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THE REPRODUCTION OF POWER:
MEDICAL AUTHORITY IN A WOMEN'S HEALTH CENTER

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THE REPRODUCTION OF POWER: MEDICAL AUTHORITY IN A WOMEN'S HEALTH CENTER

By

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ABSTRACT

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The purpose of this thesis is to discuss the ways in which power relations are maintained and reproduced in a women's health center. A field study, primarily based on observation, was conducted in the waiting room of such a health center located in a large midwestern city. The findings of the study show that patients' time and privacy are accorded less value than medical personnel's time and privacy. This process of differentially valuing time and privacy maintains a situation in which patients are powerless to exercise agency in this medical setting. The data also shows that clinic staff acknowledge "difference" and by assigning divergent values to people on the basis of social constructs, reproduce the current power structure. These findings suggest that to create an equitable balance of power in the physician-patient relationship, the hierarchy which exists in medical settings must be dismantled.

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INTRODUCTION

As women continue to struggle for equality in all facets of life, health care has emerged as one of the most dominant issues on the equal rights agenda. Women make up the majority of health care providers and health care consumers, yet have almost no power to influence the medical system (Salk 1984). As an institution of social control, medicine subordinates women in several ways. Medical professionals increasingly claim expertise over normal experiences in women's lives. Women are expected to see a physician for birth control, pregnancy, childbirth, menopause, and a host of other normal bodily experiences. This medicalization defines women as inherently defective throughout life.

When a woman makes her "expected" visits to a physician, she is further subordinated. "The relationship between a woman and her doctor is usually one of profound inequality on every level, an exaggeration of the power imbalance inherent in almost all male-female relationships in our society" (Salk 1984, p. 562). Women are often treated as hysterical, unreliable, and unintelligent by their physicians.

The emergence of numerous women's health centers beginning in the 1960s and continuing through the present, represents both the problems women face in the health care system and their attempts at resolving those problems. While some women's health centers provide their patients with an alternative to

the traditional, male-dominated health care system, many others serve to further subordinate women and medicalize their bodies.

To understand the dynamics of power in such a facility, I carried out a study in the waiting room of a women's health center in a large midwestern city in the United States.[1] The purpose of this thesis is to discuss the ways in which social power relations are maintained and reproduced in a women's health center. To locate my study within a theoretical framework, I begin with a discussion of how power has traditionally been explained in the field of Sociology. I then offer a brief review of feminist literature on the physician-patient relationship and next provide background information about the research site and a description of my methodology. I then present the findings of my study. In the conclusion, I discuss the implications of my findings for the physician-patient relationship.

THEORETICAL FRAMEWORK

Power is an important aspect of social relationships. Sociologists employ a number of different theories to explain the nature and distribution of power in society. The most widely accepted of these theories are functionalism, Marxism, and conflict theory. While I use a feminist analysis of power in my study, it is important to provide a general overview of these perspectives to locate my work within traditional sociological thought.

Functionalism assumes that the parts of society are organized into an integrated whole. It focuses on integration, stability, order, and cooperation (Shepard 1990). Arguing from a funcitonalist perspective, Talcott Parsons (1937)

regards power as something possessed by society as a whole rather than something which some individuals hold at the expense of others. There is no fixed amount of power in society. It can increase or decrease and is measured by the extent to which collective goals are reached in a society (Haralambos 1985).

The Marxist perspective offers a radical alternative to the functional analysis of power. Marxism maintains that political, legal, and educational institutions and belief and value systems are primarily determined by economic factors (Haralambos 1985). In all societies, some social groups are exploited by others depending upon their relationship to forces of production. Marxism rejects the idea that power is a societal resource directed by those in power for the benefit of all. Instead, "power is seen to be held by a particular group in society at the expense of the rest of society (Haralambos 1985, p. 101). The source of power lies in the economic infrastructure. The forces of production are owned by a minority of individuals. This relationship to the forces of production provides these individuals with power and the ability to exploit others.

The conflict perspective emphasizes conflict, competition, change, and constraint within a society (Giddens 1987: Schellenberg 1982). Society experiences inconsistency and conflict on all levels and is continually subject to change. Those with the most power have the most wealth, prestige, and privileges. "Segments compete and conflict as they attempt to preserve and promote their own special values and interests" (Shepard 1990, p. 22). The structure of institutions is such that those at the top of the institutional hierarchy monopolize power (Mills 1956). The less powerful are often constrained by those with more power through laws, customs, and institutional regulations. Thus,

competition for social resources is reduced and those with power can more easily retain it.

This discussion of major sociological theories of power has been intentionally brief and general. Many other theories and many variations of the above theories have not been explored. This section is intended merely as a foundation upon which to develop my analysis.

For the purposes of this thesis, I define power as

> the ability of individuals and groups to realize their will in human affairs even if it involves the resistance of others....Power provides answers to the questions of whose interests will be served and whose values will reign. Wherever we look, from families to juvenile gangs to nation states, we find that some parties disproportionately achieve their way (Vander Zanden 1990, p. 160).

This definition suggests an analysis of power based solely on the conflict perspective. Nevertheless, my study is also heavily influenced by a feminist analysis of power which links gender differences to the ability to both acquire and maintain power.

While there is no question as to the importance of power in the structuring of society, just how it is used to create and re-create the social structure is not as readily apparent. It is this mysteriousness that fosters the maintenance of society's power relations. If people cannot recognize the power implications of their daily interactions, they can hardly protest against them. Those with power can more easily keep it if they make the existing power structure seem natural and, therefore, not questionable.

In actuality, people negotiate power all of the time, whether or not they are aware of it. Yet, some people have more to bargain with, such as money or education, than do others. Moreover, characteristics such as gender, race, class,

and sexual orientation affect people's ability to negotiate power, regardless of the resources they bring to the process. Most of society's institutions rely heavily on this skewed negotiation to function properly.

One women's health center does not represent the entire institution of medicine in the United States. It does, however, offer a glimpse into the power structure of the health care system. By drawing on traditional sociological explanations of power as well as current feminist analysis of the physician-patient relations, insight can be gained into not only the overall structure of the health care system, but also into how power is maintained and reproduced in the specific case of a women's health care center.

REVIEW OF LITERATURE

Much work about medical authority focuses on the physician-patient relationship. There are many explanations of how patients, in particular female patients, are rendered subordinate in that relationship. For example, Bluestone (1993) suggests that the power accorded to physicians creates a situation in which patients are often dehumanized, abused, and manipulated, thereby rendering them subordinate. They are ordered to reveal their bodies to screening personnel over and over again just to be emotionally and physically violated and then sent on to the next test. In Bluestone's view, physicians have lost all respect for patients' feelings and subjective experiences. Perhaps even more troubling is that those physicians who do really care about patients are forced to forego all empathy in the name of efficiency. The authority of the medical profession is so great that, regardless of who the caregiver is, every patient is "trapped

defenseless and inarticulate in a system that doesn't hear a word they say" (Bluestone 1993, p. 2580). Bluestone cautions that until the medical profession is restructured to give patients some semblance of agency, the imbalance of power between medical personnel and patients will continue to grow.

A second explanation of patient subordination focuses on the way normative definitions of women are replicated in medical settings as a means of controlling female patients. The work of Foster (1989) exemplifies this approach. In a study of women seeking health care, she found that women suffer powerlessness both as patients and as women, and she offers four main critiques of current health care available to women. First, physicians tend to base their diagnoses of women's problems on subjective notions about women's natural drives and roles rather than on scientific or medical facts (p. 338). Second, women's medical treatment is often influenced by physicians' perceptions of women's social roles as those of mother and wife. For example, over-tired working mothers are advised by their physicians to cut down on paid work rather than to get extra help around the house (p. 339).

Third, Foster argues that physicians often try to further objectives which they believe are for the good of society, even if they are not for the good of the patient. A case in point is a physician who "pushes" or forces sterilization on women who are poor and perceived to have too many children, or who, for some other reason, the physician feels should not have more children. Finally, Foster contends, medical professionals have developed strong defense mechanisms to protect themselves from patient demands. In so doing, physicians force patients into overly passive roles rather than encourage them to be active participants in their health care plan (p. 340).

Gold (1983) offers a third, and related explanation for the subordination of patients. In her view, sexism based on essentialist notions of women affects the way gynecologists interact with their female patients.[2] According to Gold, medical professionals use sociobiologic ideas to support notions that women have genes that are different from and inferior to men's, and that these notions affect women as both gynecologic patients and as health care workers. Specifically, Gold suggests that in gynecologic practices women are treated as unintelligent, hysterical beings who are unable to give a good medical history (p. 134). Like Foster (1989), she also finds that women are treated as though they are interested only in pregnancy and giving birth and if they are not, that they are considered to be rejecting their femininity (p. 135). Moreover, Gold claims that women who seek gynecologic care are often treated as though they do not have "real" illnesses (p. 135).

These behaviors, Gold argues, are based on sexist notions that are delivered by and to medical workers. For example, often a gynecologist will parade a troop of interns into an exam, showing no respect for the patient's privacy and instilling in the interns that very same lack of respect (p. 137). Gold also cites sexist pharmaceutical advertisements which portray women as weak, anxious, and in need of sedation (p. 136). The result of all this sexism, Gold claims, is a gynecological setting in which women are not accorded agency as patients and, ultimately, do not have control over their own health care.

Yet another, and fourth explanation of women's subordination as patients is offered by Notman and Nadelson (1989) who argue that medical tradition maintains the omnipotence of physicians. They suggest that the medical profession has posed patients as child-like and physicians as parent-like. This

characterization, they claim, is compounded because patients tend to regress when ill and physicians yearn for omnipotent power (p. 894). The result is a physician-patient relationship in which physicians have excessive authority, thereby preventing patients from objectively assessing the dangers, benefits, or alternatives to recommended treatment (p. 896). Gold (1983) and Foster (1989) would suggest that women are even less able to make these assessments because the medical profession subordinates them on the basis of their sex as well as on the basis of their status as patients.

Echoing Foster (1989), Notman and Nadelson argue that physicians must differentiate their roles as agents of patients from their roles as agents of society (p. 899), forgoing the use of their medical authority to further what they believe is for the good of society rather than what is for the good of the patient.

Finally, Schwartz (1973) provides a fifth explanation for patients' subordination to physicians by maintaining that processes operative prior to the physician-patient interaction itself set the stage for the hierarchy inherent in the relationship. In his view, power can be exercised well before an interaction, such as one between a physician and a patient, takes place. In support of this contention, he analyzed "waiting" to show some of the more subtle ways in which those with power can influence an interaction with those without power.

His analysis reveals that waiting is stratified so that an individual's position in the social system is characterized by the extent to which he or she waits for and is waited for by others. "In general, the more powerful and important a person is, the more others' access to him must be regulated" (Schwartz 1973, p. 218). Subordinates, for example, may even be called on to wait while an engagement is in process, while more powerful clients are immune

from waiting because they have the resources to refuse to wait and can afford to go elsewhere for faster service (p. 219).

Schwartz notes that waiting is also affected by the availability of alternatives. When there are not alternatives, waiting is sure to be extended. For example, in courtrooms, where parties are often instructed to arrive before the judge does, they may have to wait all day to gain access to the judge's time. In this situation, clients have no alternative but to wait, and wait they do (p. 220). Alternatively, waiting can be imposed by those who wish to protest against authority. Subordinates may deliberately act sluggish to dramatize their autonomy to their superiors
(p. 223). In these many ways, the dynamics of waiting serve to create, maintain, and resist social differentiation.

In summary, sexism, notions of physician omnipotence, and waiting all serve to make the physician-patient relationship one in which women as patients are rendered subordinate. One might assume that a health center designed specifically for women would make a special effort to eliminate the powerlessness of women as patients. Unfortunately, my study reveals that this is not the case. The power of medicine is alive and well and, even in a women's health center, patients continue to exercise little agency.

SETTING AND METHODS

Located in a large medical complex, Women's Health Center (WHC) is a clinic which offers a variety of medical services for women including obstetrics, gynecology, fertility counseling, menopause information, ultrasound,

mammography, laser surgery, urinary incontinence treatment, lifestyle and pre-conception counseling, and hysteroscopes. The center was founded in the 1960s and is now a partnership owned and operated by two male physicians. The clientele are mostly white, middle-class women who range in age from young women in their teens to women in their seventies and eighties (February 5, 1993)[3]. The staff at the center includes both male and female doctors and nurses, and receptionists who are all women (April 5, 1993).

I performed my observations in eight two-hour weekly sessions beginning on February 5, 1993. I spent the two hours sitting in the waiting room of WHC as if I was a patient waiting for an appointment. While I was there, I took notes in a folder and usually had a book open beside me so as to appear to be doing homework. I was able to record direct transcriptions of conversations and events as they happened since no one ever sat close enough to me to see what I was writing. It is important to note, however, that all names I recorded have been altered for the purpose of this paper. In addition to these observations, I conducted two interviews which were tape-recorded, one with the office manager lasting seventy minutes and the other with a patient last forty minutes. For the purpose of this paper, I refer to the patient as "Janis" and to the office manager as "Mary".

REPRODUCTION OF POWER

Power relations are continually reproduced at WHC. This process relies heavily on the use of commodities, to the extent that a commodity is, "something that is of use of is valuable" (Kellerman 1985, p. 203). To engage in a negotiation

for something like power, people must have something to bargain with. Not just any old thing has enough value to exchange for a significant amount of power. Money is an obvious and visible commodity and it is often used in negotiations for power. Other bargaining tools are not so recognizable and thus have equal if not more value for precisely that reason. In the case of WHC, these commodities are time and privacy.

The importance of identifying these commodities is not readily apparent because time and privacy are not always equally valued by people. For example, if you do not consider your time valuable, you may be willing to give up a lot of it in order to gain access to someone else's time which you regard as more valuable. Further, if you do not recognize time's connection to power, you may willingly spend it and not object to the conditions under which you do so. It is by subtly exploiting your time that those in power stay in power.

> Time, like money, is valuable because it is necessary for the achievement of productive purposes; ends cannot be reached unless an appropriate amount of it is "spent" or "invested" on their behalf. On the other hand, the power that a time surplus makes possible may be protected and/or expanded by depriving others of their time (Schwartz 1973, p. 217).

The same kind of value, and connection to power, can be attributed to privacy. Those with power have more privacy, more valuable privacy, and more control over other people's privacy than those without power. Power structures, in short, are maintained by differentially allocating value to time and privacy. The skewed negotiation of these two commodities represents the process by which WHC reproduces existing power structures.

Time and Power

It is important to acknowledge that in medical settings, situations arise in which the control over time is governed by external forces. There are emergencies, some situations necessitate the use of more time than do others, and there are no doubt other happenings over which the clinic staff has no control. Nevertheless, these circumstances are not always present and some other explanation for how time is "spent" must be available. My study speaks to the spending of this internally controlled time at the Women's Health Center.

The conditions at WHC are such that a patient's time is given less value than a staff member's time. The first indication of this occurs when a patient enters WHC and signs in on a "sign in sheet" that is located at the receptionist's window. The patient rarely interacts with the receptionist and the receptionist seldom makes an effort to acknowledge that the patient is even there. She does not "waste" her time greeting or signing in patients.

> [The receptionist's] greeting to patients who come in the clinic is much different than the greeting she gives on the phone. When a patient comes in the clinic she rarely acknowledges her and if she does, it is usually just with a "hi". (March 24, 1993)

Once a patient signs in, she sits down in the waiting room. This is significant for several reasons. First, the very fact that there is a room especially designated for waiting suggests that patients are expected to wait. Second, the room is designed in such a way that maximum compliance is derived from patients, as my first impression of it indicates.

> There are 28 pink cushioned chairs....The chairs are very comfortable. The room is soft....There are three tables located around the room with magazines and pamphlets on them....They have created a very soft, comfortable space in here, there is no

> metal or chrome furniture and few sharp or shiny images. (February 5, 1993)

By making the room comfortable and giving patients magazines, WHC maximizes the amount of time a patient will wait without protesting. This design also says to the patient, "You should expect to wait." Indeed, the patients expect to and accept the wait. They read magazines or bring newspapers or books and when they do not have to wait long they are surprised.

> A large woman in black pants and a grey coat comes in....She signs in and sits down. She barely sits down and a [nurse] comes out from the door on the left and says, "Karen." The woman...who just walked in gets up. She kind of laughs and says, "Oh that was quick," and walks back into the office. (February 17, 1993)

Karen was surprised that she gained access to the nurse's time and space so quickly. Indeed, most of the patients expect to wait and they behave accordingly.

> A woman in a long black trench coat and grey pants comes in. She has long dark hair. She signs in, then hangs her purse on the arm of a chair located near the reception window, walks over to a table in the corner with lots of magazines on it, selects one, and then returns to her seat and starts flipping through it.
>
> This woman seems familiar with the waiting routine here. She knew that she would be waiting. She expects to wait, so she goes to get a magazine before she even gets tired of sitting there. (March 3, 1993)

By expecting and accepting the waiting period, patients are agreeing that access to a physician is "worth the wait." In essence, this means that the physician's time is perceived as more valuable than their own.

The staff tries to foster this image as much as possible. If they perceive that a patient may be beginning to get anxious, they attempt to pacify her.

> There is an older woman sitting near the door wearing a pink sweat suit....She is flipping through a magazine....Later I hear a nurse in the back yell out, "Jayne, I'll be right with you." The woman in pink says, "sure"....
>
> [The nurse] for some reason seems to feel that Jayne has been waiting too long or for longer than she expected to wait....The nurse has some sense that she needs to pacify her. (March 24, 1993)

If all of the patients are pacified or believe that they are not "spending" an extraordinary amount of time, then the staff does not have to worry about protests or resistance.

The staff and the patients both have an idea of how much time is appropriate to spend waiting for the physician after the scheduled time. Mary, the office manager, in response to my query reported that, "I don't like to see patients wait any more than twenty minutes. Ya know that might be an unrealistic goal [laughs] but um probably twenty to thirty minutes" (April 5, 1993). Janis, the patient interviewed, had much the same estimation of how much of her time she thinks she should spend waiting. "I think over a half hour is too long to wait. I think actually after twenty-five minutes is too long to wait" (April 6, 1993).

One strategy the staff uses to pacify patients who have spent more time than expected waiting is to remind the patient how valuable a physician's time is. Mary explains what usually happens at WHC in this situation.

> [M]y nurses go in and inform the patients, especially if they have already brought them back to a room. Say the doctor got called out ya know to go to the hospital or...maybe...the ultrasound test results have come back and

> the doctor wants to look at ultrasounds while he had the patient sitting right there. The patients tend not to get so upset about it if they are just explained ya know, if you go in and say the doctor had this happen and so forth. (April 5, 1993)

The WHC nurses, in sum, are sent to exalt the physician's time if the patient begins to feel that she is being "overcharged" for it.

WHC even has scheduling procedures that reinforce the notion that the physician's time is more valuable than the patients'. Mary readily admits that, "we book in advance, but we do book two people at one time, like at nine o'clock we'll put two people in one slot....That way the doctor is in seeing one and when he comes out of the room there will be another patient ready..." (April 5, 1993). By booking two people at one time, personnel at WHC ensure that patients will have to wait. Their overestimation of the value of a physician's time makes them willing to deliberately deprive the clients of their time so that the physician can have another patient ready at the same time he or she is. WHC knows that the patient will not be seen at her scheduled time and does not accord any value to the time that the client is taking out of her day to come and sit in the waiting room.

Patients do not seem to have the sense that their waiting is part of a deliberate policy on the part of WHC. Rather, as Janis revealed when I asked her why she thought she had to wait, they view an extended waiting time as the fault of other patients, not a strategy of WHC.

> Who the hell knows, they are just slow. Well. sometimes, ya know you get people in there like me who see the doctor and the doctor says you have this and I say okay give me a prescription and I am out the door. Otherwise he gets patients in there like my grandma and she'll tell him every little ache and pain...and ask him a lot of questions that are

> unnecessary. And if he gets a lot of those in there then obviously it takes me longer to get in. Just depends on who he sees. (April 6, 1993)

If patients are unaware that they are deliberately being forced to wait because of a power structure that says that their time is not valuable, then they are in no position to challenge that hierarchy. By assigning a higher value to the physician's time rather than to a patient's, WHC thus maintains the power structure that says physicians are more important/valuable/powerful than patients.

But this process is structured such that patients do not really recognize its significance. It is because the commodity is so invisible that people do not connect it to power. Thus, although both staff members and patients may readily admit a physician has power, they cannot always understand its roots. Even Mary has trouble identifying the source of a physician's power. Her only explanation is, "a lot of people put physicians up on this pedestal" (April 5, 1993). Because people are relatively ignorant about the process by which a physician's power is created and maintained, they often blindly participate in the very system that keeps them powerless. One of the easiest ways to stay in power is to construct a situation in which the powerless continually legitimize, accept, and perpetuate your authority. This is exactly what happens at WHC.

Not all patients at WHC are completely compliant, however. There are occasions when a person decides to complain about the amount of time she is being required to wait. After waiting for quite some time one woman tries to speed things up:

> The woman in the blue sweatshirt goes up to the reception window and asks Kim, "Do you know how long it is going to be?" Kim replies, "Well

> they should be taking you back anytime." The woman says, "Okay, cuz last time I didn't get in till 9:30."
> (March 24, 1993)

By asking the receptionist about the wait, this woman assumes that the receptionist has the power to do something to shorten it. While she appears to be resisting, she is doing so in a way that reinforces the existing power structure. That is, she relies on the receptionist to do something, thereby acknowledging her agency -- or at least assuming that the receptionist has agency and she does not. WHC has organized the waiting process in a manner that allows patients no other form of protest than appeals option to the receptionist. They cannot even protest without surrendering authority to a staff member.

Moreover, staff have the authority to deprive patients of their time as women attempt to gain access to a physician. For example,

> The nurse who made Mindy fill out those forms comes out of the door on the right [into the waiting room] and walks over to the woman holding the baby. She says in a long high voice, "Hiii...oh my god he is so tiny." ...The older lady hands the baby to the nurse and the nurse grabs him and, smiling, looks at him.
> (February 9, 1993)

The nurse does not have to, nor expect to , wait to see the patient or her baby. She has immediate access. She simply walks out and begins talking to her without waiting or filling out forms or having to be called back by someone else. Thus, it is apparent that those with power are waited for and those without power simply wait at WHC.

Privacy and Power

Like time, privacy is linked to power. Those with power have more valuable privacy, more authority over others' privacy, and more ability to regulate others' access to their own privacy. At WHC, privacy issues are magnified due to the nature of the health care services provided. Gynecological procedures involve, what U.S. society has labeled, the "private parts" of the female body. Because of this, there is a heightened awareness of privacy at WHC on the part of the patients. Patients have their bodily privacy invaded in the examining room, and one might assume that because WHC is a women's health clinic, special precautions are taken to maintain some semblance of privacy for patients in the waiting room. The opposite, however, proves to be true at WHC. The privacy of the staff is given much more value than that of the patients. Indeed, many barriers to protect the staff's privacy have been constructed. The most obvious of these is physical. The waiting room is separated from the offices by a large wall with one closable reception window and two closable doors.

The nurses at WHC carefully regulate who goes in and out of those doors -- in essence, who obtains access to the staff's privacy. They are the gatekeepers. A patient cannot go back into the office unless her name is called by a nurse. Patients are very aware of their restricted access to the office and the gatekeeping function of the nurses, as Janis indicated when I asked how she knew that it was time for her to go back into the office. "Well, the receptionist, nurse, or head nurse, comes out and calls your name" (April 6, 1993). Janis knows that she must wait for the nurse to "open the gate" by calling her name.

The patients' space in the waiting room is not similarly regulated. Anyone can walk off the street into their space. Even the chairs are arranged around the

room in a manner that gives patients the minimum amount of privacy. By having the chairs all face the center of the room, WHC forces patients to sit in full view of each other.

As with time, patients have no power to regulate access to their privacy. The staff has immediate access whenever they need or want it.

> A nurse in white pants and a black sweater comes out from the back with some papers and a little packet and sits next to Candy. She says, "Okay Candy, here is your packet, you just need to sign here." She hands Candy a pen and a form and she signs it....The nurse smiles and walks back into the offices. (February 17, 1993)

The nurse is able to walk right into the waiting room and gain access to Candy's time and privacy. She does not have to wait to fill out a form, or to be summoned by a gatekeeper. Candy has no power over the situation.

The behavior of the staff serves to further demarcate the space at WHC. When a nurse comes out from back offices to call a patient, she rarely walks all the way out into the waiting room, but rather stands in the doorway holding the knob to the office door.

> [A] nurse comes out of the door on the other side of the room, holds the door knob, and says, "Sandra." The older woman reading [a magazine] gets up, sets her magazine in her chair and walks back....(March 3, 1993)

Holding the door knob symbolizes the opening of the gate to the office by the nurse, which she also does by calling the patient's name. It is also symbolic of power. Nurses hold the door knob even when the door is already open. It is as if the knob is a tether to valued space. It signals a nurse's power to open and close the gate and restrict access to the office. She negotiates who is able to come in

and when. It also defines her own space, by signaling a border to the office, which belongs to her.

In addition to having power to regulate access to valued privacy, nurses also have authority over patients' private health information. Protecting that information is a priority at WHC, as the office manager indicated to me.

> [Patient confidentiality] is stressed, it's VERY important. And you are seeing a lot more lawsuits pop up because of breach of patient confidentiality, you have to be very careful. (Mary, April 5, 1993)

Yet, the reason patient information is considered private at WHC is for the protection of the clinic, not for any value assigned to patient privacy.

Further, the staff at WHC do not make any special effort to protect patient privacy.

> A woman in a white winter coat and black pants comes in....She glanced around the room and starts to walk toward the [reception] window. The receptionist says, "Oh, you must be looking for Jennifer." "Yes." The receptionist points her hand out the window and says, "She is down around the corner in the lab, you know, where she used to go all the time for ultrasounds and mammograms....(February 5, 1993)

The receptionist is quick to tell not only where Jennifer is, but also to reveal personal information about past health tests she has had performed. Perhaps even more revealing, she does so in a voice that I, and everyone else in the waiting room, can hear. Patients are hardly able to regulate their own privacy when nurses can approach them at any time and receptionists can blurt out personal health information into the waiting room. Clearly, the privacy of patients is not given much value at WHC.

The result of this systematic violation of privacy is that patients are left with only symbolic ways by which to regulate their privacy. One way in which patients symbolically protect themselves is through their posture.

> There is [a] woman sitting next to the receptionist's window...she has her legs crossed and her coat in her lap. (February 5, 1993)
>
> There is a woman sitting across from me and to the right....She has her legs crossed and is reading a novel. (February 9, 1993)
>
> There is a woman in a long red coat and black skirt sitting on the other side of the room....Her legs are crossed....(February 17, 1993)

Patients almost always sit with their legs crossed and often have a purse or coat in their lap. This covering or protecting of the pelvic area allows them to symbolically maintain a feeling of privacy in a situation in which they do not actually have it.

A second way in which patients attempt to symbolically maintain their privacy is through the tone of their speech.

> The receptionist calls out the window, "Yvonne." The African-American woman replies, "Yes." "You have an ultrasound scheduled, do you have any other tests?" Yvonne stands up and starts to walk toward the receptionist, "Well...I have...." Her voice is quiet and hesitant, as if she does not want to discuss this in front of the whole waiting room. (February 9, 1993)

By lowering her voice, Yvonne tries to keep information about her health private. But this strategy is only symbolic because, despite her efforts, the fact that she is going to have an ultrasound is broadcast throughout the room before she can do anything about it.

Yet a third way patients attempt to symbolically maintain their privacy is through the content of their language. For example, I observed one woman

change the words she used to talk about what would happen to her. The woman rose, walked up to the counter, and asked the receptionist, "How long will the annual exam last?" (March 10, 1993) By calling her exam an "annual" rather than a "pelvic," "gynecological," or "vaginal" she neutralizes the term. Nevertheless, her neutralizing tactic remains only a symbol because it does not change what will physically happen to her in the examining room. And indeed, everyone who heard her still knows what kind of exam she is to have, even though she changed the word.

Thus, while patients attempt to negotiate privacy, the message that they receive from the staff is that theirs is not very valuable while the staff's is. This situation leaves them with little power to regulate their own privacy or to gain access to the staff's. Their efforts to do so are merely symbolic and, ultimately, patients are subject to the will of staff members.

Hierarchies Within Hierarchies

Thus far I have argued that the differential allocation of value to time and privacy maintains a power imbalance between staff and patients. This process however, often is mediated by gender, sexual orientation, and class. That is, patients are not viewed as a homogeneous group but rather are dealt with on the basis of categories that are assigned differential value.

For example, WHC gives more value to men's time and privacy than to women's time and privacy.

> A large African-American man walks in. He walks up to the reception window and says, "I would like to make an appointment with Dr. Schultz...." The receptionist says, "Would you like me to see if he is available now?" "Yeah, could you?" (March 3, 1993)

This man simply asks for an appointment to talk to the physician, but the receptionist tries to get him immediate access to the physician's time and privacy. The women sitting in the waiting room, however, already have appointments but they are still forced to wait. The receptionist automatically accords more value to this man's time based on his gender. He, therefore, has more power and quicker access to the doctor than do women.

WHC also attaches more value to heterosexual unions than to homosexual ones, as the following excerpt from my notes indicates.

> A nurse calls out of the left door, "Rita." Both the large young women and the older woman get up, and the older woman in the dress follows the younger one into the door. The nurse asks, "Which one's Rita?" The younger woman raises her hand a little bit and says, "I am." (March 16, 1993)

The nurse is quick to question two women walking in together. Though she only appears to be clarifying who the patient is, she does so in a rather demeaning way. She refers to Rita as "one," presumable meaning "one of something," thereby according Rita little dignity.

In contrast, when a woman and a man walk into the office they are not treated the same way, as another excerpt from my notes indicates.

> A different nurse comes to the door and says, "Gina." Gina and the man she is with both walk back into the office. (March 30, 1993)

Gina and the man are not questioned. While the nurse obviously can figure out who Gina is, the fact that she says nothing to them when they both walk back into the office is telling. She assumes that nothing needs to be questioned -- that it is "normal" for men and women to be together. The heterosexual couple is faced with fewer barriers to the physician and the two women (whether

homosexual or not) are more heavily regulated as they try to gain access to the physician. This treatment reinforces the idea that heterosexual couples are "normal" and homosexual couples are not.

Finally, staff at WHC use distinctions of class to assign value, thereby reproducing existing inequality. While class relationships are not as visibly reproduced as others, WHC's differential policy concerning class became obviously apparent when I asked Mary if the clinic accepted Medicaid or Medicare as payment for services rendered.

> We don't accept new Medicaid patients....If like a patient was already established here and maybe went through a divorce and lost her insurance and stuff and then had to be on Medicaid, well, then, ...we would go ahead and accept that....But no, we don't take any new patients. (April, 5, 1993)

By refusing to take patients who cannot afford insurance other than Medicaid, WHC is differentially assigning value to time on the basis of class. A Medicaid recipient's time has no value at WHC. No matter how long she is willing to wait, she will be unable to gain access to the physician's time -- even though Medicaid would probably pay for the services. WHC does not "waste" their time with such women.

CONCLUSION

The reproduction of power in a women's health center has been the focus of this thesis. A field study was carried out in the waiting room of such a health center over the course of several weeks. In addition, interviews were conducted with both a patient and a staff member at the Center. Analysis of the data

revealed that the differential allocation of value to time and privacy by clinic personnel function to maintain the power that the medical staff holds over patients. Moreover, the data showed that this process is mediated and reinforced by social constructs (gender, sexual orientation, and class) that maintain inequality.

My study contained a number of limitations. First, it was relatively short. I spent only eight weeks in the field and conducted only two interviews. The brief nature of my study renders my observations highly tentative. Second, my observations were limited to the waiting room. I was unable to observe what happened when patients actually entered the physicians' offices. Finally, my study was conducted at only one women's health center. I was unable to develop a comparative analysis.

This study might be expanded by taking these limitations into account. A more involved study would certainly require more time in the field and additional interviews with both patients and physicians. While access to physicians' offices would be difficult to obtain, it would greatly improve the quality of data by providing more comprehensive observations and a better understanding of the external constraints placed on clinic staff. Finally, observing at multiple sites would provide data for a comparative analysis and reveal what is unique about WHC and what is common to most women's health centers.

While the power of physicians and the powerlessness of patients, especially female patients, have been well documented, my findings on waiting room interactions illuminate the process by which the hierarchy in their relationship is maintained. Interactions in the waiting room set the stage for the

physician-patient interaction. It is in the waiting room that a woman is first assigned her subordinate role as patient. She is rendered powerless before she even engages in an interaction with a physician. Patients may attempt to negotiate for agency, but these attempts remain symbolic because of the imbalance of power that is perpetuated by staff.

For patients to exercise agency, change must occur in this pre-interaction stage as well as in the actual physician-patient relationship. Perhaps the first step in effecting such change is to help patients understand the process by which medical personnel maintain and reproduce the powerlessness of patients. If a physician's power is no longer mystified and, therefore, no longer considered "natural," a patient may be in a better position to first identify the process by which it is maintained and then to resist it.

The existing power structure clearly serves the interests of medical personnel. The staff at WHC are able to retain power, gain patient compliance, and pacify patient resistance because of a hierarchy which allows physicians to exercise authority over patients. Were this hierarchy dismantled, greater autonomy would be accorded to patients in medical settings and the physician-patient relationship would ultimately reflect a more equitable balance of power than that which currently exists.

NOTES

1. The study was originally conducted as a course project for Sociology 985, "Qualitative Field Methods," at Michigan State University, Spring, 1993.

2. A general practitioner, Gold contends that her many years working closely with gynecologists have given her insight into how sexism affects their relationship with patients.

3. The dates used in this paper refer to the time when either observations were made and recorded in my field notes or when interviews were conducted.

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