14. When did you recover?

    What happened?
    What did you do?
    How did you feel?

15. Describe for me what your life is like now.

    How do you feel?
    What do you do?
    work
    family
    relationships

PART II

1. I would like to ask you some questions about any appointment you had with the doctor.

2. Tell me about one visit.

    How did you get the appointment?
    time
    who gave appointment
    referrals
    waiting at appointment

3. Other than the doctor, who else did you see at the appointment?

    Who were they?
    What did they do?
    How did that make you feel?
    What did you do?

4. What Happened when you saw the doctor?

What did the doctor do?
how did that make you feel?
What did you do?
behaviour of doctor
attitude
who asks questions
eye contact
body language
mutual understanding
length of appointment

5. How did you feel after the appointment?

emotionally
physically
What did you do?

PART III

1. I would like to ask you some questions that were asked in another study in 1968.

Qualities of a Good Physicians

Quality

Competent, qualified ("knows what he's doing")
Takes personal interest in patient
Way the doctor behaves(thoughtful, sympathetic
concerned, friendly, etc.)
Makes house calls
Tells patient the truth (says what he doesn't know)
Gives patient sufficient time
Way the doctor proceeds (reliable, thoughtful, careful)
Is available when you need him
Explains things so patients understand
Listens to patient

Source: Mechanic (1968), p.161

Conceptions of a Doctor Who is "Interested in His Patients"

Factor

He really cares about you and your family
Gives you sufficient time, doesn't rush you
Follows up after treatment ("calls you or
asks you to call him to tell him how you're doing")
Procedure (respectful, sympathetic, thoughtful, etc)
Listens to you, hears you out
Explains things, helps you to understand
Knows your history
Competent, qualified
Remembers your name
Makes house calls
is truthful, tells what he doesn't know

Source: Mechanic 1968, p.162

Reasons for Dissatisfaction with Doctor

Reason

Failed to do what seemed indicated
Lack of Interest
Made a wrong diagnosis
Treatment not successful
Poor personality
Not thorough or careful enough

Source: Mechanic 1968, p.162

4. I want to get self definitions of several concepts; health, healing, and illness.

ie: What does_____mean to you?

Health:
Illness/Sickness:
Healing/Recovery:

5. **How would you characterize your health today?**

PART IV

Demographic Variables:

1. Sex
2. Age
3. Place of birth
4. Marital status
5. Number of children
6. Occupation
7. Education
8. Ethnic/cultural background
9. Language
10. Sex of doctor
11. Age of doctor
12. Ethnic/cultural background of doctor
13. Type of doctor: G.P., specialist etc.
14. Language of doctor
15. smoke/doesn't smoke
16. drink/doesn't drink
17. on medication or not
18. level of activity/exercise

Appendix II

Table 5.1

Qualities of a Good Physicians Seen by Madison Mothers

Quality	% of 350 Respondents Reporting Quality
Competent, qualified ("knows what he's doing")	45
Takes personal interest in patient	41
Way the doctor behaves(thoughtful, sympathetic concerned, friendly, etc.)	37
Makes house calls	21
Tells patient the truth (says what he doesn't know)	19
Gives patient sufficient time	17
Way the doctor proceeds (reliable, thoughtful, careful)	16
Is available when you need him	15
Explains things so patients understand	14
Listens to patient	12

Source: Mechanic (1968), p.161

Table 5.2

Conceptions of a Doctor Who is "Interested in His Patients"

Factor	% of 350 Respondents Mentioning Factor
He really cares about you and your family	37
Gives you sufficient time, doesn't rush you	30
Follows up after treatment ("calls you or asks you to call him to tell him how you're doing")	25
Procedure (respectful, sympathetic, thoughtful, etc)	25
Listens to you, hears you out	22
Explains things, helps you to understand	12
Knows your history	11
Competent, qualified	11
Remembers your name	10
Makes house calls	9
is truthful, tells what he doesn't know	7

Source: Mechanic 1968, p.162

Table 5.3

Reasons for Dissatisfaction with Doctor

Reason	% of Respondents Changing Doctor Because of Dissatisfaction
Failed to do what seemed indicated	41
Lack of Interest	23
Made a wrong diagnosis	23
Treatment not successful	13
Poor personality	12
Not thorough or careful enough	11

Source: Mechanic 1968, p.162