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ABSTRACT

THE CONCEPT OF POWER IN DOCTOR-PATIENT INTERACTION

By

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This thesis is a commentary on Howard Brody's book The Healer's Power. I am not disagreeing with the substance of Brody's analysis or with his advice for the ethical uses of power in doctor-patient relationships. But, I do suggest that Brody's pragmatic use of the term power prevents us from gaining certain important insights in the role of power in clinical encounters. I present a more rigorous definition of power, based on Anthony Giddens' *structuration theory:* Power arises from structural resources, produced in interaction between people. Power is not something you *have*, rather it is something you *activate*.

Power thus resides in *relationships*, and not within any person. According to this definition, the healer is *not* powerful. Healing is the fortunate outcome of instances where both the 'healer' and the 'healed' invest some of their resources in a relationship, thereby activating the healing powers in a doctor-patient relationship.

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1: INTRODUCTION

There are two reasons why we should think about power in the doctor-patient interaction. First, a practical one. Howard Brody claims that medical ethics is most profoundly about power and its responsible uses (Brody 1992, p.12). Several publicly discussed themes support this claim: The physician's authority; patients' feeling of powerlessness in interaction with health professionals; the potential of coercion and manipulation; but also, the potential for positive forms of influence (which Brody calls "the healer's power"); all indicating that power does indeed play a central role in the encounter between physician and patient. In spite of the perceived importance of *power*, there is a disturbing lack of consensus as to what this word should mean. This paper is an attempt to bring some clarity to that question. A physician who employs a coherent and adequate vocabulary to evaluate the role of power in her interaction with patients, we may hope, will be more sensitive to what types of power relationships she engages in. With this sensitivity, she would be more likely to engage in power relationships which are constructive rather than detrimental for her patients.

Second, there's a theoretical reason why we should think about power. If the doctor-patient encounter often yields morally significant outcomes, and what goes on in this encounter can (partially) be described in terms of power, then an understanding of that power relationship will provide relevant information for a moral assessment. The social sciences present a large body of empirical research on the healer-patient interaction. It is not always easy to see how insights from this literature could be reformulated to fit the language of medical ethics. The original contribution of this paper is the way it forms a

'link' between moral philosophy and social sciences. The device I use to create that 'link' is the concept of power.

A rumor is spreading to the field of medical ethics these days that *postmodern critique* challenges the very foundation of its reasoning. Central to postmodern thinking is a critique of power, it is said. Nobody seems to be able to explain precisely what implications the postmodern insights should have for practical medical ethics. While the 'pre-postmodern' adherents to medical ethics are waiting for someone to formulate this critique in an intelligible way, and to point out what its practical implications may be, we would do well to make clear to ourselves what our own "modern" view of power is. That will be my major task in this paper.

We *could* say that medicine is a *powerful* knowledge, that a surgeon has the *power* to save peoples' lives, that he uses *powerful* tools and techniques, and that he partly relies on the self-healing *powers* within the patient's body. By using the word 'power' in this loose sense, we take the statement 'A is powerful' to mean simply 'A has the capacity to cause effects, or to play a part in the process of causing effects.' In this paper I will present a more rigorous definition, based on Anthony Giddens' *structuration theory:* Power arises from structural resources, produced in interaction between people. Power is not something you *have,* rather it is something you *activate.* With this definition, we are able to use power as a conceptual tool to analyze interactional aspects of the doctor-patient relationship with a high degree of precision. According to this definition, the healer is *not* powerful. Healing is the fortunate outcome of instances where both the 'healer' and the 'healed' invest some of their resources in a relationship. The power of healing resides in this relationship, and not within any person.

Based on a reading of central social science texts dealing with the question of power, I will identify and discuss three distinct views of power: models based on *agency; structure;* and a *practice approaches* (chapter two). In spite of their differences, these models are all based on the assumption that there is something definite to be said about where power is located and how it can be exercised. In opposition to these views, is an approach I call *theoretical pragmatism,* which holds that we should not base our empirical theories on any fixed ideas about power.

In chapter three, I will asses three clinical cases, using a language compatible with Giddens' version of the practices approach. In the following chapter, I will briefly suggest how opposing views of power are reflected in different theories of moral philosophy. In the last chapter, I assess Howard Brody's use of a *pragmatic* definition of power in a discussion of medical ethics. I will claim that there are problems with Brody's analysis which could be solved by applying the *practice approaches* view of power as a theoretical starting point for our ethical analysis of the doctor-patient interaction.

In chapters two and three my approach is mainly *descriptive,* and I will draw upon literature from the social sciences. In chapters four and five I introduce *normative* questions, and there will be some references to the literature of moral philosophy.

2: POWER IN SOCIAL SCIENCES

The question of where power is located is most profoundly a question of where to look for the cause of the types of effects we are interested in. A number of different reductionist models are available: the ultimate cause for human behavior is found in the genetic material; in physiological processes in the human body; in psychologically reinforced patterns of behavior; in the struggle for survival; etc. Most of these reductionist models do not provide a useful answer to the question we started out with: the question of power in doctor-patient interaction. Let us take *genetic reductionism* as an illustration: If it were *true* that our genetic material predetermined our behavior, we would have to conclude that two persons meeting are like two fancifully constructed automata, whose interaction consists of a set of precoded types of adaptive activities. Such claims have no practical implication for our understanding and evaluation of the interactional aspects of the doctor-patient encounter. Most of the models that theoretically *could* offer an answer as to why we act the way we do, do not need to be considered then, since the types of replies they would yield would not serve our purpose.

Our scope is then limited to models of the same 'scale' as our subject matter. Our focus is on the interaction between individuals in a certain social situation, not in physiological processes or Skinnerian shaping of behavior. Broadly speaking then, we will turn to theories that focus on individual behavior within a social setting, and models that focus on the social setting in which individuals interact.

Howard Waitzkin and Arthur Kleinman are two of the central authors in the social science literature on doctor-patient interaction. Waitzkin draws on

structural explanations in his work; Kleinman focuses on *agency*. Gregory Pappas claims that a disagreement about the nature of power is "at the crux of the structure/agency division in medical anthropology" (Pappas, p.199). The structural approach locates power outside individual actors, and sees it as a constraining and determining condition. The structuralist sees human action and experience as predetermined in a mechanical way by structural regularities, existing independently of individual actors. Obviously, there is no room for individual liberty and freedom of choice (agency) in such a scheme. The agency approach, on the contrary, views individual actors as knowledgeable entities, pursuing their goal-oriented strategies of action: "Agency concerns events of which an individual is the perpetrator, in the sense that the individual could, at any phase in a given sequence of conduct, have acted differently" (Giddens, p.9). This approach thus locates power within each individual, seeing power as the capacity or resource that gives agency its momentum, the individual actor's capacity of "bringing about of consequences" as Mark Philip formulates it (Philip, p.635).

Pappas argues that Waitzkin puts too much emphasis on structure in his analysis, whereas Kleinman focuses too narrowly on agency. He suggests that practice approaches offer a theoretical framework for a more adequate understanding of the doctor-patient encounters. After reviewing the literature in medical sociology, Per Måseide makes similar remarks: the structural models miss "the local production and management of power relations," whereas models that focus on interactional aspects neglect "the structural necessities of power in medical practice" (Måseide, p.546-7). In brief, the practice approaches hold that we cannot give primacy to either structure or agency, because neither one of them can be understood independently of the

other. Structure and agency mutually influence each other -- the mechanism that ties them together is the practices in which individuals engage.

The points raised by Pappas and Måseide reflect a general shift of theory within the social sciences in the 80's. After presenting an overview of anthropological theory since the 50's, Sherry B. Ortner claims that anthropological theory in the 70's found itself in a state of liminality, a period marked by profound theoretical disagreements, out of which a "new and perhaps better order" could arise (Ortner, p.127). She argues that the practice approaches, formulated by Pierre Bourdieu and Anthony Giddens, represent a synthesis of the better aspects of previous competing theoretical models.[1]

I will review some of the central works in general social science theory that address questions of power. An article by Bertrand Russell and critics of his view illustrate the agency approach to power; one version of structural thinking (the Marxist version) is represented by Nicos Poulantzas; Anthony Giddens' structuration theory illustrates the practices approach. My discussion will be guided by the following three questions: 1) What types of interaction are seen as significant for a power analysis; 2) What characterizes instances of power; 3) How are power relationships maintained, challenged and altered.

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[1] This change in social scientific theory historically coincides with changes in prevailing theoretical models of the doctor patient relationship, Måseide argues. A normative model based on justified professional domination, *the expert model*, was challenged and gave rise to its antithesis: a normative model of cooperation and equality, *the social psychological model*. After identifying problems with each of these, Måseide claims that a new model is now emerging, one that "instead of [prescribing] ideal forms,... tries to understand the form and production of competent medical work" -- *the control model* (Måseide, p.547).

Agency

Russell defines power as "the production of intended effects" (Russell, p.19). Instances of power take place when two or more actors have similar desires, and one of them achieves what he desires to a larger extent than the other. If A desires something different than B; or if both A and B have multiple desires, of which A achieves some and B achieves others, there is no way of estimating who has the more power, according to Russell. The locus of power is an intentional actor: "Alexander the Great and Julius Caesar altered the whole course of history by their battles" (Russell, p.21). The structural conditions merely provide a scene on which individual actors intentionally seek to get what they desire:

> Different types of organizations bring different types of individuals to the top, and so do different states of society. An age appears in history through its prominent individuals, and derives its apparent character from the character of these men. (Russell, p.23)

When Russell says that an organization 'brings' a person to the top, he does not ascribe agency or power to that organization, the role of which remains passive. Society provides a backdrop that makes it possible for a person with those capacities possessed by Richard Lionheart to achieve prominence in his time, whereas another historical period would have provided him with fewer opportunities to exercise power others.

Still, institutions may be possessors of power in Russell's model: a political party, for example, can be seen as a 'machine' which actively creates effects: "Sometimes,... the machine is able to secure the victory of a man without 'magnetism'; in such cases, it dominates him after his selection, and he never achieves real power." The successful politician, on the contrary, is able

to "dominate [the machine] and make it subservient to his will" (Russell, p.26).

The mechanisms by which individuals and institutions exercise power over (influence) persons are classified in three groups: use of physical force; use of rewards and punishments; influence of opinion, i.e. propaganda (Russell, p.19). Central to Russell's account, is the view that power is exercised in situations of conflict: two or more actors desire similar things, their intended actions are aimed at getting that which they desire; the most powerful agent gets it his way: "If you wish to be Prime Minister, you must acquire power in your Party, and your Party must acquire power in the nation" (Russell, p.23). Even though it is possible to define power this way, Russell's concept conflicts with the meaning commonly ascribed to power in several important ways as demonstrated by other authors:

By defining power as "the *possibility* of imposing one's own will upon the behavior of other persons" (my emphasis), Weber reminds us that it is not the *actual* exercise of influence over others we normally refer to when speaking of powerful agents, but rather their *capacity* of doing so if they want to (Weber, p.29). Weber, like Russell, maintains that an overt conflict of interests is central to instances of power:

> Power (Macht) is the probability that one actor within a social relationship will be in a position to carry out his will despite resistance, regardless of the basis on which this probability rests. (Weber 1922, quoted by Dahl, p.406)

Steven Lukes expands the concept of power further, arguing that if we only include situations with resistance (overt conflict), we will exclude those situations where the more powerful agent uses his capacities to silence and suppress the expressions of resistance, thereby avoiding an overt conflict:

> Indeed, is it not the supreme exercise of power to get another or others to have the desires you want them to have -- that is, to secure their compliance by controlling their thoughts and desires?
> (Lukes 1974, p.23)

This point may be in accordance with our intuitive understanding of power, but in the subsequent discussion Lukes runs into trouble when he defines power as instances where one agent influences another contrary to that agent's *real* interests. For -- how are we to determine what would amount to a person's real interest? Lukes does not provide us with an answer.

Pappas avoids this problem by excluding the idea of real interests from his definition of power. Not only situations where somebody is influenced contrary to their interest should count as instances of power, he argues, for power can also be used to influence others in a way that is compatible with their best interest. By doing so , he suggests that power should be understood as a value-neutral term: "Power is involved in all that is repressive and destructive, as well as all that is liberating and creative in human behavior" (Pappas, p.200).

Several authors within the social sciences have used power as a morally negative term, more often implicitly than explicitly. In such research, the scientist has seen his or her role as locating where and how power is exercised, and then assumed without additional argument that we ought to neutralize or minimize such use of power in the future. There is a large body of research on the doctor-patient relationship based on the assumption that an equal power balance is a goal for the doctor-patient encounter (Meetuwesen et al.; Street). David Nyberg points to a fundamental theoretical problem with this negative view of power: Whether or not the effect of an action is compatible

with or contrary to a person's interests is not only difficult to determine, but often it will be impossible to determine this at the time the relevant action takes place. With the negative view of power, we would have to wait until we know whether the effects of an action are 'good' or 'bad' before determining if that action was an instance of power or not. Information about the setting and the actors that engage in interaction, no matter how precise and reliable that information is, is not in itself sufficient for a power analysis. Based on the way we commonly use the word *power*, this position has something awkward to it:

> Stalin, Hitler, and Joe McCarthy are clear enough examples that power corrupts, but what of other powerful people such as Lincoln, Gandhi, Franklin Roosevelt, and Martin Luther King whose power did not apparently corrupt them?... It will not do simply to say that if what we took to be power did not actually corrupt, then it must have been something else posing as power... (Nyberg, p.38)

The discussion so far has illustrated some definitions of power and the ways in which they differ.The purpose of this paper does not require that we pursue these disputes, as all they would yield are different modifications within the agency views of power. Several additional disputes have not even been addressed here: whether power is a 'zero-sum' concept; what kind of effects are relevant for a power analysis; questions of intentionality; and of causation. Philip states that "there seem to be few, if any, convincing metatheoretical grounds for resolving disputes between competing theoretical paradigms" (Philip, p.636). Lukes concludes that "every attempt at a single general answer to the question [of defining power] has failed and seems likely to fail," and Dahl explains why this might be so: "[A] variety of simple alternative explanations seem to fit the data equally well" (Lukes 1986, p.17; Dahl, p.411). In spite of their differences, the views discussed so far have one trait in common: they

see power as a resource or capacity that characterizes individual agents, whether they are defined in terms of persons, institutions or societies. Power thus is something one agent exercises over another agent. Contrary to this view are authors who locate power outside of individual agents.

Structure

According to Poulantzas, *power* should not be applied to inter-individual relationships independent of the wider system within which they are set. What happens in the interaction between single actors, unrestricted by structural constraints, should rather be described in terms of *might* (in the original text, this distinction is between *pouvoir* and *puissance*). This is more than a play of words, for Poulantzas argues that in our social reality (the capitalist society) what happens in the inter-personal relationship is typically determined by structural power, not by might. This means that the true explanation of why people interact as they do is found in conditions located outside them: "In this sense, we can say that power is a typical phenomenon, traceable from the structures, while that of might is a phenomenon characterized by a sociological amorphy" (Poulantzas, p.146).

Whereas Russell had allowed power sometimes to be located within individual actors, sometimes within institutions (like a political party), Poulantzas sees a supra-individual entity (social class) as the only locus of power: "By power, we shall designate the capacity of a social class to realize its specific objective interests" (Poulantzas, p.144). It does not suffice to say that the difference between Russell and Poulantzas is merely that the first locates power within individuals or supra-individual entities; the latter only in supra-individual entities. The difference between agency and structure arises from

more profound differences in theory. When Russell refers to organizations, he describes them as goal-oriented actors that possess power and interests, arising from the power and interests of those individuals of which the organization consists (Russell, p.27). Poulantzas sees social class as an entity that arises from the economic reality (the distribution of the means of production). The interest of a social class is defined by the theory, and cannot be described as a function of individual characteristics of the members of that class: "[The] concept of interests can and must be stripped of all psychological connotations" (Poulantzas, p.151). In a similar fashion, structure is not a product of the behavior of single actors, but rather the condition within which the behavior of individuals must be understood. Again, structure is defined by theory, and in a way that makes it a conditioning factor for human activity, rather than a factor conditioned by human activity: "Marx goes as far as to say that class interests, in the class struggle, have an existence somehow prior to the formation itself, to the practice of a class" (Poulantzas, p.149).

The types of interaction that can be described in terms of power, according to this view, are only situations of conflict and struggle between social classes: "The capacity of a class to realize its objective interests, and so its class power, depends on the capacity, and so on the power, of its opponent" (Poulantzas, p.151). Individuals have no power, what they psychologically perceive as their 'interests' is merely a function of the true interests of the social class to which they belong.

Rather than pursuing the theoretical aspects of the structural view of power, I will illustrate some of its features by referring to an example of how Waitzkin employs his structuralist view in a critical analysis of the doctor-patient encounter. He summarizes the encounter between a 55 year old male

worker currently on sick leave, the patient's wife, and their doctor like this: "A man comes to his doctor several months after a heart attack. He is depressed. His period of disability payments will expire soon, and his union is about to go on strike. His doctor tells him that he is physically able to return to work as a radial drill operator and that working will be good for his mental health. The doctor also prescribes an antidepressant and a tranquilizer"(Waitzkin, p.76-7). The following transcript is from this conversation:

D: Yeah, so if they arrange something, they'll know if by mid June.
P: They should.
D: Is that bugging you? The idea of going back to work?
P: Well...actually I think I want to go back.
D: Yeah, I think you should go back.
P: Actually, I think I want to go back, but then go back and go on strike? That seems to bother me.
D: Yeah. But if you go back mid-June it won't, won't bother you.
P: No.....

In Waitzkin's analysis, this case illustrates how a well-meaning doctor unintentionally becomes an instrument of the medicine's social control over workers. In the doctor's utterances, Waitzkin sees a strong ideologic message -- namely that to work is good for the patient's health. The offering of psychotropic medications to the patient represents a technical solution to a contextual problem, and serves the purpose of marginalizing the social context in which the patient developed a depression. The function this physician is really serving, according to Waitzkin, is to "control a working-class patient's role in economic production by withholding the continued certification of illness" (Waitzkin, p.78).

The Marxist model illustrated by Poulantzas and Waitzkin is only one among several structuralist models of human behavior. What all these models have in common, is the view that the capacity of making decisions is determined by conditions outside the control of single individuals. According to structuralist thinking, human behavior and cognition is organized by a reality outside themselves, consisting in a number of categories/classes. These categories are related to each other in a systematic fashion -- this system is what is described as 'structure.' In Lévi-Strauss' account, the categories are classified in binary oppositions (high - low; land - water; mountain hunting - sea hunting; peak - valley; raw - cooked, etc.), the most fundamental opposition being that between *nature and culture* (Lévi-Strauss, p.471). Ortner advocated a structural model based on the opposition female - male (Ortner 1974). Another type of structuralism is the form of linguistics which views *language* as a organizing (both enabling and restricting) condition for all human reflection.

Practice approaches

There are two forms of reductionism we have to avoid if we want to understand social behavior, Giddens argues. First, a type of reductionism which suggest that we can fully explain the causes of human behavior by reference to characteristics of single individuals, reflected in their intentions and unconscious motivations. Second, the type of reductionism which sees intention and motivation as mechanically governed by a structural reality outside the individual actor. In his *structuration theory*, Giddens regards agency and structure as levels "of equivalent interest and importance, aspects of a duality rather than a mutually exclusive dualism" (Giddens, p.30). He

recognizes that the task of formulating a theory which combines structure and agency demands "a very considerable conceptual effort" (Giddens, p.xxi). This partly stems from the complexity of the subject matter, but also from the fact that in combining these two perspectives, he has to use words that are embedded with assumptions Giddens wants to disagree with. For this reason, he introduces a variety of neologisms, and he also defines already known terms in a way that differs from their traditional meaning. I will give a brief account of the meaning he ascribes to the terms most useful for the discussion in this paper.

Structure: "Rules and resources recursively implicated in reproduction of social systems. Structure exists only as memory traces, the organic basis of human knowledgeability, and as instantiated in action" (Giddens, p.377). Structure thus does not have an existence in and of itself, it's only existence is through the formative impact it has on social behavior (practices), such behavior being "reproduced chronically across time and space" (Giddens, p.xxi). Partly structure function as *rules*, conceived of as (a) normative elements which restrict the realm of permitted behavior; and (b) codes which ascribe certain significance to certain types of behavior. Partly structure functions as a *resource*, by which Giddens means (a) authority, arising form the organized and coordinated features of those social activities where some exercise a legitimized control over the other, and (b) allocative resources, stemming from control over "material products or aspects of the material world" (Giddens, p.xxxi).

At the core of Giddens theory is the concept of *duality of structure.* Giddens sees structure both as the medium through which social interaction is organized, and at the same time, as the outcome of such social behavior: "The

structural properties of social systems do not exist outside of action but are chronically implicated in its production and reproduction" (Giddens, p.374).

> [Practices] are not brought into being by social actors, but continually recreated by them via the very means whereby they express themselves *as* actors. In and through their activities agents reproduce the conditions that make these activities possible. (Giddens, p.2)

Stratification model: This is Giddens' account of human agents, described in terms of the grounds/reasons for their behavior. Giddens points out that structuralist models have treated individuals as if all human behavior arose as a mechanical response to external stimuli, in the same fashion as involuntary neurological reflex loops. This is not a probable account, Giddens says, as our experience to the contrary tells us that humans in general are able to produce some kind of verbal account of why they do what they do -- demonstrating a *discursive knowledgeability* about the reasons for the actions. Structural models fail to "adequately grasp the level of control which agents are characteristically able to sustain reflexively over their conduct" (Giddens, p.5).

Knowledgeability is thus central in Giddens' stratification model, but in a precise and limited way. He identifies three layers of cognition/motivation characteristic of the human actor: "discursive consciousness, practical consciousness and the unconsciousness" (Giddens, p.376). Self-reflexivity corresponds to the first layer in the stratification model: "To be a human being is to be a purposive agent, who both has reasons for his or her activities and is able, if asked, to elaborate discursively upon these reasons" (Giddens, p.3). But he is careful when referring to terms like 'purpose' and 'reason' -- he does not want to ascribe to them the sort of 'hermeneutical voluntarism' they have often been associated with in philosophical literature. Whereas the first level is

one of *discursive* knowledgeability, the second is one of *practical* knowledgeability (which Giddens sees as a factor of greater importance than the discursive consciousness in day-to-day activities). Both this second layer and the third (the unconscious) represent grounds for action which differ from rationalizable, goal-oriented reasons for behavior, in that they cannot be immediately represented in discursive form, indeed, often individuals would be incapable of producing a verbal account of these grounds for their action. Even if a person can present a coherent and probable explanation for her behavior, this does *not* mean that this account represents all relevant information of the causes for that behavior. *Reasons* are simultaneously found at several levels, not only that of discursive consciousness. Giddens reminds us that the tendency to "equate reasons with 'normative commitments' should be resisted; such commitments comprise only one sector of the rationalization of action. If this is not understood, we fail to understand that norms figure as 'factual' boundaries of social life..." (Giddens, p.4). The stratification model assumes that all these three levels must be included in a probable account of human social behavior, that they together form an account of social action (practice) as "embedded sets of processes" (Giddens, p.3).

Contextuality: "The situated character of interaction in time-space, involving the setting of interaction, actors co-present and communication between them" (Giddens, p.371). We may say that contextuality is a concept that describes one particular instance of social interaction between agents, whereas *practice* is used as the repetitive, structured, and reoccurring forms of social interaction. According to the stratification model, individuals who engage in social practice, are not only constantly self-reflexively monitoring their activities, they are also monitoring the conduct of the other actors, and they

are also being monitored by the others. This happens at the level of discursive consciousness, which explains part of the interactive aspects of social behavior, but not all of it. More important to the ongoing flow of social interaction is the practical consciousness, a type of knowledgeability which cannot be expressed discursively (Giddens, p.375):

> The vast bulk of... mutual knowledge incorporated in encounters, is not directly accessible to the consciousness of the actors. Most such knowledge is practical in character: it is inherent in the capability to 'go on' within the routines of social life. (Giddens, p.4)

So far we have seen that Giddens wants to describe social behavior in a multi-faceted manner, of which one level (the discursive consciousness) permits for explanations similar to that of the agency models; the two others are influenced by structure (Giddens' version of structure, that is). None of these three levels is in and of itself sufficient to describe social behavior: this is the reason why we must both consider agency *and* structure to give a probable account of any contextual interaction. Since we are all familiar with the experience of planning and deciding upon a course of action, I will assume that the agency component of Giddens' model is the one which is most readily accepted. The structurally determined components of practice, on the contrary, demands some more explanation. What are the mechanisms by which our action can be influenced 'from the outside'? One reply to this is formulated in Giddens' concept of *routinization:*

Routinization is the habitual, taken-for-granted forms of daily activities, all the standardized forms of action and interaction that makes the flow of social life smooth and predictable. Routinization is expressed in the familiar habits and standards of behavior which are central for our ability to participate

in social interaction. Not only does it serve to organize and structure groups of human individuals, it is also important for each person's sense of order and predictability: "Routinization is vital to the psychological mechanisms whereby a sense of trust or ontological security is sustained in the daily activities of social life" (Giddens, p.xxiii).

The probability of Giddens' structuration theory partly rests on the plausibility of his account of routinization. The *duality of structure* is formulated as a claim that structure is both a *medium* and an *outcome* of the ongoing flow of social interaction in day-to-day activities. We may say that structure is reflected in routines, which pose both as a medium and as an outcome of practices: "Routine is integral both to the continuity of the personality of the agent, as he or she moves along the paths of daily activities, and to the institutions of society, which *are* such only through their continued reproduction" (Giddens, p.60). The concept of routinization is grounded in the second level of human cognition/motivation in the stratification model: That of practical knowledgeability. Routines thus cannot be described merely in terms of structure (as if they were an external 'ruler' of behavior), neither can they be understood in terms of agency (as if they all represent the product of discursive consciousness). Of course, routines may be challenged, interrupted, questioned by those who engage in them. But the 'bulk' of everyday activities is so complexely composed of routinized behavior, to question them all would be perplexing for the ongoing flow of action and interaction.

Another mechanism by which the structure influences our behavior 'from the outside' is described in Bourdieu's account of 'strategies.' As social beings we are more than biological organisms -- we occupy a 'position.' Two such positions are those of 'physician' and 'patient.' Through rules (codes of

behavior), each of those positions grants the biological organism who occupies that social position access to a set of structural resources. To 'get one's will' one may try to mobilize those resources, and with skill and cunning, one may get a lot done -- be powerful. This power does not come from within, it resides in the structure, who in this sense in not only restricting, but also an enabling factor (Bourdieu, p.8-9). Again, the practices approach reminds us that we must consider both agency and structure: our 'free will' is exercised as well as modulated within a structurated reality.

The extent to which the different layers of Giddens' stratification model form an embedded, unified whole can be illustrated by the presence of routinized, practical knowledgeability at the level of discursive consciousness expressed as self-reflexibility . To illustrate this point, I will consider a face-to-face interaction between two individuals: "Focused interaction occurs where two or more individuals co-ordinate their activities through a continued intersection of facial expressions and voice" (Giddens, p.72). The ongoing self-monitoring, monitoring of the other, as well as the sense of being monitored is characteristic for interactional practice. This monitoring and awareness is grounded in the first layer of the stratification model -- that of discursive consciousness -- in the sense that each individual upon request would be able to give a verbalized account of the meaning of their behavior and that of their interactional partner. But to say that this monitoring of one's self and of another purely arises from the level of conscious knowledgeability, would be to miss the vast impact on social interaction by rules and principles, as well as the impact of the subconscious. At this level, not immediately verbalizable, often not verbalizable at all, are all the principles that preclude social behavior which most people would find bizarre, incomprehensible, threatening to their

sense of ontological order. There is no need to designate a list of what such behavior could amount to, indeed, most of it is also barred from my own imagination, let us just agree that random facial grimaces is not the most outrageous expression of what is *routinely* excluded from acceptable social behavior.

How then does Giddens account for the role of power in social interaction? He agrees with the commonly held view that power is a capability to bring about consequences, "to 'make a difference' to a pre-existing state of affairs or course of events" (Giddens, p.14). But the capability to 'make a difference' within the structuration model does not arise from some qualities or capacities internal to individual actors. Rather, the exercise of power depends on mobilization of properties found in the structure. The media through which power is exercised is that of resources:

> Resources (focused via signification and legitimation) are structured properties of social systems, drawn upon and reproduced by knowledgeable agents in the course of interaction. (Giddens, p.16)

Giddens has defined structure as a set of *rules* and *resources*, so we see that power then is one mechanism by which the components of structure may influence the course of social interaction; the other is the normative and significative impact of rules. Resources have been described as either authoritative or allocative, and from this it follows that power may either take the form of the capacity to influence and control other persons founded on the signification or legitimation allocated to the person who exercises authority; or of the capacity to influence or control others founded on the allocated command over material goods, or over other material phenomena. To 'be

powerful' should be understood as occupying a position that through ongoing practices has acquired a legitimate control over structural resources:

> Power within social systems which enjoy some continuity over time and space presumes regularized relations of autonomy and dependence between actors or collectivities in contexts of social interaction. But all forms of dependence offer some resources whereby those who are subordinate can influence the activities of their superiors. This is what I call the *dialectic of control* in social systems. (Giddens, p.16)

Power, in Giddens view, is *not* in itself a resource. Nor is it a quality of individual agents. Power is the capacity of bringing about consequences. This capacity arises as a product of a social process which involves individuals engaging in structured activities.

Russell and Weber focused on situations of conflict in their analysis of power, the same is true of Poulantzas and Marx, as well as a number of other authors adhering to both the structural and the agency theories of power. The authors within practice approaches, on the contrary, have been concerned with the whole range of social practices. Bourdieu typically uses trivial examples to illustrate his points: a handshake, a friendly greeting, a threat or a favor, or a gift. The importance of all these activities is that they are structured (and structuring) social practices, Bourdieu claims (Bourdieu, p.194-5). Giddens states that instances of power are not particular to specific types of social conduct, rather power is a capacity to activate structural resources which function as a routine element of all social interaction (Giddens, p.16).

Different ways of combining structure and agency

The agency view of power most closely resembles the trivial, ad hoc explanations people tend to form when they ascribe a causal role for social

effects to individuals or groups of individuals: 'He *caused* me to feel like an idiot'; 'They *persuaded* us to stop working,' etc. The structural view of power holds that the reason for social behavior is not found in the realities immediately available of the situation we want to analyze, and shifts the focus to some extra-individual reality: 'The ultimate reason why she acted like she did is found in some religious ideas instilled in her'; 'Society causes people to commit suicide,' etc. The practice approaches shift the focus back to the realities of the situation we are evaluating, but ascribes to power a more complex nature, one which has to include considerations about the structural reality: 'As an effect of the role ascribed to her by the organization she represents, the executive adopted an intimidating stature toward her inferiors; in that sense her behavior is not only a function of the organization, but also her particular contribution to the construction and reproduction of the organization.'

If we agree that the agency view of power alone is uncompelling as a theory of all types of human social interaction, and likewise the structural model, we are left with the task of finding a way of talking coherently about power which permits consideration of both structure and agency. I will describe four different ways this *could* be done. The first two are less compelling than the two that follow, but nevertheless described, since they reflect assumptions about power present both in informal and scholarly discussion.

The first option would be to expand the definition of agents so that it included all types of structural entities -- our social universe would then merely consist of different types of agents, some individual, others structural. Structural agents would be akin to other organized entities (like human beings),

striving to obtain its own goals, and also accountable for its actions. This way of thinking is reflected in the following statement form an article in *Time:* "How did it happen, the public wondered angrily, that Elisa's case was known to the system, and yet the system so shamefully failed her" (van Biema, p.34). In this case, the 'system' is held morally accountable for the death of a six year old girl who was abused and eventually killed by her mother. The 'system' is, in this case, the city authorities, who had been notified at least eight times about the circumstances of continued violence and terror under which Elisa lived. As an abstraction, or a metaphor, this way of speaking *may* provide useful insights, but if we want to say that a 'system' really is an agent, which should be treated similarly to individual agents, we run into problems. Whereas single actors are entities spatially limited by the extent of their bodies, social systems have no such spatial unity. For this reason, and others, the type of agency and moral and legal accountability we could ascribe to systems would have to be so different from what we could ascribe to individuals. To treat them as one class of entities (social agents) would confuse, rather than improve, our thinking. Indeed, Elisa's mother, and not the 'system' was charged with second-degree murder; and the critique of the 'system' in the Time article boils down to critique of single individuals: a judge, awaiting reports from the leader of a federally run parenting program, who in turn awaits for reports from the Child Welfare Administration caseworker, who in the article is reported to have said that he was "too busy" to stop by Elisa's home. Both for practical and theoretical reasons, this way of reconciling the opposition between structure and agency is uncompelling.

The second approach is to include the terms of structural thinking (*institutional* constraints on physicians' behavior, the impact of *culture* on the

patients' perception of illness, etc.), and then conduct a discussion which in essence is purely based on the agency approach to power. The structural elements are then merely used to represent a scenario, useful as background information, in the same way as genetic components (inherited low IQ); physiologic components (aggressiveness caused by a hormonal imbalance), etc., might provide relevant information. Once all the relevant background information is gathered, we can get down to the *real* analysis, which still deals with how the doctor and patient interact as single individual agents. Structural elements are in this view regarded as 'analytical noise,' which should be filtered away to better understand how the true selves (the knowledgeable agents) interact as they do. The central methodology and assumptions of this approach are similar to a pure agency view.

A third model is offered by the *practice approaches.* Giddens' structuration model has illustrated this view. According to the practices approach, power is not an entity possessed either by agents or the structure, rather it is the product of a social process which involves both agency and structure. In this model, the sources of power are located in a structured reality, but activated through agency.

A fourth approach, which I will refer to as *theoretical pragmatism,* holds that our models about the world should not be based on any definite location of power. This could be argued either by holding that there is no such thing as power in the real world -- power is only a theoretical construct designed to make sense of the human conditions; or by holding that *theoretically* power might well have a fixed location, but since we can never know for sure or agree on what its location is, we would be better off basing our theories on other grounds than ideas about a definite power locus. According to the pragmatic

approach, if we want to discuss the impact of social institutions, it would be permissible to view power as a purely structural entity. If, on the other hand, we want to describe single individuals, we might view power as a resource or capacity possessed by that person, independently of structural consideration. For certain types of social interaction, again, the best option might be to view power as the product of a process which involves both structure and agency. For the pragmatist, statements like 'he is powerful in himself,' and 'the structure by its own virtue exercises an influence over people,' may both be valid and sensible statements, depending on the context in which they are uttered. The proponent of the practices approaches would object to such statements, claiming that it is misleading to suggest that a person by virtue of her own characteristics and capacities could be deemed powerful, regardless of the structure in which she is situated.

Theoretical pragmatism, like all eclectic approaches, has the advantage of providing a set of different theoretical tools, which makes it a dynamic, adaptive, multi-faceted approach to theoretical problems. There is no conclusion reached from more stringent models that cannot simultaneously be reached from the pragmatic position, since the pragmatist may merely add to his toolbox the methodology of the more stringent tradition. But theoretical pragmatism also shares a problem with all other eclectic approaches: How can we decide which tool to use if two of the available tools would yield different types of conclusions in a given situation? This illustrates the strength of the practices approaches: it provides a unifying theory which describes within one coherent theoretical framework the interaction between structure and agency.

3: POWER IN THE CLINICAL SETTING

He who needs something may hope that somebody else has what he needs. The object of his hopes, the provider, has power over him. First, she has the power to shatter his hopes, to say that she does not have what he needs. Second, if the provider has what he needs, she has the power to give or withhold it.

The patient comes to the physician with a demand, assuming the physician has something that the patient needs. That 'something' is one obvious source of the physician's power. Sometimes this source is theoretical knowledge about symptoms, treatment, and prognosis. It may also consists of practical skills: diagnosing a fractured arm, putting on a cast, suturing a wound. When the patient wants a medical certificate or a drug prescription, the source of the physician's power is the formal authority to issue such documents. The physician's power can also arise from a combination of medical and psychological knowledge, and personal charisma. This may be the case in the treatment of a depressed patient, one that wants help with a drinking problem, or one that wants to lose weight.

Having something the patient needs is only one among many sources of the physician's power. She decides how much time to spend with the patient. She controls the content of the conversation: she asks the questions, she interrupts, she changes the topics (Meetuwesen et al.). She decides where the patient should sit or lie down, and whether or not he keeps his clothes on. If she finds it necessary, she touches the patient's body, sometimes even the intimate areas. Based on his own experiences in medical training, Pappas writes:

> Perhaps the most profound manifestation of power in doctor-patient interaction is its disposition of the human body. The intimate nature of the physical exam involves the physician taking control over the body, even its very motion... Descriptions of the simple techniques of percussion, auscultation, and palpation do not convey the intimacy of the physical exam, which unlike even sex, requires near total surrender of the body. (Pappas, p.202)

To be powerful

Power is thus typically unevenly distributed between the physician and the patient, and for a number of various reasons. Still, it is not the case that the physician can manipulate the patient to do whatever she wants him to do. If the patient refuses to submit himself to a clinical examination, none of the physician's sources of power give her capacity to force her will through. She might of course try to use her authority, for example by pointing out that the patient might be suffering from a dangerous condition, and that the quickest way to exclude this possibility would be to undergo a physical examination. But if the patient distrusts the physician, or for other reasons refuses to succumb to her authority, she has no power over him. Rather than the physician being powerful by the virtue of her training, her skills, or her position alone, we see that her power arises as a product of the interaction between her and the patients -- through this process the legitimacy of her power is established, reproduced (and sometimes, challenged). Skills and insights are not in themselves sources of power, they become so only when the patient 'invests' his trust in them. The physician's skills and her insights are hers, the patient cannot take them away from her. But her power is not hers alone, and can, at any moment, be taken away from her (although this does not happen very often, we should not think it cannot not happen).

In other words, the physician is not powerful by herself. Her power is a product of a social process. If the physician's power appears as a static entity, rather than a dynamic and alterable product, it is because the contextuality of each clinical encounter follows established canons of appropriate behavior for the practice of medicine: the patient adapts to a set of constraints and expectations embedded in the 'patient role,' and the physician acts like physicians are expected to act. To say this is not to suggest that the patient's and the physician's behavior are mechanical responses to the force of tradition. The two roles neither embed universal or necessary sets of behavior, rather they represent the effect of well established structural rules, which dictate both the norms and meaning of behavior in the clinical setting. Giddens refers to such a situation as the arising from *routinization*. Routinization helps to coordinate behavior without inventing the set of social rules form scratch for each new encounter, as well as it serves to produce a sense of ontological predictability, crucial for the feeling of trust, as well as control. If the physician's phone rings during the encounter, it will not profoundly challenge her patient's feeling of trust or control if the physician spends a couple of minutes on the phone. If, on the contrary, the patient's wire-less phone rings, and the patient engages in a conversation, the physician's sense of control and order would be threatened:

> We can probe the psychological nature of the routine by considering the results of situations where the established modes of accustomed daily life are drastically undermined or shattered -- by studying what may be called 'critical situations'. (Giddens, p.60)

The principle of who may answer phones and who may not in the physician's office is not a universal law, dictating the content of the clinical encounter from

the 'outside,' and it is not a rule which could not, in principle, be re-negotiated. But neither is it the product of a conscious reflective process, by which the physician and the patient come to agree that this rule is the best way to organize their encounter (at least, for most patients and physicians it is not). Rather, the phone-rule is an embedded part of the practical knowledgeability which facilitates the ongoing flow of interaction between physician and patient: a routinized form of knowledge.

Throughout the clinical encounter, both physician and patient engage in a constant reflexive monitoring of their own behavior, and of each other's behavior. The experienced physician can also rely on an embodied practical consciousness, represented in automatized sets of behavior which she performs without having to reflect consciously on them. The patient also has his practical consciousness, but since the setting is unfamiliar, and since he is alert, maybe stressed, his level of knowledgeability is of relatively less help to him than the physician's practical knowledgeability is for her. To guide his actions, he will have to rely more strongly on his discursive consciousness, and most probably, the setting will make him feel somehow stressed, incapable, and powerless.

Even if we agree that the physician's power is a product of the mutual interaction between her and the patient, it would be unwise to suggest that we should refrain altogether from speaking and thinking of the physician as a 'powerful person.' This is because phenomenologically, we have all experienced situations where we felt 'powerful' or 'powerless' in and of ourselves, and we have all been exposed to people who we perceived as 'powerful,' in that they could get us to do things we did not want to do. Not only does the statement, 'she has power over me,' correspond to a universally known experience, that

type of statement is also so widely and commonly used. We are not likely to do away with such phraseology. What we *should* do though, is to get clear on what exactly that statement signifies, to avoid being confused about the nature of power relationships. Thus, I suggest that to 'have power' and to 'be powerful' should be taken to mean the same thing. They both arise from having access to sources (skills, capacities, social position, material resources, etc.) which through a contextual process is validated as structural resources (authoritative or allocative). These structural resources may be activated by the powerful person to bring about social consequences. To 'have power' or to 'be powerful' is a relative concept, one is only powerful within a certain context, and in comparison to another agent: "Power within social systems which enjoy some continuity over time and space presumes regularized relations of autonomy and dependence between actors or collectivities in contexts of social interaction" (Giddens, p.16).

It may confuse the reader when I talk about the physician 'being powerful' and 'using power,' since the point of this thesis is to argue that power is not something you 'have' or 'use' in the same fashion as you may have money, or use your physical strength. To be in line with Giddens' theory it would indeed have been better to talk about 'having capacities' and 'activating power' -- but again, I can hardly expect to change everyday language, so I will instead accept it, but retain a sensitivity to its potential for creating confusion about the reasons why some people are conceived as powerful.

Even in well established unequal power relationships, the control exercised by the powerful is never absolute. Giddens reminds us that the subordinate always has access to some resources, which, if skillfully employed, may be used to influence the behavior of the more powerful. From

this, it follows that the mere fact of getting one's will with regard to a particular desire or objective, does not signify that one is in a position of power: To be in power entails a temporally relatively stable situation of authoritative or allocative superiority.

To use power

In the remainder of this chapter, I will be particularly interested in the expression 'to use power.' I will hold 'uses of power' to be situations where A is more powerful than B; and A consciously uses this power advantage to bring about particular changes in the conditions of B. When I say *consciously*, I want to include both the *discursive* and *practical* consciousness from Giddens' stratification model. This means that if a physician is self-reflectively aware of the fact that she uses her position of authority to influence the patient in a certain way, she is then 'using power.' But also instance where she influences the patient through practicing her skills, without being self-reflectively aware of all the consequences of her behavior, should count as uses of power. Whereas a discussion of the mechanisms by which the physician is constituted as powerful must focus on the process and mechanisms of interaction in the clinical encounter; a discussion of when it makes sense to say that the physician has exercised power takes an unequal power relationship for granted, and focus on the extent to which the power imbalance can account for specific outcomes of the interaction.

I will compare the concept of 'use of power' with the so-called placebo effect in three clinical cases. The first one is a commonplace clinical encounter, presented in an article by Brody. The other two cases are more spectacular: one told to me by a lecturer in psychosomatic medicine; the other a piece of

fiction. In discussing the cases I will focus on the impact of the physician's power on the outcome of the encounter, and in particular on the placebo effect. I will argue that the placebo effect in the first two cases represents instances of a physician using power. As for the third case, even though spectacular, I will argue that the physician did not exercise power in that case.

A patient presents to his primary-care physician with rhinitis and other signs of an upper respiratory viral infection. He expresses fears that he may have pneumonia, since a fellow worker with similar symptoms had to be hospitalized for this illness a week before.

After taking a careful history and auscultating the chest, the physician announces that pneumonia is quite unlikely and that the worrisome cough is probably due to nasal secretions. The doctor recommends a decongestant along with rest and fluids. The patient immediately starts to feel better and, two days later; is almost completely recovered (Brody 1986, p.106-7).

To assess whether or not the physician 'uses power' in this case, we must first identify an outcome; and then discuss whether or not the physician was central in *causing* this outcome. Identifying the outcome is a task that poses it's own theoretical problems. I do not want to engage in such discussion here. Rather, I will assume that it is plausible to view the outcome of this encounter as consisting of four components: 1) Agreement on a diagnosis (also excluding the probability of differential diagnosis); 2) Agreement on an appropriate treatment; 3) The patient instantly feeling better; 4) Recovery some time later.

The power to determine diagnosis: The diagnosis is reached through a process where the patient presents his complaint and the physician gathers supplementary information by asking questions and conducting a clinical exam. We can assume that the physician reasons by comparing this particular case with paradigmatic cases that come to her mind, and with her body of general medical knowledge. This reasoning leads to a conclusion that takes the form of a probable diagnosis, and a statement that the patient is most likely not suffering from what he had feared. We can only guess what line of reasoning lead to the physician's conclusion, and how sure she is about the diagnosis being correct. Maybe she feels convinced that the case is unproblematic, and she adds the modifiers (probable, quite) only because she knows that in medicine even the surest thing is never one-hundred percent sure. The use of modifiers is also encouraged by the constant threat of being sued for malpractice: most expressions of certainty will look bad if quoted in a court case.

Having analyzed audiovisual recordings of physician-patient encounters in family practice, Richard Street concludes that "through their communicative styles, patients can exert considerable control of the amount of information they receive from doctors" (Street, p.546). Physicians may also encourage patient participation and input in the clinical reasoning. In the case discussed here, the patient might ask: What do you mean by probably; What other diagnosis had you thought of; Why did you rule out those others? A physician who is motivated to encourage patient participation will give open and truthful answers to such questions. But no matter how strong the patient's desire for being in control, and how strong the physician's sympathy for this desire - the ultimate power to set the diagnosis lies with the physician. This is so, not so

much for traditional and legal reasons, as it follows from the nature of the doctor-patient encounter. It would be impossible, as well as bad medicine, for the physician to give a complete disclosure of all the reflections and whims that passed her mind in the process of reaching a diagnosis. Maybe a medical rarity, like a primary tuberculosis of the nasal septum, had come to her mind while examining a patient with a probable common cold. Though conceivable, such a diagnosis is exceedingly rare. If she felt obliged to disclose this differential diagnosis to an interested patient, her explanation would generate more questions, and the encounter would have no end.

The power to determine treatment: We do not know exactly what happens where our summary case description states that the doctor "recommends a decongestant along with rest and fluids." If the physician bluntly states what treatment is recommended, and this is accepted without questioning, we have a clear-cut example of physician using her power to influence the patient. For, obviously there are other treatment alternatives available, both more and less aggressive. If the physician presented this treatment as the only possible response to the condition at hand, the advocates of patient autonomy and informed consent would probably hold this to be an example of physician paternalism, or translated to power terms: unjustified use of physician power. According to the model of patient autonomy developed in the 1970's, the physician's role should be strictly confined to presenting facts to the patient, leaving to the patient to make his own decision, free of coercion, and purely based on his own values. In his critique of this model and later more refined versions, Brody argues for a conversation model, where "the goal is to help the patient make the best decision, not to provide the patient with maximal knowledge" (Brody 1992, p.99). Let us assume that the physician in our case

had presented to the patient her three most plausible responses to the given conditions (no treatment; decongestants; antibiotics), and the arguments for and against each of those. This could possibly enhance the patient's ability to make the choice that best fits his personal preferences. Brody points out that:

> At any rate, the general statement, 'In your situation, some people would do X, while others would do Y,' is often suggested by skilled interviewers to give the patient the widest possible permission to make a free choice. (Brody 1992, p.98)

Some studies suggest that patients are well equipped to choose between alternatives even when the alternatives entail considerable risks. Other research on the contrary indicates that chances of choosing the optimal treatment diminishes if extra options are added to a list of possible treatments: "adding new options can increase the probability of choosing a previously available alternative or, in particular, of maintaining the status quo" (Redelmeier and Shafir, 304):

> The economist Schelling, for example, tells an anecdote about going to a bookstore to buy an encyclopedia, discovering that two different encyclopedias were on sale that day, and purchasing neither because he lacked a clear reason for choosing one over the other.[2]

For the purpose of our discussion, namely to determine whether an asymmetrical power relationship is likely to have caused the patient's decision, the point is not to determine how many different alternatives the physician ought to present in order to enhance patient participation. For, ultimately it is only the physician who can judge what alternatives to present, and how to

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[2] Tversky A, Shafir E. Choice under conflict: the dynamics of deferred decision. *Psychol Sci.* 1992;3358-61 (Quoted by: Redelmeier and Shafir, p.302).

present them. Paraphrasing two social scientists, we can say that power may be, and often is, exercised by confining the scope of decision-making to issues that the physician finds acceptable.[3] This sort of influence is not objectionable per se. On the contrary, we might say that it amounts to what Måseide refers to as a necessary form of influence in competent clinical work (Måseide, p.553). The list of treatments a skilled physician finds potentially acceptable in the case of one particular patient, is exactly what the patient is looking for. One could say that by choosing to visit a physician, the patient is implicitly asking to be the object of this sort of influence.

What causes the patient instantly to feel better, and to recover some time later? In the same article as our case is taken from, Brody writes:

> Throughout the history of Western medicine, three basic types of explanations have been offered to explain ill patients' improvement. Explanation 1: The patient improve because of the specific pharmacologic or physiologic potency of the treatment prescribed. Explanation 2: The patient improved because of the natural history of the disorder and the body's inherent recuperative powers. Explanation 3: The patient improved because of the symbolic dimensions of the healing encounter (in this case, the patient's hope and expectation that the physician could help, the reassurance that the patient did not have pneumonia, and the comfort promised by the decongestant). (Brody 1986, p.115)

The placebo effect is the change in a patient's condition arising from the symbolic meaning of the clinical encounter, independent of the pharmacological properties of drugs, and other medical interventions. It corresponds to the third explanation in the scheme above. Explanations for the placebo effect are speculative: endorphins have been suggested, as well as the catecholamine

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[3] Barach P, Baratz MS. Power and Poverty. Theory and Practice. New York: Oxford University Press, 1970 (Quoted by: Lukes 1974, p.18).

system, and psychoneuroimmunological responses (Brody 1988, p.151). It is often claimed that the placebo effect has an impact in virtually all medical encounters, sometimes alone, sometimes in addition to the other two explanations suggested. The placebo effect can be demonstrated in clinical research: K.B. Thomas reported a significant difference in self-reported recovery between patients that were given "a firm diagnosis and told confidently that they would get better in a few days" and patients told "I cannot be certain what is the matter with you" (Thomas, p.1200).

As for our case, there is no reason to think that the natural history of the patient's condition would entail an abrupt amelioration at the end of the encounter; and since the patient had not yet started the proposed treatment regime, we must conclude that the 'immediately starting to feel better' was probably caused by the placebo affect.

Theoretically, each of Brody's three explanations could by itself provide a sufficient explanation for the complete recovery after some days. As we could see the placebo effect demonstrated immediately, we must believe that this effect also played a part in the process of further recovery. In cases where treatment plays a central role in recovery, the physician's skill is typically the major influential component. The physician's influence is either direct, as in surgery; or indirect, as in the choice of drugs and other treatment the patient administrates himself. In this case we can only speculate about the impact of the physician's impact on recovery via choice of treatment. The natural history of the disorder is by its definition immune to influence from the physician.

That leaves us to assess the impact of the physician's power on the placebo response. It might be tempting to see the placebo effect as a prime example of the physician's power. But, as I will argue later, all instances of

placebo are not necessarily instances of power. Dr. Thomas is clearly exercising control over the patients that get better when he assures them that they will do so. His source of power is an explicit knowledge of his ability to influence the patients: "The doctor himself is a powerful therapeutic agent; he is the placebo and his influence is felt to a greater or lesser extent at every consultation" (Thomas, p.1200). But does the physician in our case possess a similar source of power? The case is presented in a dry and sober fashion; we cannot know whether this physician shares Dr. Thomas' insight in her potential as a 'human placebo.' Still, her actions convey at least an implicit understanding of the symbolic dimensions of the clinical encounter. Even though the symptoms are relatively sparse, the physician takes a "careful history," she auscultates the chest, and she specifically addresses the patient's fears in her conclusion. She also suggests a treatment ritual that would remind both the patient and his surroundings that he is legitimately ill, and should be excused from his normal duties. The practical skills of this physician embrace an insight in the placebo effect; these skills mobilize power which rests in the structure of the clinical encounter. More specifically, the structural resource of power in this case is a type of authoritative power, founded in the patients' beliefs in the physician's healing powers. Through her practice (what Giddens calls practical knowledgeability) the physician mobilizes this power. We will now leave this case, and consider the first case of mysterious healing:

A seven year old boy comes to the physician accompanied by his mother. Part of his hands are covered with persistent warts. Several treatments have been tried, with no effect. The boy is unhappy, his mother concerned, and the physician tired of being of no use in the war against the warts. A strange idea suddenly strikes the physician, a plan he cannot resist. He takes the boy's hand

and studies it carefully. Then: 'There! There, do you see it? The mother wart. All the other warts are her children.' He proceeds to dramatically sticking a syringe in the center of the big wart, announcing 'Now that the mother wart is dead, all her children must die too.' Within two weeks the warts are gone (This story was passed on to me by Professor M. Patris, at the psychiatric clinic of Strasbourg University Hospital).

This is an example of pure placebo effect, and also a striking example of the physician's capacities. It permits us to more clearly analyze the impact of power in cases of placebo. What is the source of power in this case: the physician's cunning idea; the magic role he assumes in the interaction; or is the source of power within the boy himself? With an imprecise definition of power, we could say that all three suggestion are valid evaluations of power -- indeed, in everyday language, we would both speak of a powerful idea, a powerful magician, and the patient's self-healing powers. The physician's success here arises from a special type of knowledge. He has at least some instinctive ideas about the patient's transference mechanisms: "the process of transference leads patients to project onto the [physician] all kinds of magic expectations, hopes, and fears that are intrinsically irrational because they emerge out of confusion not only of past and present but also of fantasy and reality" (Katz, p.143). In this case the physician not only takes advantage of unconscious beliefs, he actively leads the patient into a magical world. He lies to the patient, this type of influence we might refer to as a form of benevolent manipulation.

It is true in a sense that the boy must be seen as the possessor of his own fantasy world, and consequently as possessing the source that causes the warts disappearance. But his imagination by itself had been no source of

healing. The boy's magical beliefs are consciously being used as the physicians tool for doing away with the warts. The physician knows something about his patient that the patient himself does not know: that if he believes strongly enough that the warts will disappear, that will actually happen.

Respecting Giddens' structuration theory, we should say that the physician's insight, as well as the patient's fantasy world represent aspects of the resources each of them may mobilize, but not in and of themselves power, or even sources of power. The physician's insight *becomes* a source of power in the process where the patient and the physician engage in interaction, and it does so because his patient trusts him. In this connection it would be wrong to think that boy's imagination functions as a source of power: it is nothing he uses to bring about changes in his environment. From his powerful position, the physician is able to mobilize the potential of self-healing in his patient, and this he does by employing his knowledgeability as a physician. The knowledgeability he uses in this case is partly conscious, partly practical: the innovative idea which "suddenly struck him" partly arising from a level of discursive insights, partly from a level of intuitive knowledge embedded in the practical skills of physicians. Lastly, we will look at one more case of miraculous healing:

A twenty-six year old female student comes to a general practitioner. She is experiencing an intense stomach pain. On examination, the physician finds yellowish scleras, and a mildly enlarged liver. Suspecting liver disease, he takes blood sample for liver enzymes (they later turn out to be normal). As the physician is about to end the encounter, the patient sees a crucifix he carries around his neck. She exclaims that this is the sign she had dreamed of, and that the pain is now gone. Before the physician even has time to respond, the patient

is out of his office. The physician happens to encounter the patient a week later, and notices that the scleras now are perfectly white.

Again an instance of placebo - at least for those of us who normally prefer to explain healing in other terms than divine intervention. No treatment has been suggested, and we have no reason to think that the natural history of a suspected liver affection would be to heal spontaneously while the physician watches. The symptoms are gone, and some objective signs vanish within days. Maybe the patient attributes magical forces to the physician, we cannot know. In spite of the similarities with the previous case, there is one fundamental difference here: the physician is totally without control over the outcome. Healing took place in front of his eyes, he did not initiate it, he did not suspect it, he did not understand it. We could say that the episode is powerful (meaning striking). We could refer to the fact that physicians, in general, are in a position of power. But it would be wrong to claim that this is an instance where the physician exercises power. The physician has become the object of his patient's mystical fantasies, he has been used as an instrument in her auto-healing. The patient's fantasies about the physicians healing capacities do not by themselves make the physician powerful. Only when the physician has some understanding (discursive or practical) of these fantasies, and employs these from a position of power stemming from authoritative or allocative resources, legitimated through the interactional process between physician and patient, we could say that the placebo response is mobilized through the physician's use of power.

4: POWER AND ETHICS

In order to meaningfully discuss what *we* ought to do, one must make some assumptions about what kind of beings *we* are, and about the natural conditions in which we live, act, and interact. A particular paradigm is explicitly or implicitly assumed to represent a plausible starting point for a moral discussion; the validity of the moral conclusions ultimately turns on the plausibility of the paradigm within which they are formulated. By paradigm I mean a set of fundamental assumptions about the natural world and the human mind. The focus on power makes it possible to understand one aspect which ties insights from moral philosophy to insights from social sciences. Some theoretical moves must be made to establish this connection:

Among the most fundamental problems to be dealt with at the level of paradigmatic beliefs about the social world, are questions of why people do what they do around me, and what causes me to act and feel the way I do. Such questions could be formulated in terms of power. Within social sciences *power* is, in its most general sense, seen as the capacity of causing socially relevant effects. A *locus of power* is an entity that has the capacity to generate socially significant effects. A *moral agent* is in ethical theory understood as a being who can be held morally accountable for its actions (or non-actions). One of the prerequisites for being a moral agent, thus, is the capacity to cause *morally significant effects* (or by refraining from acting, not causing such effects).[4]

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[4] For the purpose of this argument, we need not be concerned with the question of how to define *socially relevant* and *morally significant* effects. The important thing is how the two classes of effects relate to each other. I will hold that all morally significant effects are necessarily also socially relevant -- since they directly or indirectly involve at least one member of the social community. But not all socially relevant effects are necessarily

Moral philosophy might not hold all socially relevant effects to be morally significant. Being a locus of power cannot then be a sufficient condition for being a moral agent. But, an entity that possesses no power (that cannot cause any socially relevant effects), can neither cause any morally significant effects. Being a locus of power is thus a necessary condition for being a moral agent. If, for example, the locus of power is placed wholly outside individual actors (as done in *structuralism*), then there is no agent that can act morally right or wrong, and no-one to hold morally accountable. A radical structuralist, who theoretically denies individuals all form of agency, cannot coherently talk about *moral obligation*, at least not with the meaning most often ascribed to *obligation* (perceiving a impetus to act in a certain way, and then voluntarily choosing to do so).

Since an ethical theory is founded on a paradigm, and a view of power forms a central part of a paradigm, we must assume that there is some form of coherence between how people think about *power*, and what type of moral theory they adhere to. I will not suggest that this coherence takes the form of a mechanical, rigid set of interdependencies. Neither will I suggest that a view of power is developed prior to (or after) a moral theory, or moral convictions. It seems to me more plausible that there is some sort of interaction, often unconscious, between a set of ideas about power, causes and effects (beliefs about the empirical world) on one hand, and a set of ideas about moral rightness and wrongness (moral convictions) on the other. The idea that people actually think this way has its counterpart in a normative model, *wide reflective equilibrium*, which says that this is a good way of thinking -- that, morally

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morally significant. How dress codes change between social classes may for example be interesting from a sociological point of view, but not necessarily so from an ethical perspective.

speaking, we *ought to* reflect in this fashion when we are faced with moral questions:

> The method of wide reflective equilibrium is an attempt to produce coherence in an ordered triple of set of beliefs held by a particular person, (a) a set of considered moral judgments, (b) a set of moral principles, and (c) a set of relevant background theories.[5]

In certain cases then, a debate over a moral question may be founded in a difference between the paradigms upon which the moral assumptions are made. In such cases the key to a moral resolution may lie in pin-pointing and evaluating specific parts of the paradigms, for example the views about power.

Views of power in schools of moral philosophy

I want to be a little more specific in suggesting what coherence there might be between views of power and moral theories. I think that moral philosophy is limited by the view of power it assumes. The connections I make are based on what I take to be resemblance of central features. I want to *suggest*, rather than *prove*, that such relationships exist. My conclusions here will have to be modest, because of the 'looseness' in the way I have described paradigm; and because there is no space here to discuss the particular ethical theories in any detail.

The *agency* view locates power within individual agents. One way of locating moral responsibility is to trace backwards through time, in search of the *true* origin of a particular effect. Once we find the *causative* locus of the effect we are interested in, we have simultaneously found the *morally*

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[5] Daniels, N. "Wide reflective equilibrium and Theory Acceptance in Ethics," *The Journal of Philosophy* 76; 1979 (Quoted by Clarke, p.241).

responsible locus for that same effect (if the locus is an entity that can be held morally accountable). This line of thought matches fairly well with *foundationalist theories* of ethics. They will typically formulate some general rules or principles that apply to all moral agents, moral agents could here be described as self-reflective loci of power. We can then say that the agency view of power fits nicely with, and permits for foundational styles of moral reasoning (like deontological and teleological models).[6] *Moral cynicism*, the view that each and all agents act according to what fits their personal interests best, and that this is OK, is also compatible with the agency view of power.

The *structural* view gives power a definite location outside the individual. This is bound to somehow ease the moral burden that rests on the shoulders of rational agents within ethical theories based on the agency view. The extent to which single individuals are released of individual moral responsibility will depend on how consistently and deeply held the structural view of power is. A view that places all power in the structure would indeed hold that there can be no such thing as morally good or bad actions, since we are all acting exactly like the structure predetermined us to act, neither better nor worse. If anyone is to be held morally responsible, it would have to be the structure itself. We see that the idea of formulating a valid moral theory collapses within a stringent structuralist view. We could call such a position *moral apathy.*

A less extreme version of structuralist thinking is to claim that fundamental moral convictions are instilled in us by the culture in which we are raised, morality is therefore wholly context-dependent, and it is only

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6 Kant's maxim 'never treat a person as a means, but always as a goal in itself' is the base of the most prominent deontological models; Bentham/Mill's maxim 'act so that you maximize the sum of utility' has been the common starting point of teleological models.

according to the local code a person can be held morally responsible. But -- this position grants at least an element of agency to single individuals, and should not be classified as coming from a pure structuralist view of power. It would better fit with what I will describe as *ethical pragmatism.*

The *practices approach* holds that power arises from a process that takes place when individuals engage in social interaction. Rather than being a static entity, residing in agents or in structure as a quality characteristic of these, power is seen as a dynamic entity, produced and reproduced through practice. Individuals exercise agency, but within structural constraints. Through routinization, the structure also has a modeling impact on the agency of individual actors. This account of power shares some characteristics with the Aristotelian concept of virtue. Virtue is a durable, internalized disposition to act morally rightly, acquired by engaging in practical activities[7]. One view of virtue is to see it as an entity by which human qualities deemed cherishable by a community are instilled in a person.

Theoretical pragmatism accepts structure, agency, and practices approaches as plausible models of power. This happens by a completely different approach from the one by which the practice approaches assimilate structure and agency. For, whereas practice approaches still hold that there is something definite to be said about power, and indeed propose a specific mechanism by which power functions, theoretical pragmatism is skeptical, or rather indifferent, to the question of where power *really* is located. The concept of power, like the concept of God, can only be evaluated in terms of what

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[7] In his rewriting of Aristotelian ethics, Macintyre defines a virtue as "an acquired human quality the possession and exercise of which tends to enable us to achieve those goods which are internal to practices..." (MacIntyre, p.191).

capacity it has for forming coherent and probable models of social life, the pragmatist holds. For certain purposes one power model may serve, for other purposes we would be better off using another model. There is no truth about power, or--if there is, we can still not quite grasp it, and surely never agree on it, so it is strategically wiser to leave such questions aside, and see models of power as conceptual tools and nothing more. The person whose mindset makes him likely to find such reasoning attractive, will probably also be attracted to ethical pragmatism -- a method of moral reasoning that takes nothing for granted, no God, no eternal moral imperative, no universal moral truth -- and who therefore invests his moral reflection in a purely reflective, rational, coherentist theory. Central theoretical 'tools' of ethical pragmatism are 'integrity-preserving compromise' (Benjamin, p.7) and 'wide reflective equilibrium' (Beauchamp and Childress, p.20-8; Benjamin and Curtis, p.39-44; Clarke, p.241-4; Nielsen, 316-32; Rawls, p.46-54). Theories of ethics whose conclusions are based on rational reflection are exposed to a radical critique from social sciences, one which questions the solidity of ideas about rationality and reason:

A deconstructivist critique of power

So far I have avoided including any views of power arising from postmodern thinking. This is partly because of my own lack of familiarity with such thinking, and partly because nothing seems to have been formulated within the postmodern tradition which aspires to do the job that moral philosophy does today (help people deal with what they perceive as moral dilemmas). It seems that at least one version of postmodern thinking, one that radically rejects any authoritative statements, will lead to the same point as

radical structuralism: moral apathy. Such a position cannot contribute in any constructive way to a discussion about the content of moral philosophy.

I will briefly indicate what a post-structural approach to the role of power in medical ethics and medical practice could look like. Central in Michel Foucault's writings is a critical assessment of power and knowledge, formulated in terms of their disciplining potential.

> Power must be analyzed as something which circulates, or rather as something which only functions in the form of a chain. It is never located here or there, never in anybody's hands, never appropriated as a commodity or a piece of wealth. Power is employed and exercised through a net-like organization. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising power... 'Truth' is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it. (Foucault, p.98&133)

Accepted as a *methodological* starting point, Foucault provides one perspective from which to evaluate moral philosophy, without necessarily having to reject the *practical purpose* of moral philosophy. The method would consist of seeing moral philosophy as a type of *expert knowledge.* Among the names philosophers use to describe views they are strongly opposed to are "dogmatic, biased, arbitrary, or irrational views" (Beauchamp and Childress, p.31). If the dogmatist wants to engage in a dialogue with the philosopher, he will be expected to respect some basic rules, often formulated in terms of reason, rationality, and coherence. But the very question of what amounts to a reasonable, rational or coherent argument is by philosophers treated as a philosophical question, a question to be dealt with by philosophical expert knowledge, briefly, the knowledge they themselves possess. From a Foucaultian perspective, we could exchange the capital 'T' in the Truth about

rationality with a small 't' -- regarding the current truth of reason and rationality as a *constructed* truth. This gives us the possibility of evaluating the historical process which lead to what is today deemed philosophically convincing and coherent thinking (what Foucault might have called the *genealogy* of moral philosophy). This perspective would also permit for a self-critical appraisal of the practice of moral philosophy by posing the question: what are the mechanisms by which the experts (the possessors of knowledge) as well as the novices (the students of knowledge) are disciplined by the power of moral knowledge.

Applied to the field of medical ethics, this perspective would lead us to focus on forces (for example economical and political) that influence the theory as well as the practice of medical ethics from the outside. Applied to medical practice, it would lead us to see physicians as the possessors of medical 'truth' -- a knowledge which generates power, and is generated by power (the circulating relationship between power, knowledge, and truth). Through their training, physicians have subjected themselves to the power of medical knowledge, and through their practice, they function as the disciplined and disciplining instruments of this knowledge. I will not pursue this line of thinking in this paper.

5: POWER AND ETHICS IN THE CLINICAL SETTING

The questions asked about power in social sciences are descriptive: What *is* the role of power in doctor-patient interaction?; How *does* the physician exercise power? The questions we could ask about power from the perspective of moral philosophy are normative: What role *should* power play in doctor-patient interaction?; When is it *morally justifiable* for the physician to use power?

Brody argues that the term *power* was excluded from the field of medical ethics in the late sixties, as a strategic decision by philosophers and theologians. By insisting on a strictly normative terminology, avoiding concepts connected with behavioral and social scientists, the pioneers of a new movement of medical ethics sought acceptance within clinical medicine (Brody 1992, p.36-9).

> My central argument is that medical ethics is about power and its responsible uses... I wish to show that with *power* put back into the vocabulary, a few puzzling issues in medical ethics begin to make more sense and the enterprise as a whole starts to hang together in a more enlightening way. (Brody 1992, p.12)

In chapter two we saw that hidden behind the word *power* are several concepts and models, many of which are mutually exclusive. The structural view of power, for example, is not something we could introduce to the vocabulary of medical ethics, as it denies the very ground upon which moral philosophy is based, the concept of individual agency. In this chapter I will argue that the concept of power which Brody brings back to medical ethics is based on what I have referred to as *theoretical pragmatism*, with an emphasis

on reasoning founded in the *agency* view of power. As Brody claims, this helps to resolve several puzzling issues -- but not all. We come to suspect there are problems with his concept of power when it leads to what he calls "an apparent contradiction," and that the physician's healing power forms a synthesis of power and powerlessness, the "possibility that the physician's power to heal in some way depends on his vulnerability - that, ironically, powerlessness can empower..." (Brody 1992, p.260-5). I will demonstrate how the *practice approaches* view of power can resolve these theoretical problems. But first I want to discuss the role of power for an ethical appraisal of medical practice in some more general terms:

Use of power and moral accountability

It is obvious, but worthy of noting, that a theory of power alone tells us nothing about what physicians and patients *ought* to do in their interaction. Our insights about power will not serve as an alternative to ethical theory, or as an affix to a list of moral guidelines in doctor-patient interaction. Rather, the power analysis may give us a richer understanding of doctor-patient encounters, and thereby a capacity to evaluate ethical aspects of clinical encounters in greater detail.

When asking normative questions about power, we may either focus on 'power relationships,' in which case we would be interested in the dynamic, interactive process of medical encounters; or we could focus on the 'uses of power,' in which case we would be more interested in causation and effects: the outcomes of medical encounters and what causes them. Obviously, these two approaches are interrelated. In chapter three I dedicated most space to discussing the 'uses of power,' and that is the question I will start with here.

To use power means to activate resources located in a structurated relationship in order to bring about an outcome.

If we want to evaluate doctor-patient encounters in terms of outcome, we need to decide what should count as a relevant outcome. A number of studies within linguistics and anthropology measure the quality of doctor-patient communication in terms of *patient satisfaction* (Greene et al). One illustrative conclusion follows these lines: Female physicians are more *egalitarian* in their approach to patients, thus allowing patients more *control* in the encounter; this gives higher patient *satisfaction* and, it is suggested, higher patient *compliance* and better patient *health* (Meetuwesen et al, p.1148). According to such reasoning, the egalitarian doctor is the good doctor; the physician's use of power and control should be minimized. This reasoning has several flaws. First, like Måseide has already pointed out, use of power is a necessary aspect of competent medical practice. A physician who exercised no power would be seen as (and indeed be) incompetent -- if she did not use her authority to influence the patient in any way, there would be no reason for patients to see her.

Some patients come to the physician "armed with consumer reports and prescription-drug ads, demanding inappropriate treatment" (Wyman, p. 30). The physician might try to reeducate such a patient, by presenting the reasons why taking these drugs is not a good idea. If the patient insists on getting his will, the physician *ought to* exercise her power, the power to withhold a treatment that is being asked for. The patient will not be content. This point illustrates the second flaw in reasoning which holds patient satisfaction in itself to be an outcome which indicates the quality of clinical encounters: a satisfied patient is not always a proof of good medicine. Dr. Knock, the main character

in Jules Romain's comedy, provides an example of this: rarely have we seen a physician more successful in manipulating patients to benefit his personal ends (mainly, economic profit); and rarely have we heard of patients more content than those in the village of St. Maurice, where Dr. Knock has his practice.

Sometimes, then, the use of power is morally permissible, as well as demanded by the standards of competent medical practice. Other times it is morally wrong for the physician to exercise power. Instances of sexual exploitation are among the most blatant examples of the latter. When we hear of such an instance, we naturally suspect that this is a case where a powerful person exploits the thrust of a relatively powerless person. Still, physicians who engage in such behavior will sometimes refer to the episode as them having been seduced, that it was an instance of true love, or that the sex was something they offered to the patient, as part of the therapy (Kluft, p.473-4).

Sex in the physician-patient relationship provides an illustration of the role a power analysis may play for the ethical evaluation of medical practice. The example is not far-fetched: up to 20% of practicing physicians have been reported to condone sexual contact between doctors and patients (Fisher, p.5). The intuitionist may state that sex between doctor and patient is wrong in and of itself, and that any sensible and moral person would feel likewise. The proponent of rule-ethics may say that sex in the clinical situation is wrong because this is stated in the ethical guidelines of the physicians' professional code. None of these replies are very convincing. Intuitions vary, between different persons, and also within a person over time. The goal of moral philosophy is to provide a more solid ground for our moral judgments than mere intuition. Referring to guidelines is also a shallow form of argumentation, as guidelines may, and often are, changed over time -- and often because a

new consensus is reached that part of the old guidelines were wrong.

If pushed to give a more informed reason why sex between physicians and patients is unethical, many will answer that this is so, because the physician is *taking advantage* of his position. He is *exploiting* the patient, who is in a vulnerable position. We see that there are some underlying ideas about an unequal power relationship, and unethical uses of power. Maybe assumptions about the role of power, then, are probable and satisfactory underlying reasons for the moral intuition about the wrongness of sex between physician and patient, as well as for the ethical guidelines? The general features of this situation are as follows: A and B are in a professional relationship which gives A power over B; A then uses this professional power to derive a personal benefit from B, which B would not have given A were they not in this unequal power relationship.

If this is at the core of what makes sexual relationships between physicians and patients wrong, do we then have a good reason to deem all such instances morally objectionable? Maybe not. Consider the following: The physician is a single female who recently graduated from medical school. The director of the hospital where she works as a resident, a middle-aged married man, comes to her office one day for a minor complaint, and the two subsequently develop a sexual relationship. The physician falls in love with her patient, and thinks that he will leave his wife and two daughters for her sake. She does not yet know that her patient is famous at the hospital for using his position as a director to seduce female nurses and physicians.

This example is chosen to challenge the standard view that sexual relationships between doctors and patients can always be described as instances where the physician exploits his or her patients. It may not represent

the typical situation, but it reminds us that it is not by the virtue of being a physician alone that most physicians are perceived as powerful. We are back to Giddens' point: that a power relationship arises as the product of an interactive process where the two partners negotiate positions. Their power relationship depends on how much legitimacy each of the two grants to the structural resources possessed by the other. Structural resources are of two kinds: allocative or authoritative. In the case where the director has sex with a female resident who works at his hospital, the physician has virtually no structural resources on which her patient depends -- she has no authority over him, she has access to no material goods which he needs, and consequently, she has no power over him. The physician is relatively powerless, and the episode cannot be described as arising from the physician's use of power. Rather it seems that it may be the other way around, that the patient in this instance possessed structural resources which gave him a power advantage over the physician, and that he used this power to manipulate the physician to get what he wanted.

We have been reminded that we cannot take for granted a power relationship which gives the physician an advantage over her patients, rather we must evaluate each case separately if we want to make definite conclusions about when the outcome of the clinical encounter can be described as the effect of the physician's use of power. Such an evaluation is relevant for an ethical analysis: If the physician has little power in a specific relationship, like in the case described above, we are less willing to hold her morally accountable for the outcome of that relationship. If she is in a powerful position, she may use her power to bring about effects -- she will then be morally accountable for these effects. If she is in a powerful position and *does not* bring about effects,

she may still be held morally accountable. This is the case if a psychiatrist refrains from using her power to retain a clearly psychotic patient in the hospital. If the patient leaves the hospital and then kills somebody, the physician may be held morally accountable, for in this case she ought to have used her power.

Still, an analysis of the power relationship does not tell us all we need to know about whom may cause effects, and whom may not. Giddens has reminded us that there are always some resources by which the powerless may influence the activities of the powerful in a relationship. The very powerful physician may be manipulated by a very powerless, but cunning, patient. We would then say that the patient, not the physician, is morally responsible for the outcome of that interaction whereby he manipulated the physician to create a certain effect.

Where did this take us? I have not tried to demonstrate that any classes of use of power, in themselves, are ethical or unethical. Neither have I described outcomes of uses of power as ethical or unethical. What I have demonstrated is the complexity of the power relationship in doctor-patient interaction. In particular, I have shown that we cannot take for granted that the physician in and of herself is the powerful part in this relationship. This observation is missed by traditional medical ethics, which starts with the assumption that the physician is powerful -- the power of the physician is presented as a static entity. The literature on paternalism vs. autonomy has, for example, been formulated to make it seem as if patient autonomy is something the physician ought to 'give' to the patient. The physician 'has' power; the paternalistic physician uses this power based on his best judgments; the less paternalistic physician 'gives' some of this power or

authority to the patient, who thereby becomes more autonomous. Such thinking sees power as a resource in itself, like a commodity which can be used by individuals in the same fashion as technical instruments, and also as something which can be 'given' from the one who has a lot of it to the one who has less of it.

Following Giddens' approach, we would rather say that the physician's power is 'given[to her, by the patient who invests trust and legitimacy in the physician's resources, which thereby becomes a source of power. In this way, the physician does not have any power at her disposal which she might 'give' to the patient, like a present. Still, to say that power is 'given' from the patient to the physician is imprecise, because again, it gives the impression that power is a commodity, which can be passed between individuals at their will, like money or pieces of information. To be stringent, and keep our reasoning precise, it would be better to refrain from using terms like 'giving' and 'using' power, and instead say 'activating' power. If we continue to talk about 'the uses of power,' we should remember that power arises from structural resources, which always depend on the legitimacy granted to them, and that 'to use power' in this way is fundamentally different from, for example, 'the use of physical force.' The traditional approach in medical ethics, which takes the physician's power as a static entity, also fails to see that in certain cases the patient may be exercising power over the physician.

If this point is missed, we also miss the possibility to understand why it would be wrong to say that the young resident physician who engaged in a sexual relationship with her patient used power over him. A power analysis is thus central for an evaluation of the mechanisms of causation in interpersonal behavior. Empirically, as well as morally speaking, the outcome of this

encounter should not be causally attributed to the actions of the physician, in the same way it would have been in a case where a physician, from her position of power, used her authority to manipulate the patient for her own end. I will not enter into a discussion about the extent to which the young resident should be relieved of moral accountability in this specific case, for there are surely a number of other moral concerns one might want to consider. The point I have established is that a correct power analysis here yields morally relevant information.

This is a small point. For, in most cases the physician is in fact the powerful part. Giddens' approach has implications for those 'normal' situations as well, mainly for the way physicians should think about their professional role. I will return to this point in the next and concluding paragraph.

Practice approach view of power: a contradiction resolved

Brody's approach in The Healer's Power is to start out with what he takes to be the accumulated wisdom from the field of medical ethics, and then refine and reformulate this in terms of power. He uses a reformulated version of Charles Fried's list of the basic conditions for an ethically sound doctor-patient relationship as a starting point for his discussion of the physician's power. Whereas Fried had stated these principles in terms of patient rights, Brody formulates them in terms of physician obligations:

> *Lucidity:* The physician has the obligation to disclose the nature of the patient's illness as well as the nature of any proposed treatment, along with any viable alternative treatments.
> *Autonomy:* The physician has the obligation to allow the patient to make important medical-care decisions on his own behalf and to defer to the patient's competent wishes even if he feels that the course chosen may not be in the patient's best interest.

> *Fidelity:* The physician has an obligation to act in a trustworthy fiduciary manner and to view himself as the patient's agent in health-care matters.
> *Humanity:* The physician has an obligation to treat the patient with compassion and sensitivity, especially bearing in mind the increased emotional vulnerability brought about by illness and fear of death. (Brody 1992, p.45)

Brody uses these principles to develop guidelines for the responsible uses of power: *Fidelity,* he claims, requires that the physician use her power in the best interests of the patient (*aimed power*); *humanity* urges the physician to consider the relative powerlessness of the suffering patient; *autonomy* requires that the physician allow the patient to have an impact on the decision-making process (*shared power*); *lucidity* requires the physician to be accountable for the ways she uses her power (*owned power*): "We can have the highest degree of confidence that the healer's power is being used ethically and responsibly when that power can be described as *owned power, shared power,* and *aimed power*" (Brody 1992, p.43).

Brody classifies the physician's power in three types: aesculapian, charismatic, and social (Brody 1992, p.16-7). 'Aesculapian power' is founded in the theoretical and practical knowledge of the physician: she possesses insights in medical knowledge, she masters the skills for examining and manipulating the body, and through her experience she has insights in the psychological processes which are involved in the patient's experience of suffering. Aesculapian power is an impersonal power, transferable from one physician to another, and also a type of power that the physician ought to share with her patients, according to Brody. 'Charismatic power' arises from personal characteristics of the physician (courage, decisiveness, firmness, and so forth), and cannot be transferred form one person to another. 'Social power'

arises from the social status and authority that society generally accords to physicians.

With this theoretical starting point, Brody evaluates and discusses a number of clinical situations. The terminology he uses represents what I have referred to as a *pragmatic view* of power, with an emphasis on the *agency view*. He talks about the "*ability* to heal; the *power* to relieve suffering; and healing... through the *exercise* of social and charismatic power" (Brody 1992, p.19;20;35, my emphasis). Still, it would be unfair to suggest that Brody wants to advocate a pompous image of the physician's capacities. When he talks about the physician's vulnerability, and need for 'sharing power,' he is, on the contrary, urging physicians not to 'play God,' and reminding them that they are working within a close relationship, rather than as lonely soldiers combatting disease and decay. Certain passages in his book also explicitly convey an appreciation of the insights contained in the practice approaches: "A skilled healer can *facilitate* all these changes..." (Brody 1992, p.34). In my critique of Brody I will discuss passages from his book which rely on the agency approach, in order to demonstrate the advantages of the practice approaches for a discussion of the physician's power.

Let us focus on the aesculapian power. In Brody's view, power is founded on theoretical knowledge and mastering of practical skills. The one who has the insights and masters the skills of a physician, is by virtue of this a powerful person, in and of herself. She 'has' aesculapian power. To use this power responsibly, she needs to recognize that she possesses it (owned power); to direct it so that it benefits her patients (aimed power); and allow the patient insight and understanding in how she uses her aesculapian power (shared power).

How would this be regarded differently from a practice approach view of power? Giddens introduces one extra step in the process by which medical knowledge and practical skills are transformed into power. For Brody, there is a direct connection between the sources of power and the reality of power; for Giddens, the sources of power turns into a power reality through a legitimizing process, by which they are 'upgraded' to structural resources (allocative or authoritative). This extra step explains why possessing medical insights makes the physician powerful in certain contextualities (like in the typical clinical encounter); and not in other settings (for example a clinical setting where the patient does not need any of the material goods over which the physician has control, and does not experience any structural pressure to succumb to the authority of the physician -- like in the case of a sexual relationship between the physician and patient described above).

I do not wish to challenge the wisdom contained in Brody's advice (that power ought to be owned, aimed and shared), for if physicians strived to respect them, they would surely then be striving to act in a way that could improve their practical interaction with patients. What I want to challenge is the way this wisdom is formulated, because of the message about the nature of the physicians' power which comes along with such formulations. To say that the physician ought to be aware of the power she possesses by virtue of being a physician, and that she, for ethical reasons, ought not to misuse this power, is similar to telling a regent that surely, as a regent he is powerful, but ethical considerations should compel him not to misuse the power he has over his people. If the message moves the regent to act responsibly and caringly, it is good in that restricted sense; but if the regent takes the message to mean that he is powerful in and of himself, as some kind of natural law, God-given fact,

or by virtue of the special qualities he possesses, then the message might not be all that good. For, it would lead the regent to think that his goodness towards the people is some kind of charity, some generous act, for which his people ought to be thankful; and it would lead him to forget that if he is a regent, he is so because the people *allow* him to be a regent.

There are few professions which surpass medicine when it comes to communicating to its students as well as practitioners a message of *slight* superiority over the average person. Consider for example the following paragraph in a letter to students graduating from a medical school: "May your tremendous knowledge, your strength of character, and your care and compassion serve you -- and your patients -- well."[8] It is good for patients as well as physicians that physicians feel competent about their professional skills. But when physicians congratulate each other about their outstanding human qualities, they may reinforce personal traits that lead patients to feel intimidated in their presence. Talk about the physician's power *may* serve the purpose of unwarrantly boosting physicians' ideas about what role they play in the healing process. This is, the way I see it, the most important reason why we need to find a way to talk about the physician's power without communicating a wrong message about what the nature of this power is. Referring to an article by Hannah Arendt, Jürgen Habermas puts it this way: "This is the impotence of the powerful -- they have to borrow their power from the producers of power" (Habermas, p.87).

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[8] Letter to the graduating medical students from the Dean of the College of Human Medicine, Michigan State University, 29 April 1996.

> Power corresponds to the human ability not just to act, but to act in concert. Power is never the property of an individual; it belongs to a group and remains in existence only so long as the group keeps together. When we say of somebody that he is 'in power' we actually refer to his being empowered by a certain number of people to act in their name. (Arendt, p.64)

Finally, I will turn to a theoretically confusing conclusion Brody reaches based on his pragmatic use of the term *power:* that the healer's power consists in the apparently contradicting synthesis of power and powerlessness. According to the practice approach, the physician's capacity for initiating healing, and his feeling of 'powerlessness' are different entities, and neither of them is 'power' in the strict sense. Thus, the apparent contradiction is not a real one, but merely a product of an imprecise use of the concept of power. Brody discusses which of the physician's characteristics are important for engaging in a healing relationship with her patients, and concludes that her humility might be one of her most "empowering" attributes (Brody 1992, p.260). Healing takes place when the patient tells his story of confusion, pain, suffering, and fear, and sees that the physician recognizes the patient as the suffering being he is. For this to take place, the physician must enter into an intimate relationship with her patient, one where she experiences, as well as conveys to the patient "a genuine openness and vulnerability" (Brody 1992, p.258).

> To be compassionate in response to the suffering of the patient is therefore one of the most powerful things a physician can do; but this is possible only to the extent that the physician is willing to adopt a position of relative powerlessness, to acknowledge that the patient's suffering has incredible power over him and that he cannot remain unchanged in the face of it. This is a major irony of the physician-patient relationship, in which a sense both of one's healing power and of one's necessary humility forms a synthesis of the apparent contradiction of power and powerlessness. (Brody 1992, p.260)

With the practice approaches view of power, the *apparent contradiction* as well as the *irony* of Brody's description disappears. In this paragraph, *power* is described both as a characteristic of a particular action (of being compassionate); the characteristics of positions in a social relationship one may chose to occupy or to not occupy (a position of less control); the capacity a certain reality has of inducing emotional responses; and a capacity of facilitating healing (the healer's power). In line with Giddens' structuration theory, I would not like to refer to any of these as 'power' in the strict sense. I do not think the healer is powerful by herself, rather I think that healing is the fortunate outcome of certain relationships that physicians and patients may engage in. Healing is the product of a process where the physician invests some of her resources, and the patient invests some of his resources. Neither of the two have the power within themselves to heal, and neither of the two should think of themselves as a healer, in the sense of one who heals, simply by using her own skills and capacities. The last quoted paragraph from Brody's book could be rephrased in the following manner, which makes it clear what role the power plays in a healing relationship:

The physician who allows the patient's suffering to have an impact on her becomes vulnerable. In a sense, she will experience some of the patient's own fear and suffering. By suffering *with* the patient in this way, she engages in an intimate relationship with him. In stead of retaining a 'professional distance,' she might decide to expose some of her emotional reactions to her patient. This does not necessarily mean to act unprofessionally, to be in an intimidating position, or to feel intimidated. Rather, it may be an efficient and professional approach of establishing a healing relationship with suffering

patients. This approach will induce a feeling of trust and security within the patient. A physician who successfully engages in such relationships activates the potential for a healing power which lies in the structure of the doctor-patient relationship.

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