Identity and discourse: a critical philosophical investigation of the influence of the intellectual self-image of the medical profession on communicatively effective care to patients.

by

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Declaration

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Summary

Communication between doctors and patients in clinical settings is notorious for being difficult. This problem has inspired a wealth of empirical research from a variety of academic fields on the subject of doctor-patient communication. However, very little attention has been paid to the role of modern medicine's intellectual self-image as natural science in interactions within clinical medical settings. The aim of the current study was to philosophically investigate the influence of the medical profession's intellectual self-image on communication between doctors and patients. Jürgen Habermas' work on Universal Pragmatics was used to comment on doctor-patient communication as it is described in the existing empirical research literature. Michel Foucault's work on discourse and power was used to analyse and describe medical discourse and the nature of power in doctor-patient relationships. The outcome of this philosophical analysis leads to the conclusion that modern medicine's intellectual self-image has a pervasive and negative influence on communication between doctors and patients during clinical consultations. This is because medicine's positivist world-view results in an almost exclusive focus on the physical aspects of disease in clinical medicine. The patient's mind and his/her social world are not of great significance from the natural scientific perspective. Medical professionals may thus easily regard their clinical task solely as the physical treatment of physical disorders. They are very likely to consider many communicative activities as unrelated to their clinical task. Inadequate doctor-patient communication can easily affect the quality of medical care and patient outcomes in a negative manner, as well as diminish the quality of the doctor's occupational experience. For this reason I conclude that medicine's natural scientific intellectual self-image is not appropriate for the task of providing medical care to individual patients. Two additional reasons support this conclusion, namely the misidentification of clinical medicine as a natural science and the inappropriateness of a scientific conception of truth for the context of doctor-patient interactions. The implications of these conclusions are that the intellectual self-image and world-view of modern medicine should change to better agree with the nature of clinical practice and to make room for the psychological and social dimensions of the patient's life within health care. The medical profession should also revise its conception of science to a theory that acknowledges that interpretive reasoning and knowledge without guaranteed certainty are legitimate elements of science. I advocate for consciousness among the medical profession of the reality of medical discourse and its effects on doctors, patients and on their interaction with one another.

Opsomming

Kommunikasie tussen dokters en pasiënte in kliniese omgewings is daarvoor berug om moeilik te wees. Hierdie probleem het 'n magdom empiriese navorsing vanuit 'n verskeidenheid van akademiese velde omtrent dokter-pasiënt kommunikasie geïnspireer. Baie min aandag word egter gewy aan die rol van moderne geneeskunde se intellektuele selfbeeld as 'n natuurwetenskap in interaksies in kliniese mediese omgewings. Die doel van die huidige studie was om die invloed van die mediese professie se intellektuele selfbeeld op kommunikasie tussen dokters en pasiënte filosofies te ondersoek. Jürgen Habermas se werk oor Universele Pragmatiek (*Universal Pragmatics*) is gebruik om kommentaar te lewer oor dokter-pasiënt kommunikasie soos wat dit beskryf word in die empiriese navorsingsliteratuur. Michel Foucault se werk oor diskoers en mag is gebruik om mediese diskoers en die aard van mag in dokter-pasiënt verhoudings te ontleed en te beskryf. Hierdie filosofiese ontleding gee aanleiding tot die gevolgtrekking dat moderne geneeskunde se intellektuele selfbeeld 'n deurdringende en negatiewe invloed op kommunikasie tussen dokters en pasiënte gedurende kliniese konsultasies het. Die rede hiervoor is dat geneeskunde se positivistiese wêreldbeskouing lei tot 'n byna uitsluitlike fokus op die fisiese aspekte van siekte in kliniese geneeskunde. Die pasiënt se verstand en gees (*mind*) en sy/haar sosiale wêreld is nie van groot belang vanuit die natuurwetenskaplike perspektief nie. Persone in die mediese beroep mag hul kliniese taak dus maklik as bloot die fisiese behandeling van fisiese afwykings beskou. Dit is baie waarskynlik dat hulle vele kommunikatiewe aktiwiteite as onverwant tot hul kliniese taak beoordeel. Ontoereikende dokter-pasiënt kommunikasie kan die kwaliteit van mediese sorg en pasiënte se gesondheidsuitkomste maklik negatief beïnvloed, en ook die kwaliteit van die dokter se ervaring van sy/haar beroep verlaag. Om hierdie rede maak ek die gevolgtrekking dat geneeskunde se natuurwetenskaplike intellektuele selfbeeld nie toepaslik is vir die opdrag om mediese sorg aan individuele pasiënte te lewer nie. Twee verdere redes ondersteun hierdie gevolgtrekking, naamlik die verkeerdelike identifikasie van kliniese geneeskunde as 'n natuurwetenskap en die onvanpastheid van 'n wetenskaplike konsepsie van waarheid vir die konteks van dokter-pasiënt interaksies. Die implikasies van hierdie gevolgtrekkings is dat die intellektuele selfbeeld en wêreldbeskouing van moderne geneeskunde moet verander om beter ooreen te stem met die aard van die kliniese praktyk en om ruimte te maak vir die sielkundige en sosiale dimensies van die pasiënt se lewe in gesondheidsorg. Die mediese professie moet ook haar konsepsie van die wetenskap hersien na 'n teorie wat erken dat interpreterende redenasie en kennis sonder gewaarborgde sekerheid,

geregverdigde elemente van die wetenskap is. Ek pleit vir bewustheid onder die mediese professie van die realiteit van mediese diskoers en die effek daarvan op dokters, pasiënte en op hul interaksie met mekaar.

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Megan, Reims and Nala, for sitting with me.

All heirs have the right, have had the right from time immemorial, to live their fathers' lives in their own vocabulary.

Milan Kundera (1984: 273)

Why separate the science of the doctors from that of philosophers? Why distinguish between two studies that share a common origin and end?

C.-L. Dumas[1]

[1] C.-L. Dumas. Montpellier, Year XII:21, as cited in Foucault 1973:128

Table of Contents

A list of terms treated as synonyms in this dissertation

Clinical (bio)medicine; medical practice; the clinical method

Doctor-patient communication; doctor-patient interaction; clinical communication; clinical interaction; the (clinical) consultation/encounter; the doctor-patient encounter; medical interview

Doctor; medical practitioner; physician

Modern medicine; biomedicine; scientific medicine; allopathy

Positivism; Empiricism

World-view; paradigm

General Introduction and problem statement

There are times in one's life when the question of knowing if one can think differently than one thinks, and perceive differently than one sees, is absolutely necessary if one is to go on looking and reflecting at all.

Michel Foucault[2]

It is often said that modern medicine[3] is in crisis. This crisis entails a number of factors. I am especially interested in what can be referred to as medicine's **crisis of care**[4] or "the decline of humanistic medicine" (Kriel, 2000:24). Humanistic medicine refers to "medical practice that focuses on the whole patient and not solely on the patient's disease" (Schwartz & Wiggins, 1988 in Kriel, 2000:40). Patients and caregivers of patients frequently feel uncared for in their dealings with the medical profession. Medicine is often not regarded as a caring profession (Schwartz & Wiggins, 1985:331; Fehrsen, 2000: xvii). This is not least because biomedicine tends to reduce the human person to the biological functioning and structure of the body and thereby runs the risk of excluding the distinctive human dimensions of a patient's life from its area of interest.

At least two other factors need to be considered when discussing the crisis in modern medicine. Firstly, the rising cost of health care, (often growing at a rate greater than the overall inflation rate of a nations' economies [Bodenheimer, 2005:847]) makes the World Health Organisation's ideal of achieving health for all, almost unattainable. Secondly, the medical profession itself is facing a crisis. Doctors increasingly feel "caught in the middle" of the expectations and demands of those who pay for medical services (insurance companies and government organisations), health care institutions and doctors' own patients (and sometimes the patients' caregivers). Jonsen (2000: 80) quotes Robert Berenson who wrote an editorial for the New York Times in July 1989, entitled "Meet Dr. Squeezed" on the demands

[2] The quotation is from *The history of sexuality, Vol. II: The use of pleasure* (Foucault, 1985:8 as cited in Mills, 2003:6).

[3] The term modern medicine refers to the form of medicine that developed late in the eighteenth century based on the natural sciences, namely physics, chemistry and biology. Modern medicine is also referred to as biomedicine or scientific medicine and is currently the dominant approach to health care worldwide (Helman, 2007:94).

[4] Throughout the text I use bold font to emphasize word or concepts.

placed on present-day doctors. Berenson wrote that "most doctors accept the inevitable conflicts between cost and quality, patient wishes and clinical judgement, professional autonomy and consumer protection. Nevertheless, physicians feel increasingly beleaguered. Their recommendations and decisions are being questioned, constrained and overruled".

Le Fanu (1999: xviii-xix) refers to the paradox of disillusioned doctors. He writes that the "prodigious and indubitable success" of modern medicine stands in contrast with survey results that show that doctors' satisfaction with their choice of profession and the percentage of medical graduates who enter medical practice have decreased since the nineteen sixties. Le Fanu cites the results of a study by the Policy Studies Institute in London (United Kingdom) which reveals that 14% of doctors surveyed in 1966 experienced 'regrets' over their choice of career compared to 26% of the 1976 cohort, 44% of the 1981 group and 58% of the 1986 study group. Furthermore, it is a recent trend that a proportion (25% in 1996) of medical graduates decide not to practice clinical medicine after graduation, but rather to enter the job market in a different field (for instance as an employer of a company that manufactures and develops pharmaceutical products). Similarly, patients are becoming increasingly disillusioned with the medical profession. The medical profession has been demythologised in countries like the United States of America where patients and advocacy groups emphasise patients' right to be fully informed and involved in decision-making about their health care (Van Niekerk, 2002b: 227). The above-mentioned perceptions of doctors and patients are probably related in complex ways to modern medicine's crisis of care.

It seems that the crisis of care has a dual nature. Not only patients, but also doctors (and other, if not all, health care professionals) feel uncared for. Doctors do not feel protected by the state and sometimes the communities in which they work. This is especially true in crime-ridden neighbourhoods where doctors' (and nurses') property and lives may not be protected by the community despite the efforts of health care personnel to relieve suffering and save lives within the community. Fehrsen (2000, xviii) makes a very important point when he says that "caring is clearly not a purely personal matter. It is embedded in a wider socio-political and economic context". Many factors contribute to modern medicine's crisis of care. In this dissertation I focus on one very specific issue, namely modern medicine's continuing intellectual adherence to the world-view of nineteenth century natural science. I specifically want to investigate the influence of this world-view (or modern medicine's

intellectual self-image)[5] on the communication between doctors and patients, and the role of communication in the care of patients.

Communication between doctors and patients is central to the practice of medicine (Gatens-Robinson, 1986: 175-176; Malterud, 1995:184; Montgomery, 2006:34). It is estimated that a doctor will conduct 200 000 interviews with patients in his/her professional lifetime. Communication skills form a core component of a doctor's clinical competence, together with knowledge and skills in problem solving and physical examination (Kurtz *et al.*, 2005:14). Interaction between doctors and patients accomplish and assist in many of the tasks of the medical consultation, for instance arriving at a diagnosis, establishing the doctor-patient relationship, information exchange and shared decision-making (Charon *et al.*, 1994:955; Ong *et al.*, 1995:903-905). The critical, complex and fascinating nature of doctor-patient interaction has attracted the attention of researchers from a variety of academic disciplines within the humanities and health sciences and has lead to a vast academic literature on this topic (Charon *et al.*, 1994:955). Kurtz *et al.* (2005: 14-16) give various examples of such research to illustrate the six main problems of communication between doctors and patients. The problems are as follows. 1.) Doctors often do not interact with patients in a way that allow them to discover the patient's reason for visiting the doctor. This is due to many doctors' poor habit of interrupting the patient after his/her opening statement (wrongly assuming that the patient's first complaint is of greatest importance to the patient) and/or a failure to elicit all (or the majority) of the patient's concerns. 2.) Doctors typically have difficulty in gathering relevant and important information during consultations due to their habit of structuring the interaction according to their medical objectives. Medical professionals use a 'high control style' in which they pose very specific questions for patients to answer rather than allowing the patient to spontaneously tell the story of their illness and voice (all of) their concerns. Furthermore, in most cases doctors respond only to a small proportion of the patient's cues during interaction. 3.) Doctors frequently do not give patients enough information or involve patients sufficiently regarding treatment plans during consultations. Patients often have difficulty to comprehend and recall doctors' messages after

[5] I treat the terms 'world-view' and 'paradigm' as synonyms in this dissertation. With these terms I refer to the ontological and epistemological assumptions associated with a particular outlook on the world or life. [I relied on Kriel (2000:14) and 'world, n.' (2013) for these definitions]. The phrases "world-view of modern medicine" and "natural science paradigm" are thus also used as synonyms and refer to the ontological and epistemological assumptions of the natural sciences (Kriel, 2000:14). With the terms 'self-image' or 'self-understanding' of modern medicine I simply refer to the view that the medical profession has of itself. The self-image of modern medicine is ultimately influenced by its world-view.

their medical appointments. 4.) Patients often do not adhere to prescribed treatment plans. The financial cost of non-adherence is high considering the cost of unused or wrongly used medication, as well as the cost of additional medical consultations, laboratory tests, medication and so forth. 5.) Poor doctor-patient communication is the primary cause of malpractice lawsuits against doctors. 6.) Patients often experience a lack of empathy and understanding from doctors. One is likely to come across reports of such instances in the media.

Kurtz *et al.* (2005:16-19) go on to present evidence that specific communication strategies can overcome the problems listed above and that such communication strategies can and should be taught to medical students and qualified doctors alike. For instance, when doctors listen to patients, ask open-ended questions, respond to patients' cues and allow patients to ask questions, more information is received in a shorter time. Patient satisfaction has been found to be directly proportional to the amount of information delivered to patients. Specific communication techniques improve patient recall, understanding and adherence to treatment, such as asking patients to repeat the doctor's explanation in the patient's own words, or when doctors summarize or repeat their messages or provide diagrammatic representations of information. There is even evidence that specific communication skills influence patients' health outcomes, such as the degree and rate of symptom resolution and physiological outcomes, such as blood pressure and glucose control for patients with hypertension and diabetes respectively. Finally, research indicates that doctors who pay attention to communication with patients may significantly reduce the length of patients' hospitalization and thereby reduce health care costs. Such doctors are also less likely to be involved in malpractice lawsuits.

The specific communication techniques that are associated with the positive outcomes mentioned above may be grouped together and termed 'patient-centred' communication, that is communication according to the patient-centred clinical method. The patient-centred method developed over the past four decades in the medical discipline of Family Medicine (or General Practice) as reaction against the traditional medical model which focuses merely on the biological dimensions of disease and only on the patient's body (as the site of disease) at the cost of non-material realities such as the patient's perceptions and psychological needs. The patient-centred method wants to be a holistic method that fully acknowledges (in theorizing and practice) the biological, psychological and social aspects of disease and the

patient's experience of disease. Kurtz *et al.* (2005: 20-27) argue that patient-centred communication can be taught and that communication skills training should be included in undergraduate medical curricula and continued professional development programmes for qualified doctors[6]. I agree that attention to communication skills should form an integral part of medical curricula at all levels of training. Yet, I do not think that the patient-centred method or more attention to communication skills is sufficient to pull modern medicine from its crises of care or its greater professional crisis. I agree with Kriel (2000:44) that medicine can only be transformed when its view of reality (its ontology) transforms to include the non-material aspects of the human condition.

I mentioned earlier that an impressive cross-disciplinary literature on doctor-patient encounters exists. The research that is conducted on this subject is informed by a diversity of theoretical and methodological standpoints and reasons for studying doctor-patient communication. Ainsworth-Vaughn (2003:453) divides the literature on doctor-patient encounters into two separate categories which she terms "praxis literature" and "discourse literature". Praxis literature represents the majority of research on doctor-patient interaction. The research studies that form praxis literature are mostly directed towards medical praxis or the consultation process and focus on the structure of the consultation "from greeting to closure" and describe and measure concepts[7] such as patient and doctor centeredness (Elwyn & Gwyn, 2006:186). The praxis literature is atheoretical about language and thus regards language as merely expressive, as a transparent vehicle of meaning and communication. Discourse literature refers to research that is interested in the "analysis of talk itself" as informed by theories of discourse (Ainsworth-Vaughn, 2003:453). The term 'discourse' indicates a critical view of language. The structuralist and post-structuralist view of language as a system "with its own rules and constraints, and with its own determining effect on the way that individuals think and express themselves" is adopted in discourse literature of clinical communication (Mills, 1997:8). Discourse analysis is a research method that is often followed in the discourse literature. Despite the recognition in praxis and discourse literature that the complexity, importance and problems of doctor-patient communication stem from a

[6] Sarangi (2008) provides the following important criticism of the patient-centred method . He argues that this method, with its emphasis on open-ended questions and eliciting the patient's story of his/her illness places communicative pressure on the patient. Patients from linguistic and cultural minority groups may struggle with these communicative tasks and doctors may have difficulty to elicit information from such patient's about their subjective illness experiences.

[7] Pilnick & Dingwall (2011:1374) refer to the praxis literature as "code-and-count" research.

variety of related factors[8], very little attention has been paid to the influence of medicine's intellectual self image as natural science on interactions within the clinical medical setting. I believe that research on the latter is much needed to better understand the crisis of care and the communicative problems in clinical medicine. I also believe that philosophical analysis is a very useful study design for the first work in this direction. Through philosophical analysis of the existing empirical information on doctor-patient communication and medical discourse[9], the researcher can comment on these matters in general and is not restricted to specific instances of clinical communication, as is the case with empirical research designs. Empirical studies can assess and test the validity of the conclusions and recommendations of philosophical analyses for specific clinical contexts and consultations.

The aim of the current study is then to philosophically investigate the influence of the medical profession's natural scientific intellectual self-image on communication between doctors and patients. The research follows the design of a philosophical analysis. Empirical data was thus not collected or analysed as part of the research process (Mouton, 2001:146, 178). I perform my philosophical investigation with the aid of the work of two philosophers, namely Jürgen Habermas (1929-) and Michel Foucault (1926-1984). Although my study is not empirical in nature, I examined the vast empirical research literature on doctor-patient communication. I describe this research literature and summarise its findings in Chapter 4 of the dissertation. In Chapter 5 I look at these research results through the lens of Habermas' universal pragmatics. In Chapter 6 I use Foucault's thoughts on the nature of discourse to analyse medical discourse, based on the descriptions of this discourse in scholarly writings. Yet, Chapters 5 and 6 and the dissertation as a whole do not constitute discourse analysis. I shall now briefly discuss discourse analysis as a particular type of social research and thereafter I will indicate how the current project differs from discourse analysis.

Discourse analysis is a field which grows rapidly and continues to develop. Various and diverse academic disciplines use discourse analysis for research purposes. The study of discourse originated in disciplines such as linguistics, anthropology and philosophy. The models and analytic methods developed by these pioneering disciplines have been applied - and therefore extended – by disciplines such as communication, social psychology, cognitive

[8] Such as doctor and patient characteristics (most notably social class, gender, age and race [Waitzkin, 1989:233]), the broader health care context, practice or system characteristics (Aita *et al.*, 2005:303) as well as the specific disease under discussion.

[9] I define the terms doctor-patient communication and medical discourse later in this Introduction.

psychology and artificial intelligence (Schiffrin *et al.*, 2001:1). In the light of this disciplinary diversity it is not surprising that the definitions for "discourse" and "discourse analysis" vary between scholars from different academic domains. Currently many books on discourse start with a review of definitions of the term. The various existing definitions of discourse can be divided into three categories, namely:

i. discourse defined as any instance of language which extends beyond the sentence. This is a common definition, particularly in linguistics;

ii. discourse defined as "the study of language use" (pragmatics);

iii. discourse as it is used in phrases such as "discourse of power" or "discourse of feminism". In this definition discourse is a count noun which refers to a wide range of linguistic and non-linguistic social practices and ideological beliefs which together form, continuing the example above, power or feminism. This definition is used by critical theorists and scholars influenced by critical theory (Schiffrin *et al*., 2001:1).

The following three features are shared by most approaches to discourse analysis.

i. Discourse analysis is pervasively understood as "the examination of actual (not hypothetical) text and / or talk". Based on that understanding theory and data are viewed as "inseparable and mutually enriching": theoretical insights are necessary for the analysis of discourse to reach beyond "instance-specific insights", and in contrast the analysis has to be based on actual cases of language so that theory is constructed empirically and within realistic constraints (Schiffrin *et al.*, 2001:6-7). Discourse analysis does not have a single coherent theory but includes a diversity of theories and methodologies. Different approaches to discourse analysis draw on different types of data, ranging for instance from "political speeches to everyday conversation to literary texts"; consider different contexts such as "community, institutional and ideological contexts" and reflect theoretical paradigms and methodologies of many different types, including for instance "relevance theory and systemic-functional linguistics" and "interpretive, statistical, and formal methods" (Schiffrin *et al*., 2001:5-6). Discourse analysts such as Schiffrin *et al*. (2001:5-7) view this theoretical and

methodological diversity as a strength rather than a weakness. One reason for this view is the range of problems which has been and can continue to be addressed by discourse analysis. These problems include linguistic phenomena, for example word meaning; interdisciplinary phenomena, for example literary pragmatics; and social problems for example discrimination against minority groups and patients' compliance with doctors' advice (Schiffrin *et al*., 2001:6).

ii. Most forms of discourse analysis are interested in linguistic units which extend beyond the boundaries of the single sentence. Discourse analysis is interested in the interconnection of utterances in continuous conversation or text[10]. This *supra-sentential concern*[11] of discourse analysis separates it from the concern with phonology and syntactic structure of the more dominant perspectives in linguistics (Thompson, 1984:99).

iii. Most forms of discourse analysis are to some extent interested in the connection between linguistic and non-linguistic activity. Traditionally the links between "language and perception, language and thought, language and culture" were studied. Yet more recently discourse analysts have become interested in the ways that language is used in particular social contexts and thereby acts "as a medium of power and control". This sociological turn in discourse analysis makes it relevant in a methodology aimed at the study of ideology (Thompson, 1984:99).

Thompson (1984:74) provides a critical survey of work in English regarding methods of discourse analysis[12]. Although he found aspects of the different approaches surveyed interesting and original he considers the results delivered by these approaches as

[10] Discourse analysts refer to the "gift of discourse", that is the fact that new meanings are produced by the relationship between sentences. Yet the "curse of discourse" is how to decide, given that more than one meaning can be produced, which meaning is intended, justifiable and/or the most sensible (Schiffrin *et al*., 2001: 10).

[11] All words that appear in italics in quoted phrases or sentences in this dissertation are similarly italicized by the authors whose work I quote. I also use the italic font for all non-English words or phrases, such as *et al., etcetera* and *ad hoc.*

[12] Thompson (1984: 100-126) included the work of the following authors in his survey: John Sinclair, Malcolm Coulthard and other researchers associated with these scholars' Research Group at the University of Birmingham who focused their studies on the exchange structure of everyday talk; Harvey Sacks, Emanuel Schegloff, Gail Jefferson and others involved in the study of conversational structure; and finally the work of Roger Fowler, Robert Hodge, Gunter Kress and Tony Trew who studied the connection between the grammatical structure of discourse and the social world.

disappointing from the perspective of an interest in ideology (Thompson, 1984:8; 115)[13]. Thompson (1984:8) attributes the limitations of the results delivered by discourse analysis to limitations of the methodologies of these approaches. He criticizes the approaches to discourse analysis which he surveyed for neglecting to consider "some of the most interesting issues" in everyday interaction (Thompson, 1984:115). For instance, he criticizes Sinclair *et al.*'s approach for only paying attention to the structure of conversation and not to the content, that is to "*what is being said*" (Thompson, 1984:106). Similarly, Thompson (1984:115-118) criticizes Sacks *et al*. for not considering questions of power and social structure in their description of the turn-taking systems, the organization of repair and the "*narratives of everyday life*[14]" which appear in conversation. A further criticism by Thompson (1984:126) of the methods of discourse analysis which he surveyed is that their study of the non-linguistic sphere is not adequate. According to Thompson (1984:126) linguists such as Roger Fowler and his colleagues at the University of East Anglia are correct in searching for connections between "language and society". However, the terms which these scholars use to refer to aspects of the social world are not clearly defined and are not placed within "a systematic social theory". It seems that these theorists' understanding of social phenomena is far less sophisticated than their analysis of language. Although they attempt to provide a critical perspective on the use of language, their approach to the study of discourse remains mostly linguistic, that is "bound to syntactic analysis" (Thompson, 1984:124-125).

This dissertation is not a discourse analysis. I did not record and analyse actual interactions between doctors and patients. Instead, I made a summary of what is known through empirical research published in scholarly journals and books about the nature of doctor-patient communication and medical discourse. I then comment on the nature of doctor-patient communication from the point of view of Habermas' universal pragmatics. I also apply Foucault's thoughts on the nature of discourse to medical discourse. The analytic dimension of my dissertation is contained in this task of applying the thoughts of two philosophers to the current academic knowledge about the nature of doctor-patient communication and medical discourse. My aim in using the work of these two philosophers is to gain insight into the

[13] Thompson (1990:6–7) defines ideology as a concept which "can be used to refer to the ways in which meaning serves, in particular circumstances, to establish and sustain relations of power which are systematically asymmetrical" or so-called "relations of domination". Ideology according to Thompson is "broadly speaking…*meaning in the service of power*".

[14] One instance of a narrative of everyday life is the telling of or listening to a joke (Thompson, 1984:117).

influence of modern medicine's intellectual self-image on communication between doctors and patients.

I selected Habermas' (1979) universal pragmatics as an analytical tool since it is focussed on linguistic communication between a speaker and listener and is thus appropriate to my investigation into communication between doctors and patients. Another reason for my decision to use universal pragmatics is the connection between the goals of doctor-patient interaction and universal pragmatics. The goal of the doctor-patient encounter can be thought of as reaching understanding or "agreement regarding treatment of the patient's illness" (Skirbekk, 2004:246). Habermas (1979:3) states as the goal of universal pragmatics "to analyse the process of understanding" by looking at how agreement between a speaker and a hearer is brought about. Universal pragmatics thus offers great potential for meaningful insight into doctor-patient communication. Several scholars have fruitfully applied Habermas' work to the study of doctor-patient communication (Tanenbaum, 1998; 2006; Skirbekk, 2004; Greenhalgh *et al.*, 2006) and in Chapter 5 I refer to their work. The medical sociologist Graham Scambler (1987:181) regards Habermas' work on pragmatics as useful for the study (and revelation) of inconspicuous or hidden forms of domination in modern, capitalist societies; such as doctors' exercise of power over patients during clinical interactions.

Foucault's work on discourse is also very appropriate and useful for the aim of my study. Foucault views discourses as a regulated practices. He is more interested in the rules and practices that generate meaningful utterances and texts, than in the actual utterances of speakers and texts of writers (Mills, 1997:7; Hall, 2001:72). In order to investigate the influence of medicine's intellectual self-image on doctor-patient communication I wanted to describe the general rules of medical discourse. Foucault's (1972; 1981a) theory of discourse and principles for the analysis of discourse supplied me with a tool for a general and critical analysis of medical discourse. More specifically, his description of discursive formations set out in '*The Archaeology of Knowledge'* (Foucault, 1972) provided me with a conceptual framework and terminology for the study of medical discourse. His description of the procedures that control discourse in the essay '*The Order of Discourse*' (Foucault, 1981a) allowed me to explain the restrictions on what can be said about sickness and health in medical discourse, by whom and how. Furthermore, Foucault regards discourse and power as integrated. This position is very useful for any study on doctor-patient communication, since

power relations fundamentally influence communication in clinical situations. No complete analysis of medical discourse can ignore the power struggles that accompany doctor-patient encounters.

At this stage it will be useful to clarify my usage of some of the central terms in this dissertation. To start I pay attention to the closely connected terms 'medical discourse' and 'doctor-patient communication'. First I shall describe the meanings I attach to the terms **discourse** and **medical discourse**. In this dissertation I use Foucault's definition(s) of discourse. Foucault defines discourse in a number of ways in his various writings and interviews. I use his definitions of discourse as "an individualizable group of statements" and "as a regulated practice that accounts for a certain number of statements" (Foucault, 1972:90). Stuart Hall gives the following useful definition of Foucault's understanding of discourse:

> By 'discourse' Foucault meant 'a group of statements which provide a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment…Discourse is about the production of knowledge through language…' (Hall, 1992 as cited in Hall, 2001:72). It governs the way a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others (Hall, 2001:72).

When I use the word **medical discourse** in this dissertation I am referring to the discourse of the medical profession. In this sense medical discourse forms "an individualizable group of statements" (Foucault, 1972:90), namely the statements that doctors may legitimately use in the practice of their profession. I also use the term medical discourse to refer to the rules responsible for the production, distribution and circulation of doctors' statements (Foucault, 1972: 90; Young, 1981:48). In my use of the term medical discourse thus refers to the rules that doctors (have to) follow when they think and talk about health and disease (in order to be regarded as competent). Three of the most prevalent genres[15] of medical discourse are: the research paper, the doctor-patient encounter, and the textbook (Macdonald, 2002: 447). I am

[15] Wilce (2009:203) provides the following definition of (discourse) genres: "types of discourse linked to event types, patterned to fit recipients' expectations of both the discourse and the broader event".

particularly interested in the discourse surrounding the interaction between a doctor and a patient, or **the discourse of medical practice**[16].

The term **doctor-patient communication** (and its earlier mentioned synonyms[17]) has its usual meaning in my writing. The *Oxford Advanced Learner's Dictionary* (2005:291) defines communication as "the activity or process of expressing ideas and feelings or of giving people information". Doctor-patient communication occurs in clinical settings between a doctor and his/her patient and/or caregiver(s). The communication behaviour of doctors as well as patients is included in the meaning of the term. To achieve the aim of my study, namely to investigate the influence of the medical profession's intellectual self-image on communication between doctors and patients, it is necessary to analyse both medical discourse and doctor-patient communication. Medical discourse reflects the positivist assumptions of modern medicine. I chose Foucault's work on discourse as the analytic tool for examining the nature of medical discourse. I use Habermas' universal pragmatics to analyse doctor-patient communication.

I also want to make a comment about the way I use the term '**modern medicine**', 'medicine' for short, and its synonyms. With these terms I refer to the cultural institution of biomedical care, the globally dominant system of caring for the ill (Nutton, 1996:52; Helman, 2007:94). I refer to medicine in the same manner as Foucault (1972:46) in the following quotation: "…as an institution possessing its own rules, as a group of individuals constituting the medical profession, as a body of knowledge and practice, as an authority recognized by public opinion, the law, and government…" With the term medicine I thus do not refer to single medical doctors 'as individuals'. When I write about the philosophical assumptions or world-view of modern medicine I do not imply that individual medical professionals wholly or personally subscribe to this belief system. What I refer to with the term medicine is rather the norms for legitimate knowledge, practice and reasoning that doctors are taught and expected to follow. It is entirely possible, and indeed there is testimony of this in the writings of doctors with a humanistic or patient-centred orientation, that doctors' personal world-views are in conflict with the philosophical assumptions of medicine and that this may be a source of great professional frustration for these individuals.

[16] My definition of medical discourse is much narrower than the definition used by James Wilce (2009:199) in a recent review article on medical discourse. Wilce broadly defines **medical discourse** as "discourse in and about healing, curing, or therapy; expressions of suffering; and relevant language ideologies".

[17] See "Terms treated as synonyms in this dissertation" that appears before the start of this introductory chapter.

I would like to share how I came to approach this particular project with philosophical analysis. I am qualified as a speech-language therapist and audiologist. The research study I undertook for the purposes of my master's degree in speech-language therapy was a qualitative phenomenological enquiry into the experiences of doctors, mothers of sick children and interpreters regarding communication in a public paediatric multilingual HIV/AIDS clinic in South Africa (Cilliers[18], 2005). I have also acted as supervisor for students who completed research projects on doctor-patient communication in paediatric (Garcia, 2004; Steenkamp, 2004) and adult HIV/AIDS care settings (Carstens, 2005; Gouws, 2005; Strauss, 2005), as well as on communication in HIV/AIDS counselling (Rust, 2005). Six of these student research studies involved conversation analysis, a form of discourse analysis, of recorded and transcribed clinical consultations. I found this empirical work on doctor-patient communication fascinating. Nevertheless, it sparked my interest in what may underlie the difficulties of doctor-patient interactions. Many material factors have been identified as influences on doctor-patient communication and their effects have been studied and documented. These include the context of the interaction, the personal characteristics of the doctor and the patient, and the specific disease(s) they are discussing. Yet one serious question is seldom addressed directly by the empirical research on clinical communication. This is the question about the influence of medicine's positivist view of the world and of itself on communication between two persons, a doctor and a patient; engaged in a very human activity, namely attempting to identify and treat disease and to lessen the suffering that comes with it. To my mind reflection on this basic question will bring us to a fuller understanding of clinical communication.

I am critical of biomedicine in this dissertation. This is not to deny the immense benefits of biomedicine for humankind, or at least for those with access to medical services and products. Modern medicine saves and improves lives. A few common examples of biomedical technologies that enhance human lives are vaccinations against potentially life threatening or disabling diseases, antibiotic therapy for infection, and anaesthetic that makes even invasive surgery possible and bearable. The benefits of modern medicine have become so

[18] My maiden name and surname at the time of submitting the thesis.

commonplace that people living in the twenty first century can easily take them for granted[19]. Yet the prospect of life without these biomedical benefits, as was the case not so very long ago, is terrifying. I do not blame medical professionals, or anyone else involved in biomedicine, for medicine's crisis of care. If anything, I admire and am grateful to these skilled and learned individuals for their ability to administer the benefits of modern medicine. I am also concerned about the constraints that medical discourse places on doctors in their interactions with patients. What I want to achieve with this dissertation is to stimulate a consciousness of the effects that medical discourse may have on clinical interaction. In this way, my dissertation wants to play a role in liberating the medical profession from a restrictive self-image and making communicatively effective care for patients possible.

To start the conversation of the influence of modern medicine's scientific intellectual self-image on doctor-patient conversations, it is necessary to describe medicine's alleged identity as a natural science. I do this in the next chapter. In Chapter 2 I describe Habermas' research on what he terms Universal Pragmatics. Chapter 3 is devoted to a description of Foucault's theory on the nature of discourse. In Chapter 4 I provide a description of doctor-patient communication and medical discourse based on the praxis and discourse literature on this subject. I start the analytical work of my project in Chapters 5 and 6. Chapter 5 is a description of doctor-patient communication in terms of Habermas' universal pragmatics. In Chapter 6 I apply Foucault's thoughts on the nature of discourse to medical discourse. The task of critique is reserved for Chapter 7. In this chapter I critique the appropriateness of modern medicine's intellectual self-image in the light of the effects thereof on communication between the doctor and his/her patient. I also make some concluding remarks and recommendations based on the outcome of my philosophical analysis.

[19] I want to declare my personal indebtness to biomedicine for twice saving my life, or at least protecting me from serious disability. The first time was after a car knocked me off my bicycle on my way to high school and I broke almost every bone on the right side of my body. Doctors (literally) sewed and screwed me back together, nurses (and my mother) bathed and fed me, and physiotherapists helped me to regain movement of my limbs. The second time I was seventeen years old and I suffered from Guillain-Barré syndrome. A skilled neurologist promptly diagnosed the disorder and recommended plasmapheresis. This treatment was extremely effective and restored the functioning of my nerves within a matter of weeks. My gratitude is specifically directed at the health care professionals who treated me and to the nameless scientists who created the knowledge and technology that benefited me so greatly. I fully recovered from both these traumatic events with only a few unobtrusive scars to show for it.

Chapter 1

Modern medicine's intellectual self-understanding

We don't see things as they are, we see things as we are

Anaïs Nin[20]

1.1 Introduction

Today's doctor is first and foremost regarded as a scientist. His academic discipline, medicine, views itself specifically as a natural science (Simon, 2010:337). The natural sciences are the academic fields of physics, chemistry and biology. Medicine's practitioners and users did not always see their discipline as a science, nor is it self-evident that medicine should assume the self-image of natural science. Various historical, social and political factors and decisions shaped medicine into the mould of natural science as we know it today (Kriel, 2000:2).

If the above statements are true, a number of questions arise. One is interested in the historical development, or story behind medicine's self-identification as natural science. The character of medicine gradually changed from an art, as it was regarded since antiquity and throughout the Middle Ages, to a science since the eighteenth-century. Secondly, one might ask what it means to say that medicine regards itself as a natural science, and what medicine's understanding of science is. The implications of medicine's scientific status, specifically for the meaning of three concepts central to medicine, namely patient, disease and therapy (Kriel, 2000:7), also come into question. Finally, and of special concern to the aims of this project, the question regarding the nature of the doctor-patient relationship and specifically communicative interaction within this relationship according to a natural science framework, can be asked. This chapter will attempt to answer these four questions. This may seem like an ambitious goal, given the wealth of information available for responses to these questions. Yet, I shall sketch my story of how medicine came to be regarded as a science and the meaning thereof in broad strokes, given the limitations of the context of this text as doctoral dissertation and elaboration in later chapters on issues which hold special importance for the current project. The focus of this project is on the clinical method (the practice of medicine or

[20] As cited in Beveridge, 2002:101

the interaction between doctor and patient) and not on biomedical research or education, since the doctor-patient relationship and communication, two of the central concepts of this project, are matters belonging to the sphere of the physical encounter between doctor and patient.

1.2 From and art to a science

Illness and systems for dealing with the ill, the institution of medicine, have existed since the origin of mankind[21]. This is evident from skeletons and other archaeological findings that date back to the times before humans lived together in large groups (civilisations) and from the writings and drawings of the ancient civilisations (Nutton, 1996:52) up to our modern media. Medicine's goal and reason for existence has always been to promote the welfare of patients (Beauchamp & Childress, 2009:205), to treat the ill and to relieve their pain and suffering (Helman, 2007:121). A number of different systems of healing have existed throughout history and continue to exist today. Societies view illness and healing in accordance with their world-view, especially their views on the nature of reality (an ontology) and the nature of human persons (an anthropology). Helman (2007:125) reminds us that "medicine has always been more than a system of scientific ideas and practices; it has also been a symbolic system, expressing some of the basic underlying values, beliefs and moral concerns of the wider society".

One of the best known, respected and still honoured physicians of all time was Hippocrates who lived in ancient Greece in the fifth-century before Christ. Since antiquity up to the beginning of the nineteenth-century, the practice of medicine can be characterised as Hippocratic. The practice of Hippocratic medicine was based on a collection of written works named the Hippocratic Corpus. The writings were developed over decades by a variety of authors and represent "a consistent doctrine of medical theory and practice, relatively free from superstition and speculative philosophies, and setting forth rational empiricism of a strictly scientific nature" (Van Zyl, 1997:15). The Hippocratic Corpus suggests a humoral theory of illness. According to this theory any form of physical or mental difficulty is attributed to a problem in the balance of the four most important bodily fluids namely blood, phlegm, yellow bile and black bile. Illness was also believed to be closely connected with the

[21] I am indebted to Kriel (2000:1-44) for the structure of the sections numbered two (2) to four (4) in this chapter, as well as much of the content in the chapter. However, in the interest of not unnecessarily complicating the structure of the text, I only include in-text references to Kriel (2000) when paraphrasing or quoting directly from this source.

life story of the ill patient (Van Niekerk, 2002b:228). The humoral theory of illness corresponds with the dominant view of the time regarding the structure of the world as consisting of four elements namely fire, water, air and earth.

In the Hippocratic tradition doctors did not physically examine patients, but talked to them. Kriel (2000:4) explains this practice:

> [Up to] the eighteenth-century, doctors did not examine patients. Apart from possibly feeling the forehead for signs of fever, or examining the pulse and noting the facial expression and state of the tongue, doctors only talked to patients. This is understandable. For these doctors, disease was not located in an organ of the body, even though they had good anatomical knowledge, but was caused by a disturbed balance of the humors in the body. It was not necessary to examine the body, since an assessment of the balance of the humors depended on the report by the patient of his or her experience of the illness.

What the modern health care provider and consumer possibly find most striking about the pre-modern practice of medicine described above is the absence of the concept of disease (as we understand it today) and that no distinction is made between physical and psychological ailments. In the pre-modern era medicine was a form of art. The art entailed forming a personal relationship with the patient based on his/her humanity and to apply medical knowledge in a way that recognised this humanity as well as the patient's unique characteristics. This art was not based on scientific knowledge, but rather on practical wisdom which was acquired through experience and apprenticeship under the guidance of experienced physicians. To be considered a good physician, the clinician needed a reputation as skilled in the clinical method as well as virtuous of character (Van Zyl, 1997:26). It is interesting to note that altruism became part of the (expected) moral characteristics of medical professionals only from the second century AD, when Christian ideals became influential. There is very little evidence of altruism in the ethics of Hippocratic medicine. Jonsen (1990:9) describes the moral nature of ancient Greek medicine in the excerpt below.

> Hippocratic medicine was a skill, its practitioners were craftsmen, and their objective was a good living. The etiquette that went by the name of ethics consisted of counsels of self-interest: "Act in this or that way with your patients if you want to build a reputation and a clientele."

In the ancient Greek medical tradition the main goal of medical care was to increase or maintain the physician's reputation. Jonsen (1990:9) points out that the self-interest of Hippocratic physicians was not immoral or problematic since it was accompanied by the principle of non-maleficence, "at least do no harm". After some initial avoidance of Hippocratic medicine[22], the Christian church accepted "care of the sick as a duty of charity" (Jonsen, 1990:9). Medieval Western medicine had a Judeo-Christian nature in which "altruism and medical care were bound in a moral covenant" (Jonsen, 1990:7).

In the renaissance of the fifteenth and sixteenth centuries the medieval worldview started to change. During the Enlightenment, which started in the seventeenth-century, the world-view of the natural sciences replaced the pre-modern worldview. This new way of thinking and seeing proved powerful in explaining and manipulating the natural world. Although this paradigm was initially intended for studying the non-living natural world, it was later applied to the world of living matter based on the assumption that living material was structurally similar to non-living material. It was thus thought that living matter could be explained by the same principles of physics and chemistry that explained the non-living material world. Living material was simply seen as a more complex type of phenomenon compared to non-living material systems. As a consequence of the power of the natural science paradigm to explain the world and its consequent rise in social status, the way that illness and medicine were conceived and practiced was gradually transformed until medicine identified itself as a natural or empirical science and emphasized the need for a concrete understanding of disease through the examination of individual bodies (Levin & Solomon, 1990:519; Kriel, 2000:11; Rich *et al.*, 2008:221-222). The science of medicine is concerned with objectively describing disease processes[23] and uncovering the universal laws that explain the mechanical workings of the human body, or as Helman (2007:122) puts it "discovering and quantifying physicochemical information about the patient". Medicine that is conceptualised and practiced according to the natural science paradigm is known as biomedicine, scientific medicine, or allopathy and is currently the dominant approach to

[22] The early Christian Church avoided Hippocratic medicine, since it believed that God alone was the healer of man's afflictions and that relief from suffering should be asked from God through prayer. Medicine was gradually embraced in the Middle Ages (Van Niekerk 2002b:226; Van Zyl 2000:22).

[23] The description of facts is important in scientific medicine. Amard (1821:62, as cited in Foucault, 1973:140) states that "The art of describing facts is the supreme art in medicine: everything pales before it".

health care worldwide (Kriel, 2000: 21; Helman, 2007:94)[24]. The emphasis on objective empiricism and materialism leaves little room in biomedicine for subjective and less measurable psychological, social and cultural factors that impact patients' illness experiences and interactions in the health care environment (Helman, 2007:122). This is even true for psychiatry. I pay more attention to the nature of psychiatry later in this chapter (see section 1.4).

Various activities form part of the institution of scientific medicine. Three broad categories exist, namely medical science (the generation of knowledge through scientific research and the development of technology), medical practice or the clinical method (the application of medical knowledge in treating a patient's disease) and medical education (the transfer of scientific and clinical knowledge and skills to future and current doctors). The change from Hippocratic to scientific medicine did not happen simultaneously across the three institutions. In fact, a duality between medical science and practice, or the science and the art of medicine, existed for approximately two centuries. Medical science has its origins in the seventeenth-century when the scientific method was applied to the study of the function of the body (physiology). Many basic discoveries in the physiology and anatomy of the human body were made during this time, such as the circulation of blood and the existence of red blood cells (Lewinsohn, 1998:1263-1264; Kriel, 2000:4). Medicine's clinical method transformed at the end of the nineteenth-century to represent the natural science paradigm[25]. Medical

[24] Alternative forms of health care exist alongside biomedicine as the official (legally supported) system of health care in the West. Examples of such smaller health care systems are homeopathy, herbalism and spiritual healing (Helman, 2007: 81). Biomedicine makes up a small percentage of health care in most parts of the world due to the scarcity of manpower and the greater concentration of doctors in the urban areas of non-industrialised societies (Helman, 2007: 94).

[25] Lewinsohn (1998:1263-1265) emphasizes that a chasm has always existed "between medical theory and practice". This chasm was particularly great between the sixteenth- and the beginning of the twentieth-century. Girolamo Fracastoro's theory of contagious disease (published by in 1546), Harvey's theory of blood circulation and Descartes' mechanistic philosophy made no difference to the way that medicine was practiced, and therefore were of no benefit to the patient, until the early 20th century. There are various reasons for the great cleft that existed between medical science and practice since the scientific revolution (dated at approximately 1550) until the start of the previous century. Firstly, scientific medical theories could not be used by the doctor who was "*limited to surface phenomena*" in his/her examination of the patient. That is, the doctor had only his/her senses available to observe the physical signs and symptoms of the patient's disease. Secondly, these theories were not in agreement with the established medical dogma of the time and were therefore not accepted. As Lewinsohn (1998:1264) eloquently puts it: "As for Descartes, for all his enormous influence on all subsequent philosophy and science, insofar as medical practice up to the twentieth century was concerned, he might as well never have had a single thought or written a single word". Finally, it was not so much advanced anatomical knowledge, but rather overcoming the "triple barrier of pain, bleeding and sepsis" that enabled surgeons to "penetrate the depths of the living body and tissues". Surgeons' interventions were restricted to surface phenomena before the advent of anaesthesia in 1846 and the means to combat sepsis in 1877.

education became rooted in the natural sciences only in 1910 after the American medical profession accepted the Flexner Report.

Since medicine started to move away from the Hippocratic tradition a number of changes took place before it took on the form of biomedicine as we know it today. In *The birth of the clinic* Foucault (1973) discusses the changes that took place in medicine at the end of the eighteenth century. During this period medicine transformed from classificatory medicine to the anatomo-clinical method that is still used today (Sheridan, 1980:38)[26]. Classificatory medicine was dominated by Gilibert's[27] classificatory rule: "Never treat a disease without first being sure of its species". Classificatory medicine was a medicine of nosology. Diseases were organised in hierarchies of "families, genera and species" (Foucault, 1973:3). Foucault (1973:24) refers to Thomas Sydenham (1624-1689) as "the initiator of classificatory thought". Sydenham was an admired English doctor, known as the 'English Hippocrates'. He emphasised observation rather than theory in clinical medicine. He urged physicians to differentiate between diseases and to seek remedies specific to every isolated form of disease. His empirical method lead to a nosology of individual diseases, each described in terms of its unique signs and symptoms (Jonsen, 1990:84; Porter, 1996:168-169). In modern medicine disease is not seen as a single, uniform entity. Different forms of empirically identifiable substantive diseases are recognised, each with a unique pathology, specific cause and responsive to specific treatment. This view stands in stark contrast to the unified humoral concept of illness of Hippocratic medicine (Van Niekerk, 2002:227-228; Rich *et al*., 2008:222). Interestingly, in classificatory medicine, the presence of disease in a particular organ was not "absolutely necessary to define a disease: this disease could travel from one point on the body's surface to another and remain identical in nature" (Sheridan, 1980:39).

"The act of seeing" (Sheridan, 1980:39), or the "gaze" in Foucault's (1973:2) terminology, dominated the medicine of the late eighteenth century. The doctors of classificatory medicine observed disease up to the point of the death of its host – the death of the diseased patient. The "great break in the history of Western medicine" (Foucault, 1973:179), the birth of the anatomo-clinical method, occurred with the birth and raise in importance of pathological

[26] This reference is to Alan Sheridan's book, *Michel Foucault: The Will to Truth*. Sheridan (1980:1) describes his book as a guidebook to Foucault's work, a guidebook that is "profusely illustrated" with lengthy and frequent quotations to the original work and much of the rest "précis or disguised quotation". Sheridan translated a number of Foucault's books from French to English, including *The Birth of the Clinic* and *The Archaeology of Knowledge*. I occasionally refer to Sheridan to illustrate or illuminate Foucault's ideas where I did not find sufficient clarity in the original text.

[27] Foucault (1973:2) quotes Gilibert and indicates the source of this quotation as Neuchâtel, 1772, vol. I, p.198).

anatomy. Bichat (1801:xcix, as cited in Foucault, 197:180) advised the doctors of classificatory medicine:

> for twenty years, from morning to night, you have taken notes at patients' bedsides on affections of the heart, the lungs, and the gastric viscera, and all is confusion for you in the symptoms which, refusing to yield up their meaning, offer you a succession of incoherent phenomena. Open up a few corpses: you will dissipate at once the darkness that observation alone could not dissipate.

Soon after the French Revolution French physicians, including René Théophile Hyacinthe Laennec, started the practice of attending post-mortem examinations to correlate the clinical findings of examinations in hospital wards before patients died, with the organ pathology revealed by the post-mortem examination. This "simple change in clinical practice" (Kriel, 2000:3) changed the conceptual structure of classificatory medicine that has death as its outer limit, the point at which doctors' actions as well as disease end (Sheridan, 1980:39,41). The conceptual structure of the anatomo-clinical method is a trinity formed by "life, disease and death". Death is the summit of this triangular figure. "It is from the height of death that one can see and analyse organic dependences and pathological sequences" (Foucault, 1973:176-177). Whereas observation in classificatory medicine was aimed at defining "the *structures of pathological kinship*", observation in the anatomo-clinical method has "the task of mapping the *figures of localization*". The "notion of *seat*" replaced the "notion of *class"*.

> 'What is observation', Bichat was…asking, 'if one is ignorant of the seat of the disease?'[28] And Bouillaud was to reply: If there is an axiom in medicine it is certainly the proposition that there is no disease without a seat. If one accepted the contrary opinion, one would also have to admit that there existed functions without organs, which is a palpable absurdity. The determination of the seat of disease or their localization is one of the finest conquests of modern medicine'[29] (Foucault, 1973:171-172).

[28] Bichat, X. 1801. *Anatomie générale appliquée à la physiologie et à* médicine. 3 vols. Paris. p. xcix (as cited in Foucault 1973:171)

[29] Bouillaud. *Philosophie médicale,* p. 259. (as cited in Foucault 1973:172). This is the most complete reference to these words of Bouillaud in *The Birth of the Clinic*.

Kriel (2000:3-4) agrees with Bouillaud that the change in the French physicians' methods radically influenced medicine's clinical method:

> Apart from advances in therapy, most of the conceptual and technological advances of twentieth-century medicine are more sophisticated ways of examining patients and of defining tissue-pathology and pathophysiology. Modern technologies enable clinicians to image tissue changes and pathologists to obtain tissue and body fluid samples, without having to wait for the post-mortem room. Twentieth-century medicine can be described as a series of footnotes to the change in conceptual framework brought about by Laennec and his colleagues.

The humoral theory of illness was thus replaced with the concept of disease, namely organ pathology[30]. The birth of disease may be seen as the birth of modern medicine (Tavassoli, 1987 as cited in Kriel, 2000: 4). A transformation in the clinical method, from Hippocratic to scientific had thus occurred. The discovery of disease and the developments in medical treatment which followed as a consequence, were very significant in the sense that doctors acquired true power over disease in a manner unknown in previous times (Van Niekerk, 2002b:228). The role of the doctor in the scientific clinical method is to identify the appropriate disease label to classify the patient's condition by matching the disease history as elicited from the patient with the results of the physical and other special investigations, namely objective laboratory information. The disease label further determines the therapy to be followed in treating the disease.

Kriel (2000:6) believes that the new clinical method that developed at the end of the nineteenth-century was born out of a desire to follow the methodology of the physical sciences which has proved powerful in explaining and manipulating the physical world. In the following two sections I describe biomedicine's understanding of itself and of science, and how these philosophical assumptions manifest in clinical medicine.

[30] Disease was first viewed as organ pathology. With developments in medical science and technology disease was later viewed as cellular pathology (nineteenth-century) whereas molecular pathology is the twentieth-century and current definition of disease. Today's scientific medicine regards a disease as understood when its molecular basis can be fully described.

1.3 Modern medicine's scientific intellectual self-image

For the past hundred years at least medical professionals have been considering medicine as a science (Kriel, 2000: 10; Montgomery, 2006:30; Simon, 2010:337). Simon (2010:337) points to two matters to support the above statement. Firstly, he mentions a document called the Physician Charter or the Charter on Medical Professionalism which was prepared over several years by leaders of the following three important medical organisations: the American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine (2002: 243-246). The Physician Charter was simultaneously published in two highly regarded academic journals in 2002, namely the Annals of Internal Medicine and The Lancet (Sox, 2002: 243). Since its publication more than 130 world-wide organisations have endorsed the Charter and it has been translated into 12 languages (ABIM Foundation, n.d.). The Charter sets out three fundamental principles and 10 commitments or professional responsibilities to which all medical professionals in the twenty first century can and, according to its authors, should aspire. One of the professional responsibilities of medical professionals stated in the Charter is the "commitment to scientific knowledge". According to this commitment "physicians have a duty to uphold scientific standards, to promote research, and to create new knowledge and ensure its appropriate use" (American Board of Internal Medicine Foundation, the American College of Physicians Foundation, and the European Federation of Internal Medicine, 2002: 245). Simon (2010: 337) takes this statement as "perhaps the most explicit formulation of medicine's self-conception as a science". He finds a second indication of medicine's self-image as a science in the methodology of clinical research. He describes this methodology as "modeled as closely as possible on basic [natural] science research with a premium placed on objectivity, hypothesis testing, and repeatable outcomes" (Simon, 2010: 337).

If it can be said that medicine views itself as a science, this claim can be made more specific by stating that modern medicine perceives itself as a **natural science**. What does this claim mean? It is by no means easy to provide an adequate definition of the concept of "science". A fairly traditional conception of scientific practice is that it is a way or a method that humankind has developed to gain access to and a grip on the reality that she is faced with (Van Niekerk, 1992:4). Scientific practice can be defined as the systematic acquisition and transfer of knowledge (Rossouw, 1993:95). The modern day sciences or 'science subjects' each operate within a clearly demarcated area of investigation. Every individual science, such as physics or biology, corresponds with a particular modality of the knowable reality and aims

to find relevant and factual information about this specific feature of reality (Van Niekerk, 1992:5). The knowledge terrain of the natural sciences is the natural, physical aspects of reality (as opposed to the aspects of reality that are connected with the creations and actions of people)[31]. It can thus be said that the paradigmatic natural sciences, for example physics, chemistry and molecular biology, use certain well-defined methods to study features of the natural world in order to produce accurate knowledge about the structure and behaviour of those features (Oxford Advanced Learner's Dictionary, 2005:1307; Simon, 2010:337). Following this basic definition of natural science, the claim that medicine is a natural science is to say that medicine

> just like physics, chemistry, and molecular biology, investigates the entities of the natural world within its own domain and returns knowledge of those entities and that world, albeit knowledge of a particularly useful sort that allows us to improve and prolong the functioning of our bodies (Simon, 2010:337).

The claim that medicine conceives of itself as a natural science can be analysed more closely. We can ask, **what is medicine's understanding of science?** According to Kriel (2000: 14) medicine's understanding of science corresponds with the logical positivist view of science. Claims are made that most Western medical practitioners and scientists (and many researchers in the natural sciences in general) as well as the general public with a high school or university education subscribe to this positivist view of science (Van Huyssteen, 1986:16, 22; Kriel 2000:10). Kriel (2000:21) even refers to modern medicine as "positivist medicine". A look at logical positivism and the conception of science that developed from this philosophy, which may be referred to as the standard image of science, will give us insight into biomedicine's intellectual self-image. I shall thus now provide a brief description of logical positivism and the standard image of science.

[31] The aspects of reality that have been created by humans are the subjects of the human sciences (Van Niekerk, 1992:1).

1.3.1 Logical positivism

Logical positivism refers to a set of ideas that originated among a group of intellectuals (among them philosophers, mathematicians and physicists) who met regularly in the 1920s in the Austrian city of Vienna. This group of intellectuals are known as the Vienna Circle (Hanfling, 1981:2; Blackburn, 2005:214). The term 'logical positivism' helps us to understand the orientation and interests of the Vienna Circle and those who adopted their ideas, collectively known as the Logical Positivists. The seventeenth-century French philosopher and sociologist Auguste Comte (1798-1857) used the term '**positivism**' (Hanfling, 1981:6). It refers to the view "…that the highest or only form of knowledge is the description of sensory phenomena" (Blackburn, 2005:284). According to positivism our knowledge of the world is the result of sense observation ('Comte, Auguste (1798 - 1857)' 1999) and all our knowledge stems from observable phenomena (Hanfling, 1981:6). In positivism sense experience is regarded as the ultimate basis of all forms of knowledge (Van Huyssteen, 1986: 16). The word 'logical' indicates the Vienna Circle's dependence on logic or its special interest in language.

Hanfling (1981:13) identifies three main strands in the thought of the Logical Positivists, namely: "the verification principle, the elimination of metaphysics and the unity of science." I shall now pay brief attention to each of these ideas and concerns in the order that they are listed above. The Logical Positivists were[32] particularly interested in the **meaning** of statements. Their theory about what determines the meaning of statements is known as the **verification principle** and it is formulated as follows: "the meaning of a proposition is the method of its verification" (Hanfling, 1981:6-7; 'verificationism' 1999). To illustrate how this principle works Hanfling (1981:7) provides the example of 'the postman at the door'. If we were to ask the Logical Positivists the question, "What does the following statement mean: 'the postman is at the door?'", they would answer, in accord with the verification principle, as follows:

[32] I refer to the Logical Positivists in the past tense since very few present-day philosophers fully identify themselves with this philosophical movement or would be willing to call themselves Logical Positivists. Logical Positivism thrived for approximately twenty or thirty years after it was established in the 1920's (Hanfling, 1981:1; 'logical positivism also called positivism' 1999). The opening line of Hanfling's (1981:1) book on logical positivism illustrates the current status of this philosophical movement: "'Logical positivism', we are told in the *Encyclopedia of Philosophy*, 'is dead, or as dead as a philosophical movement ever becomes.'" Hanfling indicates the source of his quotation as follows: John Passmore, in *The Encyclopedia of Philosophy*, ed. Paul Edwards (1972), under 'Logical Positivism'.

> How would one verify that the postman is at the door? By looking, listening, etc.? Very well. The meaning of that proposition consists in nothing else than these methods of verifying it – or perhaps, in what happens when these methods are employed.

Following their positivist position, the Logical Positivists conceived of verification mainly in empiricist terms (Hanfling, 1981:7). In the positivist tradition, in order for a statement to have a claim to **truth**, it needs to possible to verify the statement by means of sense experience. Statements that cannot be empirically verified are not regarded as true or as meaningful (Van Niekerk, 1983:15-17; Van Huyssteen, 1986: 16). According to the Logical Positivists only two types of meaningful statements exist, namely empirical statements and analytical statements. Empirical statements are verifiable by observation (Hanfling, 1981: 9). These statements are based on experience and can be traced back to sense experience by means of logical analysis (Van Huyssteen, 1986:18). "The postman is at the door" is an example of an empirical statement (Hanfling, 1981:9). Analytical statements are not empirical but their truth or falsity can be established by analysing the meaning of the words contained in the statement (Hanfling, 1981:9; Van Huyssteen, 1986:18). Examples of analytical statements are: "a postman delivers letters" (Hanfling, 1981:9) and "all circles are round" (Van Huyssteen, 1986:215). To verify an analytical statement it is not empirical observation that is required but rather "a knowledge of the meanings of the words" in the statement (Hanfling, 1981:9). The statements of the formal sciences, namely logic and mathematics were also considered as analytical statements by the Logical Positivists (Hanfling, 1981:9; Van Huyssteen, 1986:18).

The Logical Positivists excluded **metaphysical, religious and ethical statements** from their realm of meaningful utterances, since such statements cannot be verified empirically. In other words they do not correspond with anything that one would be able to identify empirically, as required by the verification principle of meaning. According to the Logical Positivists ethical utterances are devoid of cognitive content. Such statements do not represent knowledge and are at most an expression of particular feelings. The goal of the Logical Positivists was to analyse the language and method of **science** and to remove all metaphysical content from it. In this way logical positivism formed the first systematised philosophy of science (Van Huyssteen, 1986:16-18). In fact, the greatest value of logical positivism is probably that it made an extremely detailed analysis of science possible (Van Huyssteen, 1986:20).

The third main component of logical positivism is the idea of **the unity of science**. The idea of the unity of science refers to the belief that all the empirical sciences ultimately share one particular epistemological structure. The most developed science of the time, namely natural science, determines this structure. According to the doctrine of the unity of science, only those sciences and viewpoints that correspond with the theory of knowledge of the natural sciences, can be described as sciences (Van Huyssteen, 1986:17; 'unity of science' 1999).

1.3.2 The standard image of science

The work and the ideas of the Logical Positivists lead to what may be referred to as the standard image of science[33] (Rossouw, 1980:2; Van Huyssteen, 1986:19; Van Niekerk, 1992:48). The standard image of science had been a strong influence on philosophers of science and scientists at the beginning of the twentieth-century, but has lost much of its prestige in the second half of the previous century, especially among the philosophical community (Van Niekerk, 1992:48). Yet, the standard image of science is still the dominant conception of science in modern medicine (Kriel, 2000: 14). I shall now describe the standard image of science, drawing mostly on Van Niekerk's (1992:49-52) description of this conception of science.

The standard image of science has been developed as a description of the method of knowledge acquisition in the natural sciences, and this was viewed as the model for all scientific knowledge acquisition. According to the standard image of science, "…the only truly reliable knowledge about reality…" is scientific knowledge, that is knowledge produced by the natural sciences, and more specifically by physics (Van Niekerk, 1992:49). The special status of scientific knowledge rests primarily on two aspects, namely 1.) **the objectivity of scientific knowledge claims** and 2.) **the rationality of the method of scientific knowledge acquisition**. I shall now pay attention to these two aspects.

Nel (1981:89) provides us with Paul Guillaume's[34] (1946:163) definition of the term '**objectivity**' in the context of the logical positivist philosophy of science:

[33] Chalmers (1999:3) refers to this conception of science as "…a common view of science."
[34] Guillaume, P. 1946. *Introduction á la Psychologie*. Paris: J. Vrin.

> The word objectivity has a double meaning: it means…correspondence of the thoughts with its object, … In the second meaning of the word, the science is objective because the truth thereof is impersonal, universal; an observation is objective when all the observers agree regarding the fact which is observed (my translation).

The positivist claim that scientific knowledge is objective, means that this type of knowledge is viewed as a reflection of the nature of reality as it truly is, unclouded by the personal reactions of the knowing subject to that which (s)he experiences (Rossouw, 1980:3; Nel, 1981:89; Van Niekerk, 1992:49). The standard image of science is characterised by what Popper (1963:5) refers to as "epistemological optimism: by a most optimistic view of man's power to discern truth and acquire knowledge." This optimism is based on the belief that "truth is manifest". According to this belief it is possible for the truth about reality to reveal itself to humankind, or for us to reveal the truth. Once the truth is revealed, we are capable of knowledge about it.

> At the heart of this new optimistic view of the possibility of knowledge lies the doctrine that *truth is manifest*. Truth may perhaps be veiled. But it may reveal itself. And if it does not reveal itself, it may be revealed by us. Removing the veil may not be easy. But once the naked truth stands revealed before our eyes, we have the power to see it, to distinguish it from falsehood, and to know that it *is* truth (Popper, 1963:5).

In the pursuit of scientific knowledge it is necessary and possible to eliminate any subjective emotional responses, projections of the imagination, and expectations from our scientific engagement with the world. Subjective phenomena such as these result in an unreliable and warped image of the world (Van Niekerk, 1992:49). The basic idea in the positivist conception of science is "true scientific objectivity", that is the idea that facts must speak for themselves in a neutral and unhindered manner by means of direct observation. Direct observation is seen as observation unaffected by theories or ideologies in the mind of the observer (Van Huyssteen, 1986:21).

Within the standard image of science, the claim that scientific knowledge is objective also means that this type of knowledge is **impersonal and universally valid**. According to the positivist image of science, the scientific character of a knowledge claim is not at all affected by the person who makes the scientific statement. The reliability and credibility of the speaker has no effect on the truth of his/her statement. The only thing that needs to be

considered is the truth of the statement and this can be verified through procedures that are universally accessible and valid (Nel, 1981:89; Van Niekerk, 1992:49). Similarly, the content and reliability of scientific theories are not fundamentally affected by the social circumstances or the historical context in which these theories are developed (Van Niekerk, 1992:50). In the positivist view scientific knowledge claims are universal and timeless. They apply to all persons, all time periods and in all circumstances and are thus completely objective (Van Niekerk, 1992:50).

The other aspect that bestows on scientific knowledge such a very high status in the standard image of science is the **rationality of the procedure**[35] by means of which such knowledge is acquired and justified (Van Niekerk, 1992: 50). Van Niekerk (1992:50) points out that this is **a stabilised procedure**, meaning that any person with the required background will be able to master the procedure and produce research results that will be consistent regardless of where, when or by who the procedure is performed. The point of departure of this procedure is believed to be the careful execution of repeatable experiments with the aim to establish publicly accessible facts in a controlled manner (Rossouw, 1983:3). Another assumption within the standard image of science is that the acquisition of scientific knowledge always has **observations** as starting point (Van Niekerk, 1992:50). Van Niekerk (1992:50) describes experiments as "nothing else but controlled and stabilised observations." The 'facts' that are determined via such observations are described in a neutral language of observation as so-called single judgements, observation statements or protocol statements[36] (Van Niekerk, 1992:50). According to the Logical Positivists scientific knowledge derives from an objective empirical basis. The empirical base on which the scientific body of knowledge rests, consists of single judgements or observation statements that express publicly accessible information or experiences in an impersonal and neutral manner that can be accepted by any observer (Nel, 1981:90; Van Niekerk, 1992:51). Examples of observation statements are "it is red"; "this is bigger than that" (Van Niekerk, 1992:51) and "there are mountains and craters on the moon" (Chalmers, 1999:10).

[35] This procedure is also referred to as the "scientific method" (Kriel, 2000:14-16).

[36] Blackburn (2005:297) defines protocol statements, or *Protokollsätze* (the original German term) as follows: "The basic statements in the logical positivist analysis of knowledge, thought of as reporting the unvarnished and pre-theoretical deliverance of experience: what it is like here, now, for me."

A further characteristic of the rationality of the process of scientific knowledge acquisition according to the standard image of science is an **inductive logic** (Van Niekerk, 1992: 51). As time passes the observation statements that are obtained through controlled observation and experimentation accumulate. Through close examination of this corpus of established facts the scientist is able to discover certain regularities and to formulate these as general, hypothetical statements (Rossouw, 1980:3; Van Niekerk, 1992: 51). For instance, the observation that various metals expand when they are exposed to heat leads to the hypothesis that metals expand when they are heated (Van Niekerk, 1992:51). The next step of the scientific method is to seek further experimental evidence in order to determine whether such preliminary hypotheses are true or not. This step in the scientific process is an attempt at **verification**. A knowledge claim only qualifies as a scientific fact once it is conclusively verified through supportive sense experiences, which are formulated as single judgements. If the verification attempt is successful inductive generalisation is used to conclude that a new **scientific law** has been discovered that allows the explanation and prediction of phenomena. The formation of hypotheses and theories from observation statements is thus subject to rules that can be codified. The conclusion of hypotheses and theories can also be rationally tested by means of the rules of inductive generalisation. Correlation between different scientific laws that are 'discovered' in this manner leads to more comprehensive theories that continually arrange more and more information according to a pattern (Rossouw, 1980:3; Van Niekerk, 1992:51).

Scientific knowledge gradually **grows** as verifiable experiential information is collected and verified inductive theories are framed. Through continuous observation and experimentation new facts are discovered and accumulate. New hypotheses and theories that are based on these newly discovered facts also gradually increase in number. By means of this process more comprehensive and accurate scientific theories are developed. Such new theories are more comprehensive since they can explain a greater amount of facts as well as the relationships between facts. They are also more accurate because they describe experiential phenomena in greater detail (Rossouw, 1980:3-4; Van Niekerk, 1992:51-52). Van Niekerk (1992:51-52) neatly summarises the process of growth of scientific knowledge:

> The body of scientific knowledge grows through the accumulation of factual and theoretical judgements that are true, that is judgements that raise the objective reality with certainty in a manner that is universally valid. The quality of the truth of these judgements can be verified since it is possible to reconstruct the observations that the theories rest on, as well as the logical arguments that motivate the conclusion of hypotheses and theories (my translation).

1.3.3 The ontological and epistemological assumptions of the natural science paradigm

Kriel (2000:14) uses the term '**natural-science paradigm**' to refer to the ontological and epistemological or methodological assumptions of the natural sciences. I use the term in a similar manner in this dissertation. Ontological assumptions are beliefs regarding the nature of reality, whereas epistemological assumptions are beliefs about how that reality may be accessed. An interrelationship exists between the ontological and epistemological assumptions of any thought system. Assumptions about the nature of the world and reality imply the manner in which such a reality can be known or examined. The knowledge that results from the application of the methodology of a science in turn influences the science's ontological and epistemological assumptions, sometimes to the point that a reformulation of ontological and epistemological standpoints is needed (Kriel, 2000:17).

The **epistemological beliefs** of the natural sciences, and of modern medicine, were described in the section above on the standard image of science. These beliefs are represented by the following five concepts:

i. empiricism or positivism (I treat these terms as synonyms);
ii. verification;
iii. the unity of science;
iv. objectivity;
v. the scientific method (Kriel, 2000:14-16).

Kriel (2000:16-19) also describes the ontological assumptions of the natural sciences and of biomedicine based on four interrelated concepts; namely:

i.) dualism;
ii.) materialism;
iii.) reductionism;
iv.) linear (unidirectional) causality and determinism.

I now briefly summarise his description and give examples of how some of these concepts manifest in biomedicine. Firstly, a **dualism** is assumed between material and immaterial realities[37]. The methods of natural science are more suitable to aspects of the material world, and therefore scientists placed their emphasis here. A mind-body dualism has been extremely influential in biomedicine. This means that the mind and body of a human being are considered as separate and qualitatively different entities. The human body and observable disease processes or structural malformations which affect the normal functioning of the body belong, according to this dualism, to the material world. All other aspects of the human condition, such as thoughts and emotions belong to the immaterial world. Over time the immaterial aspects of reality became seen as mere by-products of material processes. In this way dualism has been replaced by monistic materialism. Monism refers to the belief or principle that the world is constituted by one fundamental substance (Marcum, 2008:394). Monistic materialism thus refers to the belief that "everything that exists is physical" (Blackburn, 2005:238). The idea of mind-body dualism in the modern era is linked to Descartes (1596-1650). Descartes thought of the body as the research domain of science, and of the mind as the domain of philosophy and religion. More recently psychiatrists and behavioural scientists took ownership of the study of the mind, while the body belongs to medical science and is regarded as an "animated machine" (Helman, 2007:123).

[37] Two other dualisms also occur in the world-view of modern medicine, namely the dualisms of body and environment as well as individual and population (Levin & Solomon, 1990:533).

The natural world is further viewed as a complex whole based on a basic structure of atomic parts that interact with each other in various and complex ways to give rise to the entire range of existing physical and biological systems. All material matter can be reduced to a specific and unique structure of interacting atoms. These atoms are seen as the basic building blocks of reality. The primary aspect of reality is thus seen as material in nature. Immaterial phenomena, such as the human mind and soul are regarded as secondary to this basic material level of reality. This view of reality is known as **materialism**.

Thirdly, **reductionism** represents the view that the whole of a material system is the product of the interaction of its smallest constituent parts. The structure and functioning of matter can therefore only be explained by reducing the phenomenon in question to its constituent elements and explaining the interaction between such elements. Living organisms are thus seen as a specific arrangement and interaction of atoms. Helman (2007:123) points out that modern medicine's tendency to focus on the individual patient, as opposed to the family and community of the patient, stems from its reductionist approach.

The image of a machine or physical mechanism is the metaphor used in natural science to explain the world. During the scientific revolution of the seventeenth-century nature came to be considered as analogous to an enormous machine, similar to a clock. The aim of scientific activity is to discover the true inner workings of this machine and its outward observable manifestations (Doyal & Harris, 1986:31). The notion of mechanism refers to the elements and processes which constitute an entity and the relationship between these constituent parts (Marcum, 2008:394). In biomedicine the human body is viewed as a machine. The body is seen as a totality of separately functioning parts (Levin & Solomon, 1990:552; Burger, 2001:81). The structure and the functioning of the body are regarded as a product of the interaction of its smallest constituent parts. Disease may cause a breakdown in the workings of the machine. Once the molecular structure and physiology of a disease process can be explained, that is the disease-mechanism, a treatment can be developed to remove the disease and restore the machine to its normal state of functioning. A **mechanistic** view of reality thus operates in the natural sciences.

The final concept illustrating the ontology of the natural sciences is **unidirectional causality and determinism**. According to the doctrine of determinism a cause, or antecedent state, exists for every event. The relationship between the antecedent state and the event is such that a natural law will be broken should the antecedent state occur without it being followed

by the event (Blackburn, 2005:97). This doctrine is followed in natural science. The model of scientific explanation that is followed in the natural sciences is known as the deductive-nomological model. According to this model to explain something is to describe it as an event of which the occurrence can be deduced from the existence of one or more universal laws and the presence of certain initial conditions (Popper, 1968:59-62; Van Niekerk, 1992:7)[38]. For the positivist a phenomenon can be fully explained once it has been broken down into its constituent parts, and the way that these parts behave to produce the event is explained. Within the positivist framework the movement or direction of causality is always from the bottom, the behaviour of the parts, to the top, the nature of the whole. The whole is not seen as having a reality independent of the interaction between its parts. Therefore, a phenomenon such as consciousness is reduced to the outcome of the behaviour of its observable, material antecedent state – that is neural activity.

1.4 Clinical biomedicine

I have already stated that many doctors and members of the public consider clinical medicine to be a natural science (Montgomery, 2006:30). Clinical medicine is regarded as a scientific practice based on two factors. Firstly clinical medicine is seen as the direct application of scientific knowledge generated through medical science. Secondly, the clinical method reflects the process of the scientific method where hypotheses are formulated and then tested[39]. The clinical method refers to a systematic process that shapes the doctor-patient interaction. Medical students are trained in this process and scientific doctors are expected to follow this procedure in their interactions with patients. The nature of the doctor-patient relationship and interaction is thus determined by the doctor[40]. The first task of the consultation is a systematic interrogation known as history taking in which the doctor directs specific questions to the patient regarding his/her symptoms (subjective illness experience) as

[38] As modern science came into being the nomological-deductive model of scientific explanation replaced the teleological model of explanation found in the Greek world-view. A teleological explanation attempts to make an event understandable by ascribing a purpose to it (Doyal & Harris, 1986:27-28). To explain something according to the teleological model means to identify its place within a greater totality (Van Niekerk, 1992:7).

[39] Rich *et al*. (2008:225) point out that since modern medicine views the patient as the "object of medical science" the doctor may "experiment on the patient", as long as the doctor's intention is to accurately diagnose and remove the disease. For modern medicine "the experimentation on bodies became as indispensable as it is for the natural sciences". However, the bioethical principle of respect for autonomy demands that the patient provides informed consent for any experimentation intended by a doctor.

[40] Waitzkin (1989:237) notes that the traditional format of the doctor-patient interaction is commonplace in most human societies where modern medicine is practiced.

well as factors that might be related to the "still-to-be-diagnosed disease" (Kriel, 2000:22) such as the history of disease in the patient's family, the patient's work history and lifestyle. The doctor then uses this information to form a hypothesis about the organ system in question and the specific disease affecting the organ and thus causing the symptoms. The interaction between doctor and patient known as history taking is thus directed by the physician. Attention is paid to symptoms that are associated with or related to probable organ pathology. Kriel (2000:24) explains the way that history taking focuses solely on the biological dimension of the patient's condition in accordance with positivist ontological and methodological assumptions as follows. "Through directed questioning, the patient's personal agenda is drawn into the reductionistic, mechanistic and materialistic medical agenda in order to make a physical diagnosis and prescribe physical treatment. This happens even if the doctor is not a materialist in daily life" (Kriel, 2000:24).

The next task of the consultation is for the doctor to physically examine the patient with the aim of finding physical signs to confirm or reject the hypothesis formulated on the basis of the patient's disease history. Physical signs are objective evidence, such as a blood pressure reading above or below the range accepted as normal for the patient's age and gender. The physical examination is often followed by special investigations. These diagnostic technological procedures provide further objective evidence of the underlying organ pathology, and may include a laboratory analysis of a blood and/or urine sample or X-ray photographs. When the history taking, physical examination and special investigations have been completed, the doctor needs to identify the disease label. This is the disease process that best connects the history, the results of the physical examination and the results of the special investigations. The doctor bases his/her treatment plan on the selected disease label. If no objective evidence could be found during the physical examination or special investigations no disease is believed to exist, regardless of the patient's subjective experience of illness. It is then that a doctor might use the ideas of neurosis, psychogenic or psychosomatic disorder to explain a patient's complaints. When a patient has the subjective experience of being ill, but no objective physical evidence for the cause of the symptoms can be found (by means of the clinical diagnostic method), the condition is often related to the pressures of everyday life. An example of such a condition is irritable colon. The doctor's reassurance that no disease is

physically present may not sufficiently treat the patient's illness[41] (Helman, 2007:150). Marks (1999:55-56) argues that there are sound clinical reasons for doctors to take patients' subjective complaints seriously even when no physical evidence can be found to explain the symptoms, such as pain. The case of sickle-cell anaemia explains the argument. Sickle-cell anaemia is a gene disorder that episodically affects the patient's red blood cells leading to short-term attacks of severe pain when "illness, stress, distress, exhaustion, dehydration or cold" is experienced. Because the reason for the patient's pain is not readily observable and because pain cannot be verified, doctors often do not believe these patients' (extreme) complaints of pain and often deny these patients adequate pain medication[42].

Kriel (2000:23-25) describes what medicine's self-imposed identity as a natural science means for three of its central concepts, namely patient, disease and therapy. I relay his comments in the following section.

In modern medicine the **patient** is reduced to a biological organism[43]. In accordance with Descartes' view a normal functioning biological system does not require the existence or functioning of the mind. The non-material realities of consciousness, or the psycho-social realm, is not and cannot be accommodated by medicine's positivist world-view. Doctors who regard persons as more than their biology face a tension between the biomedical clinical method and epistemology (which is reproduced and transferred to students in medical school - a process of enculturation [Helman, 2007:121]) and their personal beliefs.

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[41] Medical anthropologists make a distinction between the terms illness and disease. Illness refers to "the innately human experience of symptoms and suffering" (Kleinman, 1988:3). Kleinman (1988:3-6) describes illness as the way that the sick person as well as his/her caregivers or broader social network "perceive, live with, and respond to symptoms and disability". Disease refers to the biomedical doctor's understanding of the patient's illness, namely an alteration in the structure or functioning of the patient's body. Cassell (1976 as cited in Helman, 2007:126) describes illness as what a patient feels when he goes to the doctor, whereas disease is "what he has on the way home from the doctor's office…Disease, then, is something an organ has; illness is something a man has".

[42] Marks (1999:58-59) also makes the interesting observation that racism may play a role in (Western) health care professionals' inadequate responses to the complaints of patients with sickle-cell anaemia. The disease "primarily affects people of African-Caribbean, Mediterranean, Middle-Eastern and Indian descent". Marks argues that patients with sickle-cell anaemia may be treated with suspicion in the health care sector for racist reasons. There are reports of unequal treatment of black people in mental health care as well as criminal justice systems in Western, developed countries.

[43] Burger (2001:81) points out that modern medicine's concept of biology is synonymous with the chemico-physical processes in the body. He regards this as a very narrow view of biology, and prefers the fuller conception of biology as "the science of life in *all* its aspects" (Ulrich, 1997 as cited in Burger, 2001:81). In the latter conception of biology the physicol-chemical processes in the body constitute *one part* and not *all* of life. Burger describes biomedicine's reductionist concept of biology as equivalent to "somatology".

[Burger provides the following reference to Ulrich's book: Ulrich, G. 1997. *Biomedizin. Die folgenschweren Wandlungen des Biologiebegriffs*. Stuttgart, New York: Schattauer.]

Medical anthropology describes how developments in diagnostic technology gave birth to a new patient population, namely 'paper patients' in the form of "X-ray plates, scans, printouts of blood test results or the strips of paper from an electrocardiogram" (Helman, 2007:123). These paper patients may receive more medical attention than the human patients they are related to, and may be equally or even more interesting to the doctor than the actual patient. It is understandable that paper patients may be seen as easier to work with than human patients within a biomedical framework. Paper patients are products of, and therefore fully compatible with, scientific medicine. "They are easier to interpret, control, quantify and monitor over time, and there is no danger of them being uncooperative" or contaminating physical disease with the unscientific notions such as cultural or religious beliefs. It has to be kept in mind that doctors' overuse of medical technology has been forced on them, especially due to fears over medical malpractice litigation (Helman, 2007:103).

Similar to the conception of a patient as a biological system, **disease** processes and disease causality are regarded as merely physical or biological in nature. Disease, understood as pathology on the molecular level, is regarded as the reason for the malfunctioning of the body. Diseases are perceived as 'entities', each with a unique 'personality' consisting of "a characteristic cause, clinical picture (symptoms and signs), results of hospital investigations, natural history, prognosis and appropriate treatment" (Helman 2007:123). The personalities of diseases are regarded as universal, so that, for example, tuberculosis is seen as one and the same disease regardless of the geographic, cultural, socio-economic or any other characteristics of the patients suffering from the disease. Excluded from this perspective are the psychological, social, and cultural aspects of the illness experience, and the nature of the context in which the illness occurs. The aforesaid are the very factors that determine the meaning of disease for patients and those connected to them (Burger, 2001: 81; Fabrega and Silver, 1973 as cited in Helman 2007:123). Furthermore, the role of social, political and environmental factors in the causation of disease is often ignored, such as poverty, national and/or international conflicts, pollution, and so on. A health care system ignorant of the wide range of causes of disease beyond biological factors will be ineffective in promoting the health of populations. The concept of illness as a biopsychosocial phenomenon is thus not regarded in biomedicine.

Medical professionals increasingly rely on diagnostic technology to objectively diagnose disease in patients, with less emphasis on the patients' verbal accounts of the nature and development of their symptoms. As a result numerical definitions are increasingly used to express health and disease. Helman (2007:122) explains:

> Health or normality are defined by reference to certain physical and biochemical parameters, such as weight, height, circumference, blood count, haemoglobin level, levels of electrolytes or hormones, blood pressure, heart rate, respiratory rate, heart size or visual acuity. For each measurement there is a numerical range – the 'normal value' – within which the individual is considered normal and 'healthy'. Above or below this range is 'abnormal', and indicates the presence of 'disease'. Disease, then, is seen as a deviation from these normal values, accompanied by abnormalities in the structure or function of body organs or systems.

Modern medicine's increasing reliance on diagnostic technology also results in patients being diagnosed with disease (often manifesting at the biochemical or cellular levels of the body), when they have no subjective experience of being ill. This typically happens during routine health screening visits to medical facilities. Examples are diagnoses of high blood pressure or cholesterol levels or even infection with the human immunodeficiency virus (HIV) before patients begin to experience symptoms. The possibility of early detection of harmful and life-threatening disease conditions is a biomedical achievement that should be celebrated. Yet, unfortunately, persons who are diagnosed with a disease without feeling ill often do not follow the treatment regimens that doctors prescribe (Helman, 2007:150).

A question that needs to be addressed is **what does the medical model of disease mean for the understanding of problems of the mind?** Two types of mental difficulty should be considered. Firstly, there are psychological problems that may, and often do, accompany physical illness, such as anxiety and/or depression suffered by patients with cancer. Problems of this kind are not regarded as part of the main authority and responsibility of medicine (Engel, 1977:129) and therefore doctors often do not pay much attention to the psychological difficulties of patients with (otherwise) physical conditions. Secondly, there are the difficulties that solely involve the mind, such as depression in the absence of any (other) identifiable physical disease. Within biomedicine the study and treatment of the latter category of mental difficulty is the subject of the discipline of psychiatry.

The medical model of disease poses a problem or even a crisis for psychiatry. The problem concerns the question of whether the forms of illness treated by psychiatrists can be properly thought of as disease in the biomedical sense. Psychiatry has great difficulty to clarify its status in the field of biomedicine. Psychiatrists typically respond to this crisis in an exclusionist or reductionist way. Their position is that mental disorders with biological causes, that is biochemical or neurophysiological disorders of the brain, belong to the domain of biomedicine; whereas problems that are more behavioural and psychological in nature should be the concern of non-medical disciplines (Ludwig, 1975: 603; Engel, 1977:129-130). The mind-body dualism and monistic materialism of biomedicine is reflected in its approach to problems of the mind. Physical and mental disease are treated as two distinct categories. Observable disease processes or structural malformations of the body belong to the material world and are the concern of medicine and surgery. All other aspects of the human condition, such as thoughts, emotions and relationships fall outside the scope of medicine. The immaterial aspects of reality are seen as mere by-products of material processes[44] (Kriel, 2000: 17).

Following from the conceptualisation of disease as a merely physical phenomenon, biomedical **treatments** are all physical in nature, taking either the form of pharmaceutical products, surgery or radiation therapy. These therapies are understood as functioning objectively and mechanistically. The role of psychological processes or cultural influences in the treatment process is not adequately recognised by biomedical science. Modern medicine is "above all technological" (Jonsen, 1990:111)[45]. One ethical problem of technological medicine is that it is considered a "good" when the technology that the doctor applied has reached its specific objective, regardless of whether the result has benefited the patient in his/her particular situation. To illustrate, in technological medicine the goal of antibiotics is to cure microbial infections as the goal of a ventilator is to artificially uphold breathing function. Whether such reached objectives are beneficial to the patient who is treated with the technology, is not considered when contemplating the "good" of treatment. For instance, when a potentially fatal microbial infection is cured (successfully treated) in an elderly patient

[44] The eliminativist view is a recent version of the physicalist perspective, that is the view that mind is merely "an epiphenomenon of matter". In the eliminativist view the idea of the mind is completely disappearing. "The grand march of neuroscientific discovery will extinguish the last remnants of the mental as it will be discovered that all aspects of the mind can be explained in terms of neurobiology" (Beveridge, 2002:102).

[45] Jonsen uses the word technology in a broader sense than merely referring to machines. In Jonsen's (1990:112) definition the "fundamental attribute of technology [is] a rational system for replicating results". By medical technology is meant "a complex of medical thinking, medical devices, and coordination of medical workers".

with dementia and late-stage cancer, it is not a self-evident "good". Neither is it self-evident that "artificially maintained respiration of an irreversibly comatose person" is always good. It seems that modern medicine's technology obfuscates the distinction between results and benefits. "Evaluation of a result as benefit requires a much more complex, more personal, and more humane consideration than recognition of the result itself" (Jonsen, 1990:117). In critique on this very technical understanding of medical treatment the modern doctor's role has been equated with that of a plumber (McCormick, 1996:667). Kriel (2000:24) describes the challenge that the humanistic physician faces in the institutions of biomedicine as follows: "Humanistic physicians are forced to function with a materialistic monism in their science and a dualism in their practice".

It is clear that the positivist world-view of modern medicine is problematic when it is translated into the clinical method. What complicates the problem is that the medical community is not sufficiently aware that medical research and practice is controlled by the conceptual framework of the natural sciences and of the impact that this meta-theoretical commitment has on medical research and practice. The natural science paradigm prescribes the areas and methods of medical research, as well as which findings and implications of research are meaningful. The natural science paradigm also regulates the conceptual framework for the practice of medicine. Modern medicine subscribes to a paradigmatic monism. Medical researchers and clinicians miss "the fact that the methodology of the natural sciences…has an essential hermeneutic moment - a moment of interpretation". Due to this meta-theoretical ignorance medical discourse may be described as "naïve empiricism" (Kriel, 2000:30-32).

In the final section of this chapter I shall discuss the nature of the doctor-patient relationship as it operates in biomedicine.

1.5 The doctor-patient relationship in biomedicine

The doctor-patient relationship provides the context for communication between doctor and patient. Doctor-patient communication within the biomedical model of health care is one of the most complex forms of discourse. It involves "interaction between individuals in non-equal positions, is often non-voluntary, concerns issues of vital importance, is therefore emotionally laden and requires close cooperation" (Chaitchik, Kreitler, Shaked, Schwartz and

Rosin, 1992, as cited in Ong et al., 1995:903). The clinical consultation may be seen as an interaction between the doctor's professional perspective and the patient's lay perspective on disease and its treatment. This interaction is influenced by the physical context in which it occurs (for instance a private consultation room or a hospital ward) as well as the social class, ethnicity, age and gender of the participants. Doctors' specialised, scientific knowledge and competitive, extended and gruelling training invest them with power. This power may allow doctors to override patients' ideas about disease and treatment with the biomedical perspective and method (Scambler, 1987:179; Helman, 2007:130-149).

The discovery of disease, in the modern sense, increased the power of medical science and thus of clinical practitioners over disease. Due to this power, and the authority that society has bestowed on physicians because of it, practitioners of scientific medicine have become accustomed to unilaterally shape the structure of their relationships with patients. This flows from doctors' understanding of their rights in terms of the seventeenth-century ideas of John Locke (1632-1704). Locke was a physician himself (and a good friend of Thomas Sydenham) and also contributed to philosophy and politics. Locke's philosophy views many fundamental human rights as property rights. In Locke's thinking the concept 'property' included a person's "life, liberty and estate…Every man has a property in his own person. This nobody has any right to but himself. The labour of his body and the work of his hands…are properly his" (1966 as cited in Jonsen, 1990:86). In Locke's view, when people entered into contracts with each other they not only exchanged or shared property among themselves, but also exchanged their liberty in a particular ways. In a consensual contract one party might have to sacrifice certain freedoms in order to receive the benefits that the other party makes available.

Jonsen (1990: 87-94) discusses the influence of this Lockean perspective on rights, on medical practice and doctor's modern conceptualisation of their rights. The law regards the doctor's licence to practice medicine as the doctor's property. Doctors created this property by virtue of their specialised and hard earned knowledge and skills and they have certain rights over that property. The medical profession argues that the powerful benefits that modern medicine can bestow on patients depend on the condition that doctors have the freedom to determine the nature of the doctor-patient relationship. The doctor-patient relationship is viewed as a contract into which the doctor enters with the patient. The patient can benefit from the doctor's scientific knowledge and skills if the doctor determines the

contractual terms and supervise the patient's (and/or the patient's caregivers') compliance with these terms. The nature of the doctor-patient relationship is thus determined by the doctor based on the physician's special knowledge and the assumption of his/her benevolence towards the patient.

Furthermore, doctors started to regard the phenomenon of disease, as it presents in a patient's body, as the medical practitioner's property over which (s)he has certain rights. Locke stated that "whatsoever a man removes out of the state that nature hath provided and left it in, he hath mixed his labour with it and joined to it something that is his own, and thereby makes it his property" (as cited in Jonsen, 1990:93). It might thus be argued that the doctor's medical skills are the labour that s(he) 'mixes' with the natural occurring phenomenon of disease and that disease thereby becomes the doctor's property. The doctor owns disease only to destroy it, and thereby returns the body to normal working order. To gain access to disease the doctor has to enter into a contract with the patient. Jonsen (1990:93) explains: "The…physician acquires a right over the disease and the patient by double title: he mingles his labour with the disease and masters it; he contracts the patient to do his work. Even though the physician must get access to the disease through the patient – he cannot trespass – he almost has an independent right over disease itself". The doctor's right over disease is sometimes viewed as stronger than the right of the patient to make decisions about what happens to his or her own body. Doctors are often annoyed when they are prohibited to destroy disease should a patient or other regulatory body (for instance an ethics review board) deny them access to a diseased body.

Over the past few decades the medical profession has been "demythologised" in countries such as the United States of America (USA)[46] due to the (post-)modern society's insistence on patient's rights to liberty, autonomy and shared responsibility for their bodies and the structuring of their relationships with health care professionals (Van Niekerk, 2002b:227). Potter and McKinlay (2005:465-468) review the literature to describe the changes in theoretical conceptions of the doctor-patient relationship since the middle of the twentieth-century to the early twenty-first-century. The paternalism metaphor was used to describe the doctor-patient relationship in the middle of twentieth-century. The relationship between doctor and patient was thus compared to the relationship between a parent and child. The similarities between the role of parent and the role of doctor are based on three characteristics

[46] Concern about human rights is an essential characteristic of North American culture and is particularly influenced by the Bill of Rights in that country's Constitution.

of the parent's role. Firstly, the parent's social role awards him/her with authority to make decisions on behalf of his/her child. Secondly, the parent has superior knowledge and abilities which enable him/her to understand his/her child's best interest and how it can be achieved. Thirdly, the parent is assumed to have an attitude of benevolence towards his/her child and thus desires to act in the child's best interest. The paternalism that operated in doctor-patient relationships in the modern era differs from paternalism in the era of Hippocratic medicine. Modern doctors have a duty of beneficence, rather than being required to have the virtue of benevolence, as in earlier times. The modern doctor's duty to benefit his patients is stated in and enforced by professional and ethical codes which have legal status. According to the paternalism metaphor of the previous century the physician is seen as an authority figure that enters into a contractual relationship with patients (Van Zyl, 1997:32-35). According to this contract the doctor provides the best health care available and the patient does everything (s)he can to benefit from the treatment. Even though power was not distributed equally in a paternalistic doctor-patient relationship this was not considered to threaten the quality of health care (Parsons, 1951 as cited in Potter & McKinlay, 2005:466). The long-term relationships and personal contact between doctors and patients were believed to prevent the abuse of the power imbalance between the two parties.

Conflict was introduced as an aspect of the doctor-patient relationship for the first time in the academic literature in the 1970's. It was suggested that the potential for doctors to abuse their power was inherent in the inequality in knowledge and (consequently in) power in the doctor-patient relationship. The developments in medical technology during this time period further widened the power differential and distance between doctors and patients. Doctors placed more value on objective evidence of disease such as laboratory reports, than on the patient's account of his/her condition. Engel (1977:132) expresses this as "bypassing the patient's verbal account by placing greater reliance on technical procedures and laboratory measurements". The paternalism metaphor was replaced by the "cynical consumer" metaphor[47] in which "the doctor-patient relationship is a market transaction in which economic concerns are paramount to the perceived success or failure of the encounter" (Potter & McKinlay, 2005:467). The status of the patient rose during the 1970s. In the U.S.A., for example, courts now viewed the doctor-patient relationship as a partnership, and recognised patients' rights and emphasized the medical profession's duty to present all relevant

[47] Rich *et al*. (2008) use the term postmodern medicine to refer to the "the reintroduction of the patient and other stakeholders into the medical encounter that has occurred since the 1960s and 1970s."

information to patients so that they can make informed decisions about their health care[48]. However, it seems "unlikely that the patient can be a true market consumer demanding appropriate value for money" in a relationship as unique as the one between doctor and patient – where doctors have intimate knowledge regarding their patients and patients depend on doctors for treatment (Potter & McKinlay, 2005:468).

As the twentieth-century ended doctors as well as patients lost status. A "corporatist metaphor" (Potter & McKinlay, 2005:468) now characterises the doctor-patient relationship. More people with more interests now play a role in the once private and relatively simple relationship between doctor and patient (Jonsen, 1990:80). Physician employers, pharmaceutical companies and medical insurance companies that prescribe treatment protocols have increasing influence and control on the context in which health care is practiced, and have given medicine a commercial and impersonal face. This is especially true in private health care environments and in countries with privatized health systems. In an era where cost is a common component of discussions on health care, and health care expenses are at the centre of health policies (as opposed to patients), corporate executives have become the experts on health care provision (Potter & McKinlay, 2005:465-466).

The practice of health care today is more complex than in the recent past. "The technology is more elaborate, the institutions are more bureaucratic and the financing is more byzantine" (Jonsen, 1990:80). As a consequence of these changes longstanding personal doctor-patient relationships have been replaced by "short-term encounters with numerous disparate specialists and other health workers" (Korsch *et al.*, 1968:855). The once private doctor-patient relationship now more resembles what can be called an "encounter", similar to the "fleeting relationship" between a cab driver and his fare (Davis, 1956 as cited in Potter & McKinlay, 2005:465). The reductionist nature of modern medicine has lead to a hierarchy amongst medical practitioners based on their level of specialization. Specialist doctors only diagnose and treat abnormalities of a specific part of the body. "Their professional aim, is in a sense, to know more and more about less and less (and often the result is knowing less and

[48] The bioethical rule of informed consent has its roots in the case of *Schloendorff v. New York Hospital* in 1914. Justice Benjamin N. Cardozo delivered the verdict that: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained" (Cardozo, 1999:517).

less about more and more)" (Helman, 2007:124)[49]. A patient who is admitted to hospital is likely to be cared for by a number of physicians from various disciplines as responsibility for the patient's care is divided along disciplinary lines, and at times it is often difficult to decide who should take ultimate responsibility for the patient's care. "The truly general physician has disappeared from our hospitals" (McCormick, 1996:667). The (tertiary) hospital is the main institutional structure of modern medicine. It has been described as a temple devoted "to the transcendent power of science over the forces of disease and death". Patients who are admitted to hospital are subjected to a "ritual of depersonalization". Hospital patients become a "case" in a ward of strangers, separated from their loved ones and community to be cared for by staff that they may not know. They lose many of the artefacts of their social and personal identities, as well as control over their bodies, "personal space, privacy, behaviour, diet and use of time". The relationship between hospital patients and health care professionals is mostly one of "distance, formality, brief conversations, and, often, use of professional jargon" (Helman, 2005:99-100)[50].

Many general practitioners still have long-term relationships with their patients in which they know the patient's family and forms part of the patient's community. Yet, the increase in group practices, duty rosters and the general mobility of modern societies are generally destroying continuing, personal doctor-patient relationships. The intimacy of the doctor-patient relationship is also endangered by the growth of the health care team (McCormick, 1996:667). Sir Theodore Fox (1960 as cited in MacCormick, 1996:667) expresses concern over the loss of contact between the general practitioner and patient as follows:

> …the particular object of his [the doctor's] independent existence may be defeated if he leaves all dressings to the nurse, sympathy to the receptionist, messages to the secretary, and the solution of home problems to the social worker…if somebody else is to do all

[49] Helman (2007:124) further points out that the income and status of specialist doctors are higher than those of generalists. A "hierarchy of prestige" also exist among specialist doctors. Those who are seen to cure (such as surgeons or other doctors who treat acute conditions) have a higher status than those who care (such as oncologists or those who treat chronic conditions). In surgery there is a separate hierarchy based on the symbolic value that the society awards to different body parts. Heart and brain surgeons have more prestige than, for instance, rectal surgeons.

[50] An example of this is the experience of the late Mary O'Flaherty Horn (1999:940). Horn was an internist or specialist physician who was diagnosed with amyotrophic lateral sclerosis (ALS), a degenerative and fatal neurological disease. Her initial diagnosis of ALS was confirmed at a large tertiary teaching hospital. She describes her one-off encounter with the physician who performed the diagnostic test (electromyography) at this large medical centre as traumatic, dehumanizing and "the antithesis of caring". She writes for instance: "I might not have been present except for the obvious need for my muscles".

> the small things for the patient under the doctor's distant supervision, personal contact will be reduced to a minimum.

A third party became part of the doctor-patient relationship in recent modern medicine. This third party is the machine. The machine and medical technology in general has made large and important impacts on the practice of medicine. New diagnostic technologies can detect disease even before birth and can bring diseases to the surface long before they become obvious to the patient and cause irreversible damage or even death. Diseases can now be diagnosed with greater precision and accuracy than before. Life sustaining technologies can help the body to function for long periods after the breakdown of vital organs that would have meant the end of life were the technology not available, as in the case of haemodialysis for patients with chronic kidney failure. Yet, critics of modern medicine, such as Illich (1976 as cited in Helman, 2007:96) are worried that medical technology may harm the population's health by diminishing their autonomy, creating a dependence on the medical profession and injuring them with the side effects of medication and surgery.

The central role that technology has come to play in the practice of medicine has created a distance between doctor and patient (Schwartz & Wiggins, 1985:331-332; Jaspers, 1989:254, 256; Jonsen, 1990:98-99; 2005 RSNA Professionalism Committee, 2006; Helman, 2007:100-104). When technology takes over the role of the physician, the patient is treated in an impersonal way and the physician "is metamorphosing into a technocrat and a businessman. The physician retreats behind the machine and becomes an extension of the machine" (Grouse, 1983 as cited in Helman, 1990:104). As Jaspers (1989:256) puts it, it is difficult to understand how "a thing which helps the physician at his successful work" (that is technology) "turns itself against the very being of the physician", who appears "to have become a technician". Medical technology thus affects not only the diagnosis and treatment of disease but also the interaction between doctor and patient. A current development in medical technology is that doctors are encouraged to collect and store all patient records in a standardised electronic format[51]. The rationale is to reduce medical error and to make medical care safer by, for example, allowing easier transfer of patient's records between health care professionals when referrals are made or when patients are treated by more than one professional. Yet, when doctors have to focus their attention on administering

[51] This is especially true in the USA where $17 billion of the federal economic stimulus package, resulting from the American Recovery and Reinvestment Act of 2009 has been put aside for incentive payments to doctors and hospitals who change from traditional to electronic record keeping (Armstrong-Coben, 2009).

standardised questionnaires on computer screens they loose personal contact with the patient and the freedom to structure the clinical interview according to what naturally and spontaneously unfolds in the consultation room. A paediatrician and critic of electronic record keeping writes in an Op-Ed contribution in the *New York Times* (Armstrong-Coben, 2009) that "the computer depersonalises medicine. It ignores nuances that we do not measure but [which] clearly influence care". She also makes the valid point that room for error in clinical medicine is not necessarily reduced by electronic recordkeeping.

> A box clicked unintentionally is as detrimental as an order written illegibly – maybe even worse because it looks official. It takes more effort and thought to write a prescription than to pull up a menu of medications and click a box. I have seen how choosing the wrong box can lead to the wrong drug being prescribed.

Another factor that challenges doctor-patient communication in the biomedical model, which has been alluded to before, is the use of medical terminology in doctor-patient interactions. The vast expansion of scientific medical knowledge and the way that this knowledge has been transferred to medical students during their training have lead to a technical and esoteric medical language that is often not understood by the everyday man. Mutual misunderstanding may occur when either the doctor or the patient uses a medical term as these two parties often do not interpret medical terms in similar ways. The consequence of such misunderstandings may be serious since errors in diagnosis and prescribed treatment may result, or a patient may exercise the treatment instructions erroneously and thereby negatively influence his/her health outcome (Helman, 2007:151-152).

Doctors' specialised and powerful knowledge and skills create an unequal distribution of power in the doctor-patient relationship. Differences in socio-economic status and general level of education are often superimposed on the doctor-patient relationship, especially in developing nations such as South Africa and may increase the unbalanced power distribution even further. Scepticism exists about whether even optimal respect for patient autonomy can ever level the distribution of power between doctors and patients. McCormick (1996:667), for instance, considers the power balance in the doctor-patient relationship as *a priori* unequal since doctors are the gatekeepers to medical care. Regardless of the extent to which information is provided to the patient, the doctor inevitably determines the nature of the

information[52]. Furthermore, patients who are sick are in a vulnerable position. When in pain people are reminded of their mortality. The sick person regresses "towards childlike dependence" (McCormick, 1996:667). Biomedicine doesn't help patients to find meaning in their suffering[53].

1.6 Conclusion

In this chapter I discussed modern medicine's intellectual self-understanding. I started by describing the changes that occurred in the manner that doctors practice medicine as Hippocratic medicine was transformed into the biomedicine that exists today. I then described modern medicine's view of itself as a natural science and its conception of science in line with the positivist standard image of science. I also mentioned the ontological and epistemological assumptions of medicine. Thereafter I described the implications of medicine's scientific self-understanding for clinical medicine. I also described the doctor-patient relationship and the changes that have occurred in the nature of this relationship over the past four decades. The point was made that the doctor-patient relationship and consequently doctor-patient interaction is a complex phenomenon. It also became clear that modern medicine's natural scientific character influences the doctor-patient relationship in a fundamental manner.

This project wants to philosophically investigate the role that medicine's self-identification as natural science has on the interaction between doctors and patients. In order to fulfil this aim certain tools for analysis are needed. I selected Jürgen Habermas' universal pragmatics and Michel Foucault's theory on the nature of discourse for this purpose. Habermas' work will be used in Chapter 5 to analyse the linguistic communication between doctors and patients during consultations. Foucault's work is used in Chapter 6 to analyse of medical discourse, that is the rules that doctors must follow when they think and talk about health and disease. Attention to both doctor-patient communication as well as medical discourse is necessary to approach the current research problem in a complete and fruitful manner. In the next two

[52] One has to keep in mind that in the age of the World Wide Web (internet) a wealth of health information is available at the fingertips of (computer literate) patients and caregivers. The doctor's status and authority as sole possessor of valid medical advice is weaker than in previous eras. Especially when one considers that the dawn of the internet age broke in the era of supremacy of human rights in the western world.

[53] In Jungian (depth) psychology the goal of life is seen as meaning, and not happiness (Hollis, 1996:8). The illness experience may be a very rich source of meaning for the patient, yet biomedicine doesn't allow or equip the doctor to guide or even accompany the patient on this journey.

chapters I provide detailed descriptions of the works of Habermas and Foucault that I later apply in an analysis of clinical communication and medical discourse.

Chapter 2

Habermas' universal pragmatics

What raises us out of nature is the only thing whose nature we can know: *language*.

Thomas McCarthy (1978:287)

2.1 Introduction

In this chapter I shall describe Jürgen Habermas' (1929-) research on what he terms **universal pragmatics**[54]**.** I refer specifically to his essay entitled "What is Universal Pragmatics?" (Habermas, 1979). I shall pay attention to the validity basis of speech as well as Habermas' model of linguistic communication. Habermas (1979:7) regards the speech-act theory which was introduced by John L. Austin (1911-1960) as "the most promising point of departure for a universal pragmatics" and he primarily uses this theory as the basis of his research. I therefore start this chapter with a description of the main features of Austin's (1962) theory of speech acts.

I have already mentioned that Habermas' work is included in this dissertation for two reasons. Firstly, Habermas addresses the nature of linguistic communication between a speaker and listener. The focus of this dissertation is on the influence of the medical profession's intellectual self-image on communicatively effective care to patients. The communication between doctors and patients is central to the problem I consider and Habermas' insights into interpersonal communication promises to serve my purpose. Secondly, Habermas' work is suited to my project due to the connection between the goals of doctor-patient interaction and universal pragmatics.

[54] As in the previous sections of this dissertation I use bold font to emphasize words or concepts. This emphasis does not appear in Habermas' (1979) writing. Whenever I quote a passage in which the author used the italic font for emphasis, the italics is preserved in my quotation. All words that appear in italics in quoted phrases or sentences in this dissertation are thus similarly italicized by the authors whose work I quote. I also use the italic font for all non-English words or phrases, such as *et al., etcetera* and *ad hoc.*

2.2 Austin's theory of speech acts

John L. Austin's (1962:1, 12) theory of speech acts questions an age-old assumption in philosophy, namely that to say something is "always and simply to *state* something", and that to state something means to truly or falsely 'describe' a situation or to "state some fact". In Austin's (1962:12) opinion the aforementioned assumption "no doubt is wrong". He argues that there are some cases and senses in which **saying** something amounts to **doing** something. A speech act is performed when a sentence is uttered. In other words, linguistic utterances are actions in nature, they are **speech actions**. One does things "by saying something" (Habermas, 1979:34) . When a speaker utters a promise, an assertion or a warning (s)he also performs an action, namely an attempt "to make a promise, to put forward an assertion, to issue a warning" (Habermas, 1979:34).

In Austin's opinion philosophers have for too long neglected to study this notion. Yet it is increasingly realised that "the occasion of an utterance matters seriously, and that the words used are to some extent to be 'explained' by the 'context' in which they are designed to be or have actually been spoken in a linguistic interchange". It is not only the meaning (sense and reference) of words that should be studied, but also to the **illocutionary force** of utterances. The illocutionary force of an utterance refers to the particular action that was performed in saying something. Speech has numerous functions and can be used in numerous ways. The sense in which an utterance is used makes a great difference to a speech act. Whether an utterance is a promise or the announcement of a vague intention makes a great difference (Austin, 1962:99-100).

Austin (1962:94) attempts to answer the following question: "How many senses are there in which to say something is to do something?" He concludes that language can be used in at least three senses. These "three kinds of 'actions'" are listed and defined below (Austin, 1962:108-109).

i. The **locutionary act**. In the sense of the performance of locutionary actions "…to say anything must always be to do something" (Austin, 1962:92). The locutionary act is the act **of** saying something or the act of using speech (Austin, 1962:99). It "is roughly equivalent to uttering a certain sentence with a certain sense and reference,

which again is roughly equivalent to 'meaning' in the traditional sense" (Austin, 1962:108).

ii. The **illocutionary act** refers to "the performance of an act **in** saying something". It refers to the way and the sense in which a sentence was used on a particular occasion (Austin, 1962:99). Whereas the locutionary act has a meaning, the illocutionary act has a particular "**force** in saying something" (Austin, 1962:120). The illocutionary force of a speech act may for instance be that of advising or suggesting or ordering (Austin, 1962:99). The performance of a locutionary act is also and *eo ipso* the performance of an illocutionary act. Every genuine speech act is both a locutionary act and an illocutionary act (Austin, 1962:98,146).

iii. The **perlocutionary act** refers to the consequences or effects achieved **by** saying something, such as "convincing, persuading, deterring" (Austin, 1962: 101).

In saying something a number of things are thus done or accomplished. A speech act is happily or successfully performed if a certain **effect** is achieved. "Generally the effect amounts to bringing about the understanding of the meaning and of the force of the locution" (Austin, 1962:115-116). Before Austin (1962:6-7) arrived at the three ways in which we use language [which he calls the theory of speech-acts (Austin, 1962:149)], he investigated whether a clear distinction can be made between two types of utterances, namely constatives and performatives. A **constative** utterance states a fact which is either true or false. A "*performative sentence*" or performative utterance or in short "**a performative**" refers to utterances which are not statements of fact. "The name is derived…from 'perform', the usual verb with the noun 'action': it indicates that the issuing of the utterance is the performing of an action – it is not normally thought of as just saying something". Austin (1962:5) provides the following examples of performatives:

"'I give and bequeath my watch to my brother' – as occurring in a will", and

"I bet you sixpence it will rain tomorrow".

Performatives may, at least with regard to their grammatical make-up, appear to be 'statements' or constatives, yet it cannot be said of performatives that they are either true or false – which is traditionally the characteristic sign of a statement (Austin, 1962:12). Performatives are rather happy (successful) or unhappy (unsuccessful), that is they are

capable of infelicity (Austin, 1962:25). Austin (1962:14-15, 26, 39) provides the following scheme of the conditions for the 'happy' operation of performatives:

A. An accepted conventional procedure must exist which has a particular conventional effect. The procedure must include the uttering of particular words by particular persons in particular circumstances;

B. The procedure must be performed correctly and completely by all participants;

Γ Where the procedure is designed to be used by persons who have particular thoughts, feelings or intentions, or to inaugurate certain consequential behaviour on any of the participants' part, then a person who participates in and thereby invokes the procedure has to possess those thoughts, feelings, or intentions, and the participants must have the intention to act accordingly and must subsequently behave accordingly.

If certain conditions must be satisfied for a performative utterance to be happy then certain statements must be true for a performative to be happy, for instance statements that particular conditions exist (Austin, 1962:45,53). Similarly, a constative speech act implies that certain other statements are true. Austin (1962:47) draws our attention to the fact that we can "do wrong" in uttering constatives in more than one way. To explain what can go wrong with statements one cannot simply concentrate on the proposition involved as has been done traditionally. The total situation in which an utterance was produced, that is the total speech-act, must be considered to appreciate the problems which can be experienced with constatives. This leads Austin (1962:52) to question whether a significant distinction does in fact exist between statements and perfomatives.

When attention is moved away from studying the sentence, and focus is placed on "the issuing of an utterance in a speech situation" it becomes clear that to make a statement is to perform an act (Austin, 1962:138). Austin (1962:149) concludes that a dichotomy between performatives and constatives does not exist. The theory of speech acts aims to elucidate the "total speech act in the total speech situation". Statements and descriptions are merely two "families" among many other families of illocutionary acts and do not have a unique position. They are not related to facts "in a unique way being called true or false" (Austin, 1962:147-148). Austin (1962:144) states that it is important to realise that the terms 'true' and 'false'

do not represent "anything simple at all". 'True' refers to a general dimension of being the appropriate thing to say in contrast with the wrong thing in particular circumstances, to a particular audience, for particular purposes and with particular intentions. Whether a statement is true or false does not merely depend on the meanings of words but on which act was being performed and in which circumstances.

Austin's theory of speech acts made a very valuable contribution to philosophy and linguistics by pointing out that speech itself is a form of action, and not merely a way of describing or reporting actions. An adequate account of language needs to take the active character of language use into account. Theoretical and structural linguists' treatment of language as a homogenous and autonomous object which can be studied as though it had no exterior is misleading (Thompson, 1984:6-7; 175). Critics of such modern linguists point out that language is acquired and used in specific social-historical conditions. A speaker's competence should not be conceptualized merely as the ability to produce an infinite number of grammatically correct sentences, but rather as the ability to produce grammatical sentences which fit the particular speech situation and the power relations therein contained (Thompson, 1984:7).

Now that the speech act theory that forms the basis of Habermas' universal pragmatics has been described, I can continue with a description of universal pragmatics itself.

2.3 What is Universal Pragmatics?

"The task of **universal pragmatics** is to identify and reconstruct **universal conditions of possible understanding**" (Habermas, 1979:1). The project of universal pragmatics wants "to analyse the process of understanding" by looking at how agreement between a speaker and a hearer is brought about (Habermas, 1979:3). Habermas (1979:1) refers to the **presuppositions** of **communicative action**. Communicative action is action "aimed at reaching understanding" (Habermas, 1979:1). This action flows from the relation between at least two subjects who have the ability to speak and to act (Van Niekerk, 1992:182[55]). Habermas' (1979:1) universal pragmatics is built on the assumption that communicative action is the fundamental form of social action and that other forms of social action, for

[55] I occasionally refer to secondary texts to illustrate or illuminate Habermas' ideas where I did not find sufficient clarity in the original text or where I found exceptional clarity in the secondary source.

instance conflict and competition, are derivatives of communicative action. Since communicative action happens mainly through language, Habermas (1979:1) focuses on "explicit speech actions[56]" in his theory of communication. He does not pay attention to nonverbal actions or "bodily expressions". Habermas' (1979:4) focus is on "consensual speech actions". A consensual speech action is an "idealized case of communicative action…in which participants share a tradition and their orientations are normatively integrated to such an extent that they start from the same definition of the situation and do not disagree about the claims to validity that they reciprocally raise" (Habermas, 1979:208-209).

2.3.1 The validity basis of speech

Speakers and listeners involuntarily make certain presuppositions or assumptions the moment that they perform, understand or react to a speech act. These presuppositions are the conditions of possible understanding. With regard to the conditions of possible understanding Habermas (1979:2) refers to the "**validity basis of speech**". He develops the thesis

> that anyone acting communicatively must, in performing any speech action, raise universal validity claims and suppose that they can be vindicated {or redeemed: *einlösen*}. Insofar as he wants to participate in a process of reaching understanding, he cannot avoid raising…validity claims.

The speaker has to raise the following **validity claims** if (s)he wants to bring about understanding. The speaker claims that his/her utterance is:

i. understandable, in the sense that it is grammatically correct;
ii. true, in the sense that it accurately represents a fact about the world of objects and events which can be known through sense experience;
iii. truthful, in the sense that the utterance corresponds with the speaker's intentions;
iv. correct, concerning a prevailing normative background (Habermas, 1979: 2, 27; Van Niekerk, 1992:183).

[56] The term 'explicit' speech act refers to utterances with the grammatical form of "first person singular present indicative active". "I promise that I shall be there" is an explicit speech action (Austin, 1962:62, 69).

The conditions for reaching understanding are the following. The speaker has to use an utterance that is **comprehensible** in order for the speaker and the hearer to understand each other. The speaker should also have the intention of uttering a proposition that is **true** in order that the hearer can share the speaker's knowledge. Furthermore, the speaker should wish to produce a **sincere** expression of his/her intentions in order for the hearer to believe the speaker's utterance (so that the hearer can trust the speaker). Lastly, the speaker has to use an utterance that is **right**, in order for the hearer to accept the utterance, and so that the speaker and the hearer "can agree with one another in the utterance" with respect to a reciprocally recognised normative background. A further condition for undisturbed communicative action is that the participants have to believe that the validity claims which "they reciprocally raise are justified" (Habermas, 1979:2-3).

> The goal of coming to an understanding {*Verständigung*} is to bring about an agreement {*Einverständnis*} that terminates in the intersubjective mutuality of reciprocal understanding, shared knowledge, mutual trust, and accord with one another. Agreement is based on recognition of the corresponding validity claims of comprehensibility, truth, truthfulness and rightness…Coming to an understanding is the process of bringing about an agreement on the presupposed basis of validity claims that can be mutually recognised (Habermas, 1979:3).

When one acts communicatively, you do not merely say something but you say something based on the presupposition that what you say can be criticised or grounded. Speakers and hearers in everyday contexts share a **background consensus** about those interpretations which they accept as a matter of course. The four validity claims which are implicitly raised and reciprocally recognised constitute the background consensus of communicative action in everyday contexts. This background consensus is crucial for reaching understanding (Habermas, 1979:3-4; Thompson, 1984:262; Van Niekerk, 1992:190). Consensual action happens against an unproblematic background consensus. The participants in communication implicitly know that each has to raise the necessary validity claims (McCarthy, 1978:290), and are convinced that any validity claims raised during the process of communication could be justified or vindicated since "the sentences, propositions, expressed intentions, and utterances satisfy corresponding adequacy conditions" (Habermas, 1979:4). The "vindication … of validity claims" means that the speaker provides good reasons to support the claim's validity and that a suprasubjective recognition of the claim's validity is accomplished, either

through "an appeal to intuitions and experiences or through argumentation and action consequences". When the hearer accepts the validity claim that was raised by the speaker, the hearer "acknowledges the validity of symbolic structures; that is, he acknowledges that a sentence is grammatical, a statement true, an intentional expression truthful, or an utterance correct" (Habermas, 1979:4-5). Social interaction must not be understood as static. Typically the participants have to follow a dynamic process of working out or "negotiating" a shared definition of the situation (McCarthy, 1979:290).

When the validity claims that the speaker raises implicitly cannot be redeemed, communicative action cannot continue. The participants in communication can then resume their action aimed at reaching understanding at the level of **discourse** (Habermas, 1979:3-4). Habermas (2001:100-101) distinguishes between *communicative action* and *discourse*. When validity claims cannot be vindicated in the context of interaction, it may require communicative partners to "step out" of the context of communicative action and to "step into" a discursive situation (McCarthy, 1978:289). "In communicative action, the validity of utterances is naively presupposed in order to exchange information…In discourse, validity claims that have been problematized become explicit topics of discussion, but no information is exchanged". The goal of discourse is to reinstate the agreement which existed in communicative action and then became problematized. The "discursively produced, justified agreement" thus achieved can "of course…settle once again into a traditionally pregiven, secondary habitual agreement" (Habermas, 2001:100). In Habermas' thought the term discourse thus has a meaning distinct from the already wide-ranging definitions of discourse which appear in discourse theories, such as in the writings of Michel Foucault which will be discussed in the next chapter.

Communicative partners do not necessarily resume their communication at the discursive level when validity claims cannot be justified in the context of interaction. They may also break their communication off altogether and go their separate ways or switch to strategic action (Habermas, 1979:3-4; McCarthy, 1978:289), that is action aimed at achieving success or a self designed goal such as conflict or competition (versus communicative action which aims to achieve understanding) (McCarthy, 1978:290; Van Niekerk, 1992: 182). With strategic action the speaker aims to produce an effect on the listener with his/her speech acts (Scambler, 1987:181). Habermas realizes that discourse, the type of speech that is used to discuss problematic validity claims, does not often occur "in its pure form", and that "breaks"

in communicative action are usually resolved nondiscursively in the real world (Bernstein, 1983:186).

In conclusion, the research programme entitled **universal pragmatics** is aimed at "reconstructing the universal validity basis of speech" (Habermas, 1979:5).

2.3.2 Locating Universal pragmatics on the semiotic map[57]

In logical positivism as well as in mainstream linguistics an abstract distinction is made between the form and content of language (that is, phonetics, syntax and semantics) and the use of language (pragmatics). Yet, in these disciplines only the former, that is the structure of language, has been submitted to logical or linguistic analysis. The pragmatic aspect of language has only been studied empirically in disciplines such as psychology, sociolinguistics (McCarthy, 1978:273; Habermas, 1979:5-6) and speech-langauge pathology. Habermas (1979:5-6) does not object to "an abstractive distinction between language as structure and speaking as process". In fact, he finds it meaningful. Here language refers to a system of rules according to which expressions can be generated. All properly formed expressions (for example, sentences) may then be accepted as elements of a particular language. Conversely, subjects with the ability to speak can use such expressions when participating "in a process of communication". Such subjects can articulate sentences and can also understand and respond to the sentences expressed by other speakers. Habermas (1979:6) argues that the fact that a distinction can be made between language and "the use of language in *speech*" does not lead to the conclusion that pragmatics cannot be studied formally[58]:

> The fact of the successful, or at least promising, reconstruction of linguistic rule systems cannot serve as a justification for restricting formal analysis to this object domain…not only language but speech too – that is, the employment of sentences in utterances – is accessible to formal analysis. Like the elementary units of language (sentences), the elementary units of speech (utterances) can be analyzed in the methodological attitude of a reconstructive science.

[57] I borrow this phrase from McCarthy (1978:279).

[58] Habermas (1979:15) uses the term "formal analysis" to refer to the method of rational reconstruction. I shall shortly make a few remarks on the nature of rational reconstruction.

2.3.3 A note on the method of rational reconstruction

A note on the nature of rational reconstruction is needed at this point. Habermas describes his theory of communication as a **reconstructive theory**. It is a scientific theory that seeks to reveal, by means of reflective (and not transcendental) enquiry, the conditions of possibility for achieving understanding by means of communicative action. The methodological attitude of rational reconstruction is also evident in the theories of Chomsky, Piaget and Kohlberg. These theories attempt to reveal the universal conditions and rules which are implicitly assumed in the execution of individuals' linguistic competence and cognitive and moral development, respectively (McCarthy, 1978:278-279; Van Niekerk, 1992:189-190). Habermas (1979:9) describes reconstructive procedures as "characteristic of *sciences that systematically reconstructs the intuitive knowledge of competent subjects*".

Habermas (1979:12-13) borrows Ryle's[59] distinction between and *know-how* and *know-that* knowledge to illuminate the nature of reconstructive theorising. Know-how is "the ability of a competent speaker who understands how to produce or perform something" while know-that is "the explicit knowledge of how it is that he understands this". In so far as a speaker produces an utterance that is correctly formed and therefore intelligible, (s)he produced the utterance by following certain rules or by basing the utterance on certain structures. The competent speaker draws on his/her implicit knowledge and abilities when producing meaningful sentences without being aware that (s)he is following specific rules. The competent speaker is also not able to explicitly describe the rules upon which his/her performance is based (McCarthy, 1978:276). The speaker has a pre-theoretical understanding and knowledge of the rule system of his/her language and its context-specific application which at least allows him/her to produce well-formed, understandable utterances (Habermas, 1979:12-13). "This implicit rule-consciousness is a know-how" (Habermas, 1979:13). To understand the competent speaker's implicit knowledge, this know-how must be transformed to know-that. The task of rational reconstruction is to reconstruct pre-theoretical rule consciousness, that is to make the structure and elements of a speaker's pre-theoretical know-how explicit or, to put it another way, to reveal the rules and structures which speakers master in order to produce meaningful utterances (Habermas, 1979:13; McCarthy, 1978:276-277). Rational reconstruction refers to the "reconstruction of generative structures underlying the production of symbolic formations" (Habermas, 1979:12-13).

[59] Ryle, G. 1949. *The concept of mind*. London: Hutchinson's University Library. Cited in Habermas (1979:12).

Reconstructive theories seek to explain pre-theoretical or intuitive *knowledge*, and not implicit opinions. Reconstructions are aimed at understanding "pre-theoretical knowledge of a general sort". They are directed at *universal capabilities* and not only at the specific capabilities of individual groups or individuals. For example, Chomsky's (reconstructive) grammatical theory aims to reconstruct the rule-consciousness shared by all competent speakers of all natural languages, and not only the competence of a specific group, such as persons speaking in a particular dialect, such as Low-German or Cape-Afrikaans.

> If the pre-theoretical knowledge that is to be reconstructed expresses a universal know-how, a universal cognitive, linguistic, or interactive competence (or subcompetence), reconstruction is aimed at species-competences. Such reconstructions can be compared with general theories in their range and status (Habermas, 1979:14)[60].

The reconstructive method belongs to the empirical sciences. Habermas insists that the method of rational reconstruction is not transcendental in nature. Rational reconstruction breaks with the strong apriorism of Kant's philosophy (Habermas, 1979:21). However, in rational reconstruction the distinction between making use of *a priori* knowledge and making use of *a posteriori* knowledge becomes unclear. Whereas the pre-theoretical knowledge or rule-consciousness of competent speakers is *a priori* knowledge for them, the linguist acquires *a posteriori* knowledge when (s)he questions competent speakers in order to reconstruct their rule consciousness. "The procedures employed in constructing and testing hypotheses, in appraising competing reconstructive proposals, in gathering and selecting data, are in many ways like the procedures used in the nomological sciences" (Habermas, 1979:24-25). Habermas does, however, make a distinction between reconstructive theories and empirical-analytic theories, typical of the natural sciences. Empirical analytic studies follow the hypothetico-deductive method (Habermas, 1979: 15-16; Van Niekerk, 1992:189). This means, most simply, that a hypothesis is formulated and that consequences are then deduced based on the hypothesis. The postulated hypothesis is then subjected to testing against experience. If the tested hypothesis proves to be false, some learning has occurred and an improved hypothesis can be formulated and tested. If the hypothesis is proved correct, further tests can be attempted (Blackburn, 2005:175). An empirical-analytic theory can thus rebut

[60] This quote from Habermas' (1979) essay "What is Universal Pragmatics" also appears in McCarthy's (1978) commentary on Habermas' critical theory. McCarthy translated "What is Universal Pragmatics" in the collection of Habermas' (1979) essays. In his 1978 commentary, McCarthy translated the quoted passage somewhat differently from the translation in Habermas (1979). I use McCarthy's 1978 translation here to create coherence between the quotation and the paragraph preceding it.

the knowledge of a specific object domain which existed prior to scientific investigation, and replace it with theoretical knowledge that is provisionally regarded as true. Conversely, a reconstructive theory can describe pre-theoretical knowledge to a degree of explicitness and adequacy, but it can never falsify the pre-theoretical knowledge which is its object domain (Habermas, 1979:16).

> At most, the report of a speaker's intuition can prove to be false, but not the intuition itself. The latter belongs to the data, and data can be explained but not criticized. At most data can be categorized as being unsuitable, that is, either erroneously gathered or wrongly selected for a specific theoretical purpose (Habermas, 1979:16).

2.4 Three aspects of Universal Pragmatics

Habermas (1979:26) states that the speech-act theory assumes that every competent speaker has an "implicit, reconstructible knowledge" which forms his/her communicative competence, that is the competence to use sentences in speech acts. Habermas (1979:26) further states that the speech act theory also assumes that the core of this communicative competence is universal. According to Habermas (1979:26) the goal of a general theory of speech acts would thus be to describe the fundamental system of rules which competent speakers master insofar as they are able to fulfill "*the conditions for a happy employment of sentences in utterances*", regardless of the specific language of the sentences or the "accidental contexts" in which the utterances may be fixed (Habermas, 1979:25-26).

A difference exists between "the production of sentences according to the rules of grammar" and "the use of sentences in accordance with pragmatic rules that shape the infrastructure of speech situations in general". It is only when a sentence is uttered that it becomes embedded in "relations to reality" (Habermas, 1979:27). When it is uttered a grammatically correct sentence is placed in relation to

i.) the external reality (the world of events and objects which is the basis for true or false statements);
ii.) the internal reality (the speaker's inner world of intentions which can be expressed to a public either truthfully or untruthfully);

iii.) the normative reality of society (the shared values, norms, rules and roles of a social life world against which an interpersonal relationship can be judged to be legitimate or not) (McCarthy, 1978: 280; Habermas, 1979:27).

When a speaker utters a sentence, the sentence is placed under validity claims which it did not have to and could not fulfill as a mere grammatical formation ("a nonsituated sentence", or a sentence which is not embedded in a speech act). A grammatical sentence only needs to satisfy one validity claim, namely "the claim to comprehensibility". The claim to comprehensibility is satisfied when a speaker utters a sentence which is comprehensible to a hearer who has mastered the grammatical rules of the language in which the sentence was expressed. For an utterance to be successful three additional validity claims need to be fulfilled, namely claims to the truth, truthfulness and correctness of the utterance (Habermas, 1979:28).

> … a successful utterance… must count as true for the participants insofar as it represents something in the world; it must count as truthful insofar as it expresses something intended by the speaker; and it must count as right insofar as it conforms to socially recognized expectations (Habermas, 1979:28).

Habermas (1979:29) makes a distinction between linguistic competence and **communicative competence**. To produce a grammatical sentence a speaker must have mastered the equivalent grammatical rule system. This refers to the speaker's linguistic ability, which is susceptible to linguistic analysis. For a speaker to succeed in using sentences in speech acts, that is to fulfil pragmatic functions, communicative competence is required. An utterance has "three general **pragmatic functions**", namely, "to represent something, to express an intention, to establish a legitimate interpersonal relation" (Habermas, 1979:28). These pragmatic functions are occupied the moment that a sentence is uttered. A mere grammatical formation, independent of a speech situation, does not occupy these functions. Communicative competence refers to the ability of a speaker who aims at achieving mutual understanding to fix a grammatical sentence in "relations to reality", that is

i.) to select propositional content in such a way that he represents…an experience or fact (so that the hearer can share the knowledge of the speaker);

ii.) to express his intentions in such a way that the linguistic expression accurately renders what is meant (so that the hearer can trust the speaker); and

iii.) to carry out a speech act in such a way that it satisfies recognized norms or accepted self-images (so that the hearer can agree with the speaker in these values) (Habermas, 1979:29[61]).

To the degree that the above three abilities are not dependent on specific epistemic presuppositions and shifting contexts, but generally cause sentences to take part "in the universal pragmatic functions of representation, expression, and legitimate interpersonal relation", they represent a communicative competence which "is susceptible only to pragmatic analysis" (Habermas, 1979:29). Different speech actions are for the most part aimed at fulfilling one of the three general pragmatic functions. The achievement of these general pragmatic functions is assessed "against the validity conditions for truth, truthfulness, and rightness" (Habermas, 1979:33). Different types of speech actions are thus studied from different analytic perspectives. A comprehensive universal pragmatics would have to combine the study of the representative, expressive and interactive functions of speech. However, Habermas is especially interested in communicative action, and for this the interactive function of communication, "namely the establishment of interpersonal relations", is of most importance.

2.4.1 The standard form of the speech act

A **speech act** is performed when a sentence is uttered. A distinction can be made between the semantic content and the relational aspects of an utterance. This means that when a sentence is uttered it is embedded in particular interpersonal relations. To some extent "every explicitly performative utterance both establishes and represents an interpersonal relation" (Habermas, 1979:34). A further characteristic of speech actions is that a singular speech act can either succeed or fail, due to "the generative power of speech acts" (Habermas, 1979:34).

[61] Points i –iii are quoted from Habermas (1979:29). Again I used McCarthy's 1978 translation (McCarthy, 1978:280) in favour of the somewhat less lucid 1979 version.

An utterance can only be understood in a prearranged situation if it succeeds, at least implicitly, in establishing and bringing to expression a particular relation between the speaker and his/her communicative partner. A speech act is successful if a relation - the relation that the speaker aimed at - is reached between the speaker and the hearer, and if the hearer can understand and accept the content of the speaker's utterance in the sense that it was suggested (for instance as a promise, a statement or a threat). "We can also say that the illocutionary force[62] of a speech action consists in fixing the communicative function of the content uttered" (Habermas, 1979:34). The generative power of speech acts are found in the fact that the speaker, by executing a speech act, can influence the hearer to enter into an interpersonal relationship with him/her (Habermas, 1979:35).

Habermas' (1979:216) universal pragmatics is restricted to the analysis of explicit, "*propositionally differentiated* and *institutionally unbound speech actions*" (Habermas, 1979:39). I shall now describe the meaning of these qualifications. Habermas' (1979:39) analysis is limited to speech acts "with an explicit linguistic form". An explicit speech action has a surface structure with the **standard form** comprising of "an *illocutionary* and a *propositional* component" (Habermas, 1979:36). The **illocutionary component** is made up of an illocutionary act which is performed with the help of a performative sentence. A performative sentence generally has as its main parts a personal pronoun in the first person as subject, a personal pronoun in the second person in the object position and a performative verb as predicate (McCarthy, 1978:282; Habermas, 1979:36). McCarthy (1978:282) provides the following examples of performative sentences: "I (hereby) promise you…"; "I (hereby) command you…"; "I (hereby) assert to you…" The predicate of performative sentences generally allows the particle "hereby" (Habermas; 1979:36), which indicates that the utterance is the instrument which effects the act represented by the performative verb (Austin, 1962:57). The **propositional component** of speech acts with the standard form is formed with the help of a sentence with propositional content. Habermas (1979:36) refers to speech acts with this standard form as being **propositionally differentiated**. This "level of differentiation of speech" is a prerequisite for the ability of an action to assume representational functions, namely "to say something about the world". A propositional

[62] Later in this chapter I pay specific attention to Habermas' thoughts on the nature of the illocutionary force of utterances.

content, which expresses a particular state of affairs, always belongs to an explicit speech action (Habermas, 1979:37) [63].

Habermas' (1979:38-39) universal pragmatics is further restricted to **institutionally unbound speech acts**. By this is meant speech acts which are not tied to only one institution. An example of an institutionally bound speech act is to christen a child in a church or to marry two people. To understand institutionally bound speech acts one needs to consult the institution represented by the act. Habermas' (1979:38-39) project of universal pragmatics is only interested in speech acts which do not belong to a single institution but which can fit various institutions. "With institutionally unbound speech actions, only conditions of a generalized context must typically be met for a corresponding act to succeed"[64]. The final exclusion from Habermas' (1979:39) analytic project are "those explicit speech actions in standard form that appear in contexts that produce shifts of meaning". He (1979:39) is referring here to situations where the pragmatic meanings of context-dependent speech acts are different from the meanings of the sentences uttered in the speech acts. Habermas (1979:39-40; McCarthy, 1978:427) does not regard the narrowing of his analytical focus (as mentioned above) as a threat to the generality of his work, since he adopts a weaker version of Searle's "principle of expressibility", namely

> that in a given language, for every interpersonal relation that a speaker wants to take up explicitly with another member of his language community, a suitable performative expression is either available or, if necessary, can be introduced through a specification of available expressions" (Habermas, 1979:40).

[63] The grammatical form of explicit speech acts makes explicit that an utterance is performative, and also makes explicit which act is being performed (Austin, 1962:62). Austin (1962:71-73) makes "a fair guess" that the explicit performative developed later in the evolution of language than utterances which are more primary. Primary utterances may be included as parts of explicit performatives, such as "…I shall be there" in the explicit performative "I promise that I shall be there". Language in its primitive stages is neither precise nor explicit. Precision in language means that the **meaning** (what is being said) of utterances are clear, whereas explicitness means that the **force** (how an utterance is to be taken) of utterances is clear.

[64] Habermas (1979:39) admits that the classification of speech acts in terms of "institutional bond" does not always allow an unambiguous classification. "Commands can exist whenever relations of authority are institutionalized; appointments presuppose special, bureaucratically developed organizations; and marriages require a single institution (which is, however, found universally). But this does not destroy the usefulness of the analytic point of view".

2.4.2 The double structure of speech

Habermas (1979:41) makes the following remark on the double-structure of speech actions with the standard form: "…the illocutionary and propositional [components of speech acts] can vary independently of one another". The same propositional content can appear unchanged in relation to various types of speech acts. Habermas (1979:41) refers to this phenomenon as "*speech-act-invariance of propositional content*", and provides the following examples. The propositional content of "Peter's smoking a pipe" can appear unchanged in different types of speech acts, such as

"I assert that Peter smokes a pipe"

"I beg of you (Peter) that you smoke a pipe."

"I ask you (Peter), do you smoke a pipe?"

"I warn you (Peter), smoke a pipe."

The illocutionary and propositional components of speech acts can thus be uncoupled to form and transform speech acts. This uncoupling allows the double structure of speech, that is, for speakers and hearers to communicate simultaneously on two different communicative levels. The two levels are:

i. "*the level of intersubjectivity*" on which speaker and hearer, by means of illocutionary acts, set up the relations which allow them "to come to an understanding with each other";

ii. "*the level of propositional content*", or "the level of *experiences and states-of-affairs* about which they want to reach an understanding in the communicative function determined by" i.) (Habermas, 1979:41-42; McCarthy, 1978:282) [65].

Speakers and hearers must simultaneously reach an understanding on both communicative levels if they wish to communicate their intentions to each other.

[65] This quotation is from McCarthy's 1978 (p. 282) translation.

2.4.3 Types of validity claims and modes of communication

It was stated above that communication in language is only possible when the speaker and hearer simultaneously become involved in two levels of communication when communicating with each other regarding a particular topic. Habermas (1979:50-53) now introduces another concept, namely "**modes of communication**". A speaker can make either of the two communicative levels the central theme of his/her utterance. An "*interactive use of language*" thematizes the relation which the speaker and listener take up, while it only mentions the propositional content of the utterances. Conversely, the theme of the "*cognitive use of language*" is the contents of utterances as statements about what is happening or could be happening in the world, expressed as knowledge claims that can be either true or false, while the interpersonal relation between the communication partners is only indirectly expressed. The difference in thematization is caused by the difference in the validity claim that is stressed in the various modes of communication (Habermas, 19 79:53, 55)[66].

Different types of speech acts belong to the different modes of communication. Each type of speech act presupposes a particular validity claim. Only speech acts with a propositional component in the form of explicit propositions are allowed in the cognitive use of language. These speech acts are known as **constative speech acts**. Examples of constative speech acts are "reports, explications, communications, elucidations, narrations, and so forth". Constative speech acts raise the validity claim of truth for the proposition that was expressed (Habermas, 1979:52-53). In the interactive use of language only **regulative speech acts** are allowed. These are speech acts which characterise a particular relation that the communication partners can adopt towards norms of action or evaluation. Examples of regulative speech acts are commands, admonitions, prohibitions, refusals, promises, agreements, notices, excuses, recommendations and admissions. Regulative speech acts always presuppose the validity of conventions, that is "the normative background of institutions, roles, socioculturally habitual forms of life". The illocutionary force of speech acts which brings about legitimate (or illegitimate) interpersonal relations between the communicative partners comes from "the binding force of recognised norms of action (or of evaluation); to the extent that a speech act is an action, it actualises an already established pattern of relations" (Habermas, 1979:53-54).

[66] Habermas (1979:57) points out that there is no mode of communication in which the intelligibility of an utterance is thematized, since all speech acts have to satisfy the presupposition of *comprehensibility* in the same manner. "If in some communication there is a breakdown of intelligibility, the requirement of comprehensibility can be made thematic only through passing over to a hermeneutic discourse, and then in connection with the relevant linguistic system" (Habermas, 1979:57).

A regulative speech act contains an implicit claim that the interpersonal relation produced by the speech act is valid in terms of the normative context of the speech act. The presupposed norm implicitly referred to by a regulative speech act is valid if it is intersubjectively recognised. Regulative speech acts thus make a claim to rightness or appropriateness (Habermas, 1979:54, 56). A regulative speech act can only succeed when the validity claim that the speaker implies is covered by existing norms, "and that means by (at least) *de facto* recognition of *the claim that these norms rightfully exist*" (Habermas, 1979:54).

Habermas (1979:57-58) describes a third mode of communication, namely the "*expressive use of language*". **Representative speech acts**, such as "to reveal, expose, admit, conceal, pretend, deceive, express" (McCarthy, 1978:285) belong to this mode of communication. Representative speech acts include intentional verbs, such as "think, believe, hope, fear, love, hate, want, desire" (McCarthy, 1978:285) to disclose the speaker's desires, feelings, intentions, *etcetera* (Habermas, 1979:57). A representative speech act stresses the *truthfulness* with which a speaker expresses his/her intentions. "Truthfulness guarantees the transparency of a subjectivity representing itself in language" (Habermas, 1979:57).

Habermas (1979:58-59) does not claim that every series of speech actions can be unambiguously assigned to one of the modes of communication he describes. Furthermore, the validity claims of truth, rightness and truthfulness universally inhabit speech. Although each speech act explicitly raises one particular validity claim in accordance with the mode of communication to which it belongs, the other validity claims implicitly inhabit that speech act. For example, regulative speech acts stress the normative validity claim – the claim to rightness or appropriateness. The claim regarding the truth of the propositional content of the speech act, as well as the claim that the speaker truthfully expressed his/her intentions (to create a specific interpersonal relation with the listener), remain implicit. In this example the claims to truth and truthfulness are necessary conditions. However, the importance lies in the question of whether the speech act is in accordance with the existing normative context (Habermas, 1979:54-55, 58).

> …every competent speaker has in principle the possibility of unequivocally selecting one mode [of language use] because with every speech act he *must* raise three universal validity claims, so that he *can* single out one of them to thematize a component of speech (Habermas, 1979:59).

2.4.4 The illocutionary force of utterances

The next question that Habermas (1979:59) examines concerns the nature of the illocutionary force of utterances. Habermas (1979:53-54; McCarthy, 1978:283) describes the illocutionary force of an utterance as its power to produce the interpersonal relation between speaker and listener which was intended by the speaker. Only successful speech acts produce interpersonal relations. Habermas (1979:59) analyses illocutionary force by investigating the "conditions of success or failure of speech acts".

> An uttered content receives a specific communicative function through the fact that the standard conditions for the occurrence of a corresponding interpersonal relation are fulfilled. With the illocutionary act, the speaker makes an offer that can be accepted or rejected (Habermas, 1979:59).

Habermas (1979: 59) is not interested in the various contingent reasons which may cause the hearer to refuse to enter into the relationship offered by the speaker. He is only concerned with situations in which the failure of the speech act is due to an unacceptable utterance produced by the speaker. "When the speaker makes an utterance that manifestly contains no serious offer, he cannot count on the occurrence of the relationship intended by him" (Habermas, 1979: 59). Habermas (1979:59) considers a speech act successful if the listener understands the meaning of the utterance and also enters into the relationship intended by the speaker. He analyses "the conditions for the success of speech acts in terms of their '*acceptability*' " (Habermas, 1979:59). A speech act is considered acceptable only if the speaker "sincerely makes a serious offer"[67] and not when the speaker merely pretends to make an offer. A serious offer requires a certain engagement by the speaker (Habermas, 1979:59).

Habermas (1979:60-61) uses Searle's[68] analysis of the kinds of conditions that have to be met for a speech act to be successful as a point of departure (McCarthy, 1978:283). Searle groups these kinds of conditions into three groups of rules, namely "preparatory rules", "essential rules" and "sincerity rules" (Habermas, 1979:60-61; McCarthy, 1978:283). **Preparatory rules** refer to "generalised or restricted contexts for possible types of speech actions" or "speech-act-typically restricted contexts" (Habermas, 1979:60, 65). For example, a promise is only acceptable if the following conditions, among others, are fulfilled:

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[67] In Austin's (1962:9-10) words: "…words must be spoken 'seriously'…to be taken 'seriously'…Thus, 'I promise to…' obliges me – puts on record my spiritual assumption of a spiritual shackle".

[68] Searle, J.R. 1969. *Speech acts*. Cambridge: Cambridge University Press.

i. H (the hearer) prefers that S (the speaker) does A (a particular action) to S not doing A, and in addition S believes that this is the case;

ii. It is not clear to S or H that S will perform A in the usual course of events.

If conventional assumptions of this type are not satisfied there is no point in performing the act of promising, "that is, the attempt by the speaker to carry out the illocutionary act anyway makes no sense and is condemned to failure from the outset" (Habermas, 1979:60). **Essential rules** seem to only paraphrase the meaning of the equivalent performative verb. For instance, "requests: 'count as an attempt to get H to do A'; or questions: 'count as an attempt to elicit information from H' " (Habermas, 1979:61). Such paraphrases all include the phrase "counts as an attempt to" (Habermas, 1979:61; McCarthy, 1978:284). **Sincerity rules** place speech-act-specific limits on the speaker's "psychological state". For instance, for a promise to be acceptable S must have the intention of performing A. Different speech acts assume different psychological states on the part of the speaker, "for example, belief in asserting, wish or desire in entreating, intention in promising, gratitude in thanking". When a speaker does not have the required psychological state the relevant speech act is insincere (McCarthy, 1978:284).

Habermas (1979:61) considers the essential assumption for the success of a speech act as "the speaker's entering into a specific *engagement*, so that the hearer can rely on him. The speaker must engage himself, that is, indicate that in certain situations he will draw certain consequences for action". In other words, an acceptable illocutionary act means that the speaker made an offer that (s)he is on the point of fulfilling to the degree that the hearer accepts it. The "*content* of the engagement" (as referred to by essential rules) must be differentiated from the "*sincerity* of the engagement" (as referred to by sincerity rules). When Habermas (1979:61) speaks about the speaker's engagement, he presupposes "both a certain content of engagement and the sincerity with which the speaker is willing to enter into his engagement".

In the context of the aforementioned ideas regarding the acceptability of speech acts and the engagement of the speaker, Habermas (1979:65) makes the following statement regarding the illocutionary force of speech acts: "*The illocutionary force of a speech act consists in its capacity to move a hearer to act under the premise that the engagement signalled by the speaker is seriously meant*". When a speaker performs an illocutionary act (s)he enters into a bond, which

> means a guarantee that, in consequence of his utterance, he will fulfil certain conditions – for example, regard a question as settled when a satisfactory answer is given; drop an assertion when it proves to be false; follow his own advice when he finds himself in the same situation as the hearer; stress a request when it is not complied with; act in accordance with an intention disclosed by avowal, and so on (Habermas, 1979:62).

The question that now arises is how a hearer can be motivated to base his/her action on the presumption that the speaker is serious about the engagement that (s)he suggested (Habermas, 1979:62)? Is there more to illocutionary force than the "power of suggestion"? It is here that Habermas' thoughts "take a decisive turn" (McCarthy, 1978:285). Habermas (1979:63) argues that the illocutionary force of (institutionally unbound[69]) speech acts has a **rational basis**. In performing speech acts communicative partners raise validity claims and demand these claims to be recognised. Such recognition does not have to follow irrationally, since validity claims are cognitive in character and "can be checked" (Habermas, 1979:63). Habermas (1979:63) defends the following thesis:

> *In the final analysis, the speaker can illocutionarily influence the hearer and vice versa, because speech-act-typical commitments are connected with cognitively testable validity claims* – that is, because the reciprocal bonds have a rational basis. The engaged speaker normally connects the specific sense in which he would like to take up an interpersonal relationship with a thematically stressed validity claim and thereby chooses a specific mode of communication.

[69] In the case of institutionally bound speech acts, such as "betting, greeting, christening, appointing", the hearer can possibly depend on the binding force of a recognized rule of action. "In the case of institutionally unbound speech acts, however, illocutionary force cannot be traced back directly to the binding force of the normative context" (Habermas, 1979:54, 62).

Different types of constative speech acts have different particular meanings, yet the claim put forward in each of them is based on the truth of the matching propositions or on the subject's ability to have cognitions. In the same way various types of regulative speech acts have different particular meanings, but the claim put forward in each of these different interpersonal relationships refers to the rightness of the normative context or the subject's ability to assume responsibility (Habermas, 1979:63).

> We might say that in different speech acts the content of the speaker's engagement is *determined by different ways of appealing to the same, thematically stressed, universal validity claim*. And since as a result of this appeal to universal validity claims, the speech-act-typical commitments take on the character of obligations to provide grounds or to prove trustworthy, the hearer can be rationally motivated by the speaker's signalled engagement to accept the latter's offer (Habermas, 1979:63).

In the cognitive use of language a "speech-act-immanent *obligation to provide grounds*" is offered by the speaker. Constative speech acts include the offer to recur if needed to the "*experiential source*" from which the speaker obtains the "*certainty*" that the statement (s)he made is true. If an *ad hoc* doubt is not dismissed by this immediate grounding, the problematic truth claim can be discussed in a theoretical discourse. In the interactive use of language a "speech-act-immanent *obligation to provide justification*" is offered by the speaker. Regulative speech acts include only the offer to point to, if needed, "the *normative context*" from which the speaker obtains the "*conviction*" that his/her utterance is correct, in other words that "the speech action performed fits an existing normative background". Similarly, if an *ad hoc* doubt is not dismissed by this immediate justification, the problematic claim to rightness can be discussed in a practical discourse. The subject of such a practical discourse is not the rightness claim immediately connected with the speech act, but "the validity of the very norm from which the rightness claim of the speaker is merely borrowed". Lastly, in the expressive use of language a "speech-act-immanent…*obligation to prove trustworthy*" is offered by the speaker. The consequences of the speaker's actions thus have to prove that the intention (s)he expressed is truly the intention which guided his/her behaviour. If an *ad hoc* doubt cannot be dismissed by immediate "*assurance* expressing what is *evident* to the speaker himself", the problematic truthfulness claim can only be verified against the consistency of the speaker's subsequent behaviour (Habermas, 1979:63-64).

2.5 Habermas' (1979) model of linguistic communication

The analysis of the illocutionary force of speech acts thus led Habermas (1979:65) back to "the validity basis of speech". A participant in communication can be said to aim towards reaching understanding on condition that (s)he acceptably raises three validity claims through understandable sentences in his/her speech acts, namely claims to truth, rightness or appropriateness and truthfulness. Individual validity claims can be thematically stressed based on the mode of language use employed by the speaker, yet all the different types of validity claims come into play in each communicative action (Habermas, 1979:65-66). "…the system of all validity claims…must always be raised simultaneously, although they cannot all be thematic at the same time" (Habermas, 1979:66).

Habermas (1979:66) explains the universality of the validity claims intrinsic to the structure of speech by referring to the "systematic place of language". "Language is the medium through which speakers and hearers realise certain fundamental demarcations" (Habermas, 1979:66). Through language the subject separates him/herself from four "domains of reality":

i. "*External nature*", the environment that the subject objectifies "in the third-person attitude of an observer". External nature refers to the segment of reality which the subject can perceive and manipulate. This includes inanimate nature as well as all objects and situations which can directly or indirectly be accessed through sense experience.

ii. "*Society*", an environment or "symbolically prestructured segment of reality" that the subject "conforms to or deviates from in the ego-alter attitude of…a participant in a system of communication". Valid interpersonal relations, institutions, cultural values, and traditions belong to this domain of reality.

iii. "*Internal nature*", the subject's own subjectivity which (s)he communicates or conceals "in a first person attitude". This domain includes all desires, feelings, and intentions "to which an 'I' has privileged access and can express as its own experiences before a public".

iv. "*Language*", that is "the medium of language itself". Communicative actions are performed in language but language also appears (preconsciously) to the speaker and actor as a domain of reality of its own kind, *sui generis* (Habermas, 1979:66-67).

According to Habermas (1979:66) the validity claims inherent in speech aimed at achieving understanding show that these four domains must always appear at the same time. Habermas' (1979:67-68) **model of linguistic communication** depicts the correlations between the domains of reality, the basic attitudes of speakers which exist in the various modes of language use, validity claims and the general functions of speech. According to this model grammatical sentences are embedded, by means of validity claims, in three connections to reality and as a result take on the equivalent pragmatic functions of "representing facts, establishing legitimate interpersonal relations, and expressing one's own subjectivity" (Habermas, 1979:67). In Habermas' (1979:67) model language is the medium which connects three worlds. A threefold relation exists in every successful communicative act between the utterance and i.) "the external world"; ii.) "our social world" and iii.) "a particular inner world (of the speaker)" (Habermas, 1979:67). Every utterance can be examined in order to determine whether it is true or not, justified or not, truthful or not since

> in speech, no matter what the emphasis, grammatical sentences are embedded in relations to reality in such a way that in an acceptable speech action segments of external nature, society, and internal nature always come into appearance together. Language itself also appears in speech, for speech is a medium in which the linguistic means that are employed instrumentally are also reflected (Habermas, 1979:67-68).

Table 2.1 below depicts Habermas' (1979) model of linguistic communication.

Table 2.1: A tabular depiction of Habermas' model of linguistic communication (Adapted from Habermas, 1979:68 and Thompson, 1984:265)

Domains of reality	Modes of communication: basic speaker attitudes	Types of speech act	Themes	Validity claims	General functions of speech
"The" world of external nature	Cognitive: Objectivating attitude	Constatives	Propositional content	Truth	Representation of facts
"Our" world of society	Interactive: Conformative attitude	Regulatives	Interpersonal relation	Rightness	Establishment of interpersonal relations
"My" world of internal nature	Expressive: Expressive attitude	Representatives	Speaker's intention	Truthfulness	Disclosure of speaker's subjectivity
Language				Comprehensibility	

2.6 Concluding remarks

Habermas views the purpose of speech and language as understanding (McCarthy, 1978:287; Van Niekerk, 1992:184). Universal pragmatics is aimed at identifing and reconstructing "universal conditions of possible understanding" (Habermas, 1979:1). With regards to consensual speech actions, Habermas' (1979:2-4) central thesis is that understanding is based on a background consensus produced by the reciprocal raising and shared recognition of four universal validity claims, namely claims to comprehensibility, truth, truthfulness and rightness (McCarthy, 1978:288). These validity claims may be thought of as "four different dimensions in which communicative interaction can break down or suffer disturbances" (McCarthy, 1978:288). If the hearer cannot understand the speaker's utterance, communication cannot resume before the misunderstanding is solved within the interactive context "such as through explication, elucidation, paraphrase, translation, semantic stipulation" (McCarthy, 1978:288). Consensus is also endangered if the truth, truthfulness or correctness of a speaker's utterance is questioned. If the problematic validity claim cannot be vindicated in the interactive context the communicative partners face the alternatives of breaking off communication altogether, changing to strategic action or resuming communication at the discursive level (Habermas, 1979: 3-4; McCarthy, 1978:288-289).

To the extent that ordinary interaction entails regarding the other as subject, it entails the supposition that "he knows what he is doing and why he is doing it, that he intentionally holds the beliefs and pursues the ends that he does, and that he is capable of supporting them with reasons if necessary" (McCarthy, 1978:291). Even though the "supposition of responsibility" is often or mostly counterfactual, it is of fundamental importance for the structure of human relationships that we continue interaction as if the supposition were valid (McCarthy, 1978:291): "on this unavoidable fiction rests the humanity of intercourse among men who are still men" (Habermas, 1971:120 as cited in McCarthy, 1978:291)[70]. McCarthy (1978:291) points out the significance of the possibility to discursively resolve differences in belief and values which may prevent the initiation or continuation of communicative relationships. Discourse represents an opportunity to establish or re-establish a consensual basis for communication without having recourse to force in any form (such as open violence or latent

[70] Habermas, J. 1971. Vorbereitende Bemerkungen zu einer Theorie der kommunikativen Kompetenz, in Habermas, J. & Luhmann, N. (eds.). *Theorie der Gesellschaft order Sozialtechnologie – Was leistet die Systemforschung?* Frankfurt: Suhrkamp. 101-141.

manipulation). Discourse represents "the possibility of reaching agreement through the use of reason and thus by recourse to, rather than violation of, the humanity of those involved" (McCarthy, 1978:291).

In Chapter 5 I shall comment on doctor-patient communication from the perspective of Habermas' universal pragmatics. There I shall describe doctor-patient communication against the background of Habermas' model of linguistic communication. I shall identify the mode of communication in which each member of the clinical dyad mostly communicates and I shall also discuss the interactive mode of communication in clinical encounters. Furthermore I shall consider the validity claims that are typically raised and responded to during the medical interview in an attempt to cast light on the problematic character of doctor-patient interactions. My Habermasian commentary on doctor-patient communication will continuously refer to the medical profession's natural scientific intellectual self-image.

In the next chapter I shall describe Michel Foucault's (1926-1984) theory on the nature of discourse and power.

Chapter 3

Foucault on discourse and power

One cannot speak of anything at any time; it is not easy to say something new.

Michel Foucault (1972:49)

3.1 Introduction

In this chapter I shall describe Michel Foucault's (1926-1984) theory on the nature of discourse. In Chapter 6 I will use Foucault's ideas on discourse to investigate the effects of medicine's identity as a natural science on medical discourse. I turn to Foucault's work because it enables a general and critical analysis of the nature of medical discourse, as opposed to in-depth analyses of specific conversations between doctors and patients that mainly reveal specifics about the communication partners and the location of their communication. A wealth of research studies of the aforementioned type exists, none of which, to my knowledge, pays sufficient attention to the influence of medicine's identity as a natural science on the effectiveness of communicative care to patients. To my mind this issue is indispensable for an understanding of doctor-patient communication. Furthermore, the outcome of any intervention with the aim of improving the quality of said communication is doomed to disappoint unless such a project is based on an overhaul of medicine's ontology and epistemology. Moreover, Foucault views discourse and power as integrated. This position is very helpful in any study regarding doctor-patient communication, as power relations fundamentally influence communication in clinical situations.

My discussion of Foucault's work on discourse has two main parts. The first part describes Foucault's understanding of discourse, mainly as articulated in two of the philosopher's earlier works, namely *The Archaeology of Knowledge* (1972) and *The Order of Discourse* (1981). The second part of my discussion focuses on Foucault's view of power, and specifically the relationship between discourse and power. However, before I start with this description of Foucault's works a comment is needed about the way the works of Habermas and Foucault are used alongside each other in this dissertation.

I use specific works of each author for distinct purposes related to the general aim of this project, namely to investigate the influence of the medical profession's intellectual self-image on communication between doctors and patients[71]. To achieve this broad aim it is necessary to analyse both doctor-patient communication and medical discourse. I use Habermas' universal pragmatics to investigate doctor-patient communication, that is the interaction between doctors and patients in clinical settings. This work will be especially helpful in examining the different perspectives from which the doctor and patient typically communicate and the difficulties that such differences in perspective may cause for the participants of clinical communication in terms of reaching understanding and agreement. I further my investigation of the influence of medicine's natural scientific self-image on clinical communication by using a collection of Foucault's writings on discourse and on power to critically analyse medical discourse, the power relations within the doctor-patient dyad and the potential effects thereof on clinical interactions. With 'medical discourse' I refer to my Foucauldian-inspired definition of the term, namely the rules that doctors (have to) follow when they think and talk about health and disease (in order to be regarded as competent) (please refer to page 11 and 12 for a more detailed explanation of how I use this term).

The mentioned works by Habermas and Foucault are presented and applied separately from each other in this dissertation. I do not juxtapose Habermas' universal pragmatics and Foucault's writings on discourse and power at any point in the dissertation. Such juxtaposition is not performed since the goal of my project is not to critique the works of Habermas and Foucault, but rather to use their insights for a critical analysis of doctor-patient interaction in our time. However, I shall now briefly describe some of the broad similarities and differences between the thoughts of these two authors on the subjects of rationality, critique and power. I mostly draw on an essay by Thomas McCarthy (1994) for this purpose. The similarities and differences in ideas outlined below refer mostly to Foucault's work that was published in the 1970s (and does not include *The Archaeology of Knowledge*) and

[71] The rationale for specifically selecting Habermas' universal pragmatics and a collection of Foucault's works on discourse as well as power as analytical tools for my project is provided in the general introduction of the dissertation (see page 10 and 11).

Habermas' *The Theory of Communicative Action*, volumes 1 and 2[72] (McCarthy, 1994:273-274).

As is characteristic of philosophers in the late twentieth century, both Habermas and Foucault critique subjectivistic rationalism (McCarthy, 1987:viii-ix; Kelly, 1994:4; McCarthy, 1994:243-244). They acknowledge the overwhelming and intrinsic impurity of reason. They conceive of reason as embedded in culture and society, entangled with power and interest, and possessing categories and criteria that are historically variable. They recognize that the subjects of knowledge are embodied and social beings and that their thoughts and actions are ineradicably marked by their situations and interests (McCarthy, 1994:243-244). The two thinkers thus agree that reason is "a thing of this world" (McCarthy, 1987:x) and that knowledge is a social product (McCarthy, 1994:244-245). According to both Habermas and Foucault to examine the "nature, scope and limits of human reason" it is necessary to study social practices by means of sociohistorical inquiry. Both authors are of the opinion that sociohistorical analyses of the seemingly rational beliefs and practices that influence our lives provide a critical perspective on those practices with implications for practice (McCarthy, 1994:244-249).

Habermas and Foucault's work thus have much in common and may be considered as neighbours in the world of contemporary theory. Yet, many disagreements exist between them that are as real as their agreements (McCarthy, 1994: 247-248). It will become clear in this chapter that Foucault's critique of reason is radical. According to Foucault power produces knowledge and practice and modern reason is simply a disguised will to power. In contrast with Foucault's radical critique of reason, Habermas understands critique as a determinate negation of subject-centered reason in favour of a more adequate conception of reason, namely reason understood as communicative action (McCarthy, 1987:vii, xiii-xiv; Kelly, 1994:1-2; McCarthy, 1994: 248). The description of universal pragmatics in the previous chapter indicated that Habermas construes reason in terms of an intersubjectivity that is noncoercive and characterised by mutual understanding and reciprocal recognition (McCarthy, 1987:xvi). For Foucault the attempt to move beyond the subject-centeredness of modern Western philosophy means the "end of man" and the entourage of humanist conceptions that accompanies it. Habermas on the contrary responds to the problematic of the

[72] Habermas, J. 1984. *The Theory of Communicative Action. Volume 1: Reason & the Rationalization of Society*. Boston: Beacon Press.; Habermas, J. 1984. T*he Theory of Communicative Action. Volume 2: Lifeworld & System: A Critique of Functionalist Reason***.** Boston: Beacon Press.

rational subject by attempting to reconstruct the concepts of subjectivity and autonomy in ways that are in agreement with the social aspects of individual identity as well as the situated nature of social action (McCarthy, 1994:248). A further important difference between the approaches of Foucault and Habermas is that Foucault does not regard his analyses to be in the service of reason, truth, freedom and justice. For Foucault we can never completely get away from the relations and effects of power since they correspond with and form part of social life (McCarthy, 1994:248). According to the French thinker abstract concepts such as truth, justice and human reason are likely to reflect the interests of the dominant social group (Merquior, 1985:148-149). Contrary to Foucault, Habermas regards the critique of ideology to have the function of reducing the relations and effects of power (McCarthy, 1994:249). For Habermas the role of critique is to suspend power so that the universal norms that are pragmatically presupposed in ethical, political and social theory can be justified (Kelly, 1994:2). The relation between communicative action and validity claims that permit argument and counterargument is what makes learning and consequent transformations of our world-views possible (McCarthy, 1987:xvii).

It may be acceptable to set aside the differences between the approaches of Habermas and Foucault for the purposes of my current project. However, when the focus of reflection is on the possibilities of bringing about change in the world-view and self-image of modern medicine as well as in the power relations within the doctor-patient dyad, these differences will have to be taken into account.

3.2 Defining discourse

Discourse is defined in various ways by different scholars and in different academic fields. Foucault (1972:90) admits that he has added to the fluctuating meaning of this term, and that he does not treat the term in the same manner throughout his writings. He treats the term in the following three ways in his work:

> sometimes as the general domain of all statements, sometimes as an individualizable group of statements, and sometimes as a regulated practice that accounts for a certain number of statements (Foucault, 1972:90).

Foucault thus uses the term discourse either to refer to the totality of utterances that have meaning, or to a group of statements that forms a unity, such as the discourse of medicine, or

to the rules responsible for the production of statements. It is specifically the rules that are responsible for the production of discourse and the rules that regulate the distribution and circulation of statements and discourses that interest Foucault. Foucault's study of discourse moves beyond the actual words uttered by speakers and writers to include the *a priori* rules and categories that are regarded as a component of discourse, and thus knowledge, and which are so fundamental that they are not uttered or consciously thought of (Young, 1981:48). For Foucault (1972:53-54) discourse, in the form of speech or written material, is more than an intersection of a materiality and a system of signs (language) which represent such a reality. Discourses are **practices** which follow rules to systematically bring about the objects to which they refer. In a summary of a course that he presented at the Collège de France between 1970 and 1971 Foucault (1977:199) provides the following definition of discursive practices:

> Discursive practices are characterised by the delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge, and the fixing of norms for the elaboration of concepts and theories. Thus, each discursive practice implies a play of prescriptions that designate its exclusions and choices.

The function of discursive practices is to make it almost impossible to think and speak outside their borders. Whoever does so risks being regarded as insane or incompetent or in some other way outside of 'the true' (Mills, 2003:57; Young, 1981:48; Foucault, 1981a:61).

Foucault argues that objects in the material world do not carry *a priori*, inherent and ultimate meanings that can be revealed to us by the reading of discourse. It is rather the case that discourse enables us to have knowledge of the world, to determine truth values and to map the scope of things that we can reasonably utter. Foucault is not arguing that nothing exists beyond discourse. Certainly there is a material reality outside of discourse, but meaning can only be found within the boundaries of discourse (Foucault, 1972:53-54; Hook, 2001: 536-537). We think about and experience physical objects and the world in total through discourse and the structures it forces on our thinking. It is very difficult to recognise and challenge the structures that we use to categorise and interpret events and experiences, since they have infiltrated our thinking to the level that we regard them as self-evident (Foucault, 1981b:6; Mills, 2003:56). Discourse determines what are acceptable and unacceptable ways to talk, think, and conduct oneself in relation to a specific topic, such as health and illness.

In *The Archaeology of Knowledge* Foucault provides a highly detailed and technical account of the rules that govern the formation of discourses. These rules operate outside the consciousness of individuals and are not determined by the subjects of discourse or by external factors such as social, economic and political conditions. Instead, Foucault regards the rules of discourse as an internal feature of discourse. I will now provide a brief summary of Foucault's description of discursive regularities in *The Archaeology of Knowledge*, focussing on the issues that hold most value for the aims of the current project. To structure the discussion I use the chapter titles of Foucault's book as subheadings. The discussion that follows may seem overly technical. I will explain the value of these ideas for the purposes of my project before commencing the discussion on the relationship between discourse and power.

3.2.1. The unities of discourse

Foucault (1972:23-29) wants us to question those notions, categories and themes whose validity seem self-evident and which organise our thoughts according to the principle of continuity. An example is the division and grouping of discourse into discrete categories such as science and philosophy, or medicine and psychiatry. Such divisions "are not intrinsic, autochthonous and universally recognizable characteristics" (Foucault, 1972:25) but are constructed. We must scrutinise the rules and justification for the construction of such pre-existing unities (Foucault, 1972:28). Foucault (1972:27) wants us to break up the uncritically accepted continuities by which discourses are organised before the study of discourse commences. Foucault (1972:27) urges us to renounce the wish

> that it should never be possible to assign, in the order of discourse, the irruption of a real event; that beyond any apparent beginning, there is always a secret origin – so secret, so fundamental that it can never be quite grasped in itself.

Foucault thus rejects the idea of a fundamental moment of creation beyond any point present in history, which reduces the beginnings of all statements and discourses to mere commencements. Another theme of continuity that must be given up in the analysis of discourse, is the idea that

> all manifest discourse is secretly based on an 'already-said'; and that this 'already-said' is not merely a phrase that has already been spoken, or a text that has already been written, but a 'never-said', an incorporeal discourse, a voice as silent as a breath, a writing that is merely the hollow of its own mark (Foucault, 1972:27-28).

The latter theme views discourse analysis as interpreting the voice of the 'already-said' which is also a 'not said'. In Foucault's (1972:28) view the task of discourse analysis is rather to abandon all ideas which work to ensure a limitless continuity of discourse. Instead of searching for discourse's distant origins, "we must be ready to receive discourse in its sudden irruption" and treat it "as and when it occurs". Instead of uncritically accepting the validity of familiar ideas that create a unity between separate statements and discourses, all statements should be regarded as events. Foucault (1972:31-32) wants to isolate the occurrence of the statement or event for two reasons. Firstly, he wants to ensure that the occurrence of the statement is not related to synthesizing psychological operations, for instance the intentions, interests, methods and inspirations of an author. Secondly, he wants "to be able to grasp other forms of regularity, other types of relations" between statements, groups of statements and also relations between groups of statements and events with a very different nature, for instance events that are "technical, economic, social, political".

3.2.2 Discursive formations

Foucault (1972:40-41) asked himself what the basis of the unity of a large group of statements, such as medicine or economics, might be. He hypothesised that the unity is created by homogeneity of the respective elements of discourse, namely the discourse's objects, concepts, themes or types of statement. Yet, based on these said elements, any (apparent) discursive unity appears as a "series full of gaps, intertwined with one another, interplays of differences, distances, substitutions and transformations" rather than a "full, tightly packed, continuous" unity. Following this realisation Foucault decided to turn to the dispersions between the elements of a group of statements in an attempt to discover some regularities. Such an analysis would study forms of division and describe *systems of dispersion*.

Foucault (1972:41) uses the term *discursive formation* to refer to a group of statements which has a regularity ("an order, correlations, positions and functionings, transformations")

between its elements. He uses the phrase *rules of formation* to refer to the conditions that influence the elements of a discursive formation. "The rules of formation are conditions of existence (but also of coexistence, maintenance, modification, and disappearance) in a given discursive division".

3.2.3 The formation of objects

In order to provide content to the notion of *rules of formation*, Foucault (1972:44-54) asks how the objects of discourse[73] are formed, or according to what rule their appearance occurred. He specifies three types of rule to answer his question. The first rule refers to the *surfaces* of the *emergence*, namely those social and cultural fields in which a discursive formation appears (Sheridan, 1980:97). The second rule refers to the *authorities of delimitation*. Since the nineteenth-century, for example, medicine became the main authority in the eyes of the law, public opinion and the government to define and describe insanity as an object based on the medical profession's corpus of knowledge and skills and professional and institutional structures. The third rule refers to the *grids of specification*. In the example of insanity these are the systems used to distinguish, compare and relate different types of insanity from and to each other "as objects of psychiatric discourse" (Foucault, 1972:46). These three rules in themselves do not supply objects that a discourse then merely has to name and classify and take up in "a network of words and sentences". One must also not conceptualise the objects of discourse as pre-existing, "the object does not await in limbo the order that will free it and enable it to become embodied in a visible and prolix objectivity" (Foucault, 1972:49). The object of a discourse emerges with the discourse itself, in a single process (Sheridan, 1980:98). The objects of a discourse are formed when a group of relations are created between the "authorities of emergence, delimitation, and specification". The complex interaction between the rules of formation named above creates the conditions of possibility for an object of discourse to appear. This explains why

> one cannot speak of anything at any time; it is not easy to say something new; it is not enough for us to open our eyes, to pay attention or to be aware, for new objects suddenly to light up and emerge out of the ground (Foucault, 1972:49).

[73] The objects of discursive formation are "that of which one can speak in a discursive practice" (Foucault, 1972:201).

These constraints are not merely negative. They create the conditions necessary for new objects to emerge (Sheridan, 1980:98). Yet, these relations ("between institutions, economic and social processes, behavioural patterns, systems of norms, techniques, types of classification, modes of characterisation") do not exist in the object itself. They do not describe the internal structure of objects, but are merely the conditions necessary for an object to appear in the exterior (Foucault, 1972:49-50). A discursive formation can be defined if such a group of relations can be established, if it can be shown how a particular object of discourse finds the place and rule of its emergence in such a group of relations (Foucault, 1972:47,49).

Foucault (1972:54) argues that although discourses are made up of signs, (spoken or written words that represent external realities) discourses are more than this. When discourses themselves, and not their referents or the meaning of specific words, are analysed the tight embrace which appear to exist between words (signs) and things loosens and a group of rules belonging to the practice of discourse emerges. Discourses thus can not be reduced to speech and language. Foucault wants to reveal and describe what discourses do above the task of using signs to refer to things.

3.2.4 The formation of enunciative modalities

By *enunciative modalities* Foucault means different types or styles of statement. Different forms of statement occur in the same discourse. Examples of the types of statement that occur in medical discourse are listed by Foucault (1972:55) as "qualitative descriptions, biographical accounts, the location, interpretation, and cross-checking of signs, reasonings by analogy, deduction, statistical calculations, experimental verifications". In order to answer the question of what ties these different types of statement together to form a unity Foucault (1972:55-58) investigates the rule that operates behind these statements, as well as the site of their origin. In order to do this one needs to determine who the subject of the discourse is: who is awarded the right and is qualified to use this specialised type of language? Who receives his/her prestige from using this discourse and from whom does the subject receive the presumption that (s)he is speaking the truth? What status does the individual have that is sanctioned to use this discourse? Furthermore, the institutional sites wherein the discourse is used and that provides the discourse its source and "point of application" needs to be described. Finally the various positions that the subject of a discourse is able to occupy in

relation to the perceptual field and information networks need to be defined. In medical discourse for instance the subject of the discourse, that is the medical professional, may take up the position of interrogation, listening, observing or describing. "He is situated at an optimal perceptual distance whose boundaries delimit the wheat of relevant information" (Foucault, 1972:58). The medical professional's access to technology allows him or her to move beyond the immediate perceptual level, ever deeper into the "interior space of the body": from outward symptoms, to signs in the organs, the tissues and finally the cells. The positions that the medical professional (the subject of medical discourse) can occupy in the information networks include his/her position in teaching activities in the classroom or at the bedside and his/her position in spoken or written communication as the sender or receiver of messages in the form of "observations, case-histories, statistical data, general theoretical propositions, projects and decisions".

Diversity in modalities of enunciation of a discourse can be attributed to a relation between the elements discussed above, namely the status of the subjects, the site from which they speak and the position that they occupy as subjects. A discourse, as a practice, creates this relation between various elements and provides it the quality of a unity. The unity of a discourse is thus provided by a system of relations that are external and prior to the conscious activity of individuals (Sheridan, 1980:99).

3.2.5 The formation of concepts

The set of concepts that occur in a discipline such as biology does not form a coherent unit, but rather an organisation of disparate notions. Foucault (1972:62-63) asks whether a law that explains or is responsible for the consecutive or simultaneous appearance of disparate concepts in a single discourse could be found. To achieve this, a description of the organisation of the field of statements in which concepts occurred and circulated would be necessary. This organisation includes forms of *succession*: "a set of rules for arranging statements in a series". The first of these rules is the different *orderings of enunciative series.* This includes the rule according to which statements are organised to form inferences and descriptions of matter and events. The second rule concerns the different *types of dependence* of statements, such as the dependences between a hypothesis and its verification, an assertion and its critique or a general law and its practical application. The final rule involves the different rhetorical *schemata* for the *combination* of groups of statements: "how descriptions,

deductions, definitions, whose succession characterises the architecture of a text, are linked together". The emergence and recurrence of concepts in a discipline is governed by the general organisation of the statements, the consecutive arrangement of statements to form particular wholes. A discipline is not simply a form of knowledge that gives new definitions to (some of its) already existing concepts and introduces new concepts to a discourse, but it is an obligatory set of rules according to which statements are organised in a series. A discipline is a schema that specifies rules of dependence, order and succession between statements in which concepts appear.

3.2.6 The formation of strategies

The discourses of disciplines, such as medicine, lead to "certain organisations of concepts, certain regroupings of objects, certain types of enunciation which form according to their degree of coherence, rigour and stability, themes or theories" (Foucault, 1972:71). Foucault (1972:71) refers to these theories or themes as strategies. He wants to find out how such strategies are distributed throughout time. He asks whether it is possible to discover a regularity between such strategies and to define the shared system according to which they are formed (Foucault, 1972:72). The following three elements are involved in the formation of discursive strategies:

i. The *points of diffraction of discourse*. Foucault (1972:73-74) talks here about *points of incompatibility*. He refers to the situation where two different concepts, objects or types of statement belonging to the same discursive formation, cannot "enter…the same series of statements". These incompatible elements are referred to as *points of equivalence*. Yet, rather than forming a faulty coherence these elements constitute an alternative, "they appear in the form of 'either…or' ". Such elements do not necessarily appear at the same time, may not have equal importance or be equally distributed among the statements of their discursive formation. These incompatible but equivalent elements are also *link points of systematization*. Out of each occurrence of such incompatible but equivalent elements, a 'discursive subgroup' develops: "a coherent series of objects, forms of statement and concepts". New points of incompatibility are possible in each of these discursive subgroups.

ii. However, not all of these possible alternatives are realized. There are many discursive subgroups that could have developed, but did not. To explain why only certain discursive subgroups were chosen to develop, the specific authorities that guided this choice must be described. An important authority in this respect is the role of the discourse under study in relation to contemporary or related discourses. Foucault (1972:74) refers to this as the *economy of the discursive constellation* to which a discourse belongs. The discourse under study may for instance act as a formal system with other discourses as its applications, or it may play the role of a concrete model that is applied to more abstract discourses. Furthermore, the discourse under study may be related to other discourses in the form of an analogy, as opposition or in a complementary manner. Finally, relations of mutual delimitation may exist between discourses, in which each discourse defines the other by distinguishing its specific field of application. An example is the differentiation between psychiatry and medicine that occurred at the end of the eighteenth century and which has characterised these two discourses ever since. The relations between a particular discourse and other discourses act as a principle of determination that allows or disallows particular statements (concepts, types of statement and objects that are entirely possible in terms of the rules of formation pertaining to them), from entering a discourse. For this reason a particular discursive formation may display new elements when it is positioned and interpreted in a new discursive constellation.

iii. There is another authority that determines which discursive subgroups or theories are chosen to develop. The first characteristic of this authority is the *function* that the discourse of interest plays *in a domain of non-discursive practices.* This authority is also characterised by *the rules and processes of appropriation* of discourse. In western, industrialised societies discourse as a property, belongs (often with legal permission) to a certain group of people. Medical discourse, for instance, does not belong to all groups of individuals in our society but the chosen few who are accepted (based largely on their academic merit) as students by the health sciences faculties of universities. The final characteristic of this authority is the *possible positions of desire in relation to discourse.* Put in a different way, a particular discourse may be related to desire, or play a role in the realization of desire. A discourse may for instance "be the place for phantasmatic representation, an element of symbolization, a form of the forbidden, and instrument of derived satisfaction" (Foucault, 1972:76).

A discursive formation can be defined by describing the system of formation of its different strategies. A particular discursive formation "is defined by a certain constant way of relating possibilities of systematization interior to a discourse, other discourses that are exterior to it, and a whole non-discursive field of practices, appropriation, interests and desires" (Foucault, 1972:77).

3.2.7 Science and Knowledge

The elements of a discursive formation, namely its objects, types of statement, concepts and strategies "can be called knowledge" (Foucault, 1972:201). Foucault defines knowledge with the following four descriptions: a.) knowledge is the domain formed by the various objects of a discursive formation ("that of which one can speak in a discursive practice"); b.) knowledge also includes the space or the group of functions that the subject of a discourse may occupy to speak about the objects of his/her discourse; c.) furthermore knowledge acts as the area of coordination and subordination according to which all new statements can be integrated with what was already said (the field "in which concepts appear, and are defined, applied and transformed"), and lastly d.) knowledge includes all the possibilities of articulation of a specific discursive formation on other discursive and non-discursive practices ("the possibilities of use and appropriation offered by discourse"). Not all bodies of knowledge are scientific. No knowledge can exist outside of a specific discursive practice and any discursive practice can be defined by the knowledge that it produces.

Thus far I have described the rules that govern the formation of discourses, as laid out in *The Archaeology of Knowledge*. In the next section I turn to Foucault's description of the procedures or systems that control and restrict discourse. Foucault provided this description in his inaugural lecture at the Collège de France in 1970. The lecture is titled *The Order of Discourse* and was published in 1981 in a post-structuralist reader, edited by Robert Young (1981). Ian McLeod translated the lecture from the original French.

3.3 The order of discourse

Foucault (1981a:52) puts forward the hypothesis

> that in every society the production of discourse is at once controlled, selected, organised and redistributed by a certain number of procedures whose role it is to ward off its powers and dangers, to gain mastery over its chance events, to evade its ponderous, formidable materiality.

It is possible for speaking subjects to utter an indefinite number of different statements. Yet, when one considers the unlimited possibilities for formulating new utterances based on the permutations provided by the grammar of a particular language and the abundance of vocabulary[74] available to form sentences and phrases, it becomes clear that relatively few things are in fact said within specific contexts and during certain historical time periods (Foucault, 1972:134). Foucault (1981a:61) points out three different procedures that are at work in modern, western societies to select certain statements for and exclude others from discourse. These are

i. the prohibition (external or social procedures of exclusion);
ii. a group of internal procedures of rarefaction[75] ; and
iii. "a rarefaction…of the speaking subjects". I shall now pay attention to these three procedures.

[74] Claims are made that English received its one millionth word on June 10, 2009. The word is Web 2.0 (The Global Language Monitor, [s.a.]).

[75] Young (1981:49) makes the meaning of 'rarefaction' clear by noting that "the French term 'rarefaction' includes not only the meaning of the rarefaction of gases, but also the sense of depletion (of supplies), of growing scarcity, of dwindling, drying out and exhaustion".

3.3.1 Social procedures of exclusion

Three social or external procedures of exclusion are at work in discourse. The first and most obvious and familiar of these is the **prohibition** or **taboo**. Foucault (1981a:52) distinguishes between three types of prohibition:

> We know quite well that we do not have the right to say everything, that we cannot speak of just anything in any circumstances whatever, and that not everyone has the right to speak of anything whatever.

There are thus restrictions on the object of speech, that which we can speak about; on "the ritual and circumstances of speech"; and on who owns the privileged and exclusive right to the act of speaking. These three types of prohibition intersect and reinforce one another, or compensate for each other, forming a complex, constantly changing grid. Examples of strictly controlled discourses in our time are the domains of sexuality and politics. Discourse may appear to be of little importance, as a transparent and neutral place "where sexuality is disarmed and politics pacified" when it is in fact a place where sexuality and politics exercise "some of their most formidable powers". The taboos that surround discourse reveal its connection with desire and power. Discourse does not only express or conceal desire, "it is also the object of desire;…discourse is not simply that which translates struggles or systems of domination, but is the thing for which and by which there is struggle, discourse is the power to be seized" (Foucault, 1981a:52-53).

The second principle of exclusion is a division and a rejection. Foucault (1981a:53) refers here "to **the opposition between reason and madness**[76]". Since the Middle Ages the speech of the madman could not be accepted in the same way that the discourse of the sane is accepted. The madman's words were not valued as true, important or legally valid. He could neither enter into a written contract nor even bring "about the trans-substantiation of bread into body at Mass". Although the madman's words were treated as the evidence of his

[76] I am aware that the terms "madness" and "the madman" may seem derogatory to individuals suffering from mental illness, their families, friends and caregivers. However, I am using the terminology that Foucault used 38 years ago, feeling comfortable that Foucault was not using these specific terms to insult or discriminate against people with mental illness. In fact, Foucault's work rather points to the oppression of the mentally ill by society and the so-called helping professions. Acceptable terminology with regards to disability, and mental disability in particular, is subject to frequent change and it is therefore, as well as for the reason mentioned above, that I decided to use Foucault's original words.

madness and thus acted as the site for the division between reason and madness, no doctor prior to the end of the 1700's paid any attention to these words, or to how and why they were spoken. One may then be quick to argue that things have changed and that the madman's speech is now considered valid and important and receives much attention. Yet,

> you only have to think of the whole framework of knowledge through which we decipher that speech, and of the whole network of institutions which permit someone – a doctor or a psychoanalyst – to listen to it, and which at the same time permit the patient to bring along his poor words, or, in desperation, to withhold them. You only have to think of all this to become suspicious that the division, far from being effaced is working differently, along other lines, through new institutions, and with effects that are not at all the same. And even if the doctor's role were only that of lending an ear to a speech that is free at last, he still does this listening in the context of the same division" (Foucault, 1981a:53).

Mills (2003:58) gives a recent example to show how the speech of the mentally ill is treated as non-existent. In Britain persons who are certified as mentally ill and have been prescribed medications for their conditions are prevented by legislation to refuse treatment. Thus, when a person with mental illness verbally turns down prescribed medication, his/her statement will not be acknowledged by the authorities who may force the patient to take the medication.

The third procedure of exclusion that Foucault (1981a:54) describes is "**the opposition between true and false**". It may seem curious and also risky to place the constraint of truth in the company of the exclusions mentioned above. The divisions just mentioned are arbitrary or at least dependent on historical contingencies; modifiable and continuously replaced; have the support of a network of institutions; and are constraining and violent at times. At the level of the proposition, "on the inside of a discourse", the divide between true and false does not seem arbitrary, modifiable, institutional or violent. However, when one examines the nature and history of our **will to truth**[77] and the division that controls our will to know, "a system of exclusion, a historical, modifiable, and institutionally constraining system" appears (Foucault, 1981a:54).

[77] Foucault uses the phrases 'will to truth' and 'will to know' interchangeably. Sheridan (1980:123) also refers to the will to know as the wish to know.

The opposition between true and false is historically constituted. Foucault (1981a:54) justifies this statement with the following example. The Greek poets of the sixth-century before Christ regarded the true discourse as the one spoken by men as of right and according to the necessary ritual. It was the discourse that "inspired respect and terror, and to which one had to submit because it ruled…; the discourse which dispensed justice and gave everyone his share". The true discourse, which was associated with the exercise of power, resided in **how** and **by whom** something was said. A century later, for Plato's generation, a new division between true and false was established. The truth now no longer resided in "the ritualised, efficacious and just act of enunciation", but in the statement itself. Truth is now found in **what** is said, in the meaning, form and object of the utterance and its relation to the external world. Our will to know received its general form from this division between true and false. Our will to know transforms constantly and has its own history which starts at the Platonic divide. Transformations in scientific thinking can at times be read as the results of a discovery, "but they can also be read as the appearance of new forms in the will to truth". For example, the will to truth of the early nineteenth-century is different from that of the early seventeenth-century. The will to know specifies the range of objects to be studied, "the functions and positions of the knowing subject" and the material and technical investments in the search for knowledge. The will to know imposes on the knowing subject "a certain position, a certain gaze and a certain function…and in some sense prior to all experience" (Foucault, 1981a: 54-56).

The will to truth rests on institutional support, similar to the other systems of exclusion. The truth is reinforced and renewed by layers of practices, such as the educational system and the system that distributes information, including libraries, the publishing industry and laboratories (Foucault, 1981a:55; Sheridan, 1980:123-124). Only statements that are 'in the true' are circulated, while those that are considered outside 'of the true' are excluded (Mills, 2003:58). The will to truth is also renewed by the values that particular social systems place on particular forms of knowledge. The will to truth is further likely to affect other discourses (Foucault is still speaking of societies similar to his own, which is western European in the second half of the twentieth-century). Examples are the way that Western literature has sought for centuries its foundation in notions such as nature, authenticity, sincerity and science- "in short, on true discourse". The penal system has also gradually loosened its connection to religious morality and has, since the nineteenth century, sought its justification in the proliferation of social sciences, including sociology, psychology and psychiatry. "It is

as if even the word of the law could no longer be authorised, in our society, except by a discourse of truth" (Foucault, 1971:55; Sheridan, 1980: 123-124).

Of the three systems of exclusion described by Foucault, the will to truth is the most dominant and all-pervasive. The other two systems of exclusion, the taboo and the division between reason and madness, are invaded by the will to truth. Yet, the will to truth is discussed least of all. It is as if it is masked by truth itself. The reason is perhaps that desire and power are at stake in the will to speak the true discourse. The 'true' discourse cannot recognise the will to truth whereby it is influenced; "and the will to truth, having imposed itself on us for a very long time, is such that the truth it wants cannot fail to mask it" (Foucault, 1981a:56; Sheridan 1980: 124).

> Thus all that appears to our eyes is a truth conceived as a richness, a fecundity, a gentle and insidiously universal force, and in contrast we are unaware of the will to truth, that prodigious machinery designed to exclude (Foucault, 1981a:56).

The three social procedures of exclusion operate from the exterior. They are concerned "with the part of discourse which puts power and desire at stake". The three procedures just discussed are thus those responsible for averting the powers and dangers of discourse, as stated in Foucault's hypothesis (quoted at the start of this section). The second group of procedures that control and delimit discourse are 'internal procedures', thus procedures whereby discourses control themselves (Foucault, 1981a:56). I shall now discuss these internal procedures of control.

3.3.2 Internal procedures of control

The internal procedures of control function as principles of classification, ordering and distribution. Their role is to master another dimension of discourse, namely discourse as irruption, or chance event (Foucault, 1981a:56; Sheridan, 1980:124). Foucault specifies three internal procedures of control, namely commentary, the author and the 'disciplines'. I limit my discussion of these procedures to **the disciplines**, since this principle is actively and evidently at work in medical discourse and is very helpful for the purpose of the current project.

The principle of disciplines allows construction, but within narrow confines. "A discipline is defined by a domain of objects, a set of methods, a corpus of propositions considered to be true, a set[78] of rules and definitions, of techniques and instruments". Disciplines are anonymous systems that may be used by anyone with the desire or ability to do so. Disciplines exist where there is the possibility to formulate new propositions, *ad infinitum*. Yet, a discipline does not equal the sum of everything that can be said in truth about something. It does not even encompass all that can be accepted about a single data set because "of some principle of coherence or systematicity". Medicine, for instance does not equal all statements that can be truthfully expressed about illness, in the same way that botany does not constitute all that can be said in truth about plants. Two reasons explain this. First, any discipline contains truth and errors. These errors are not foreign bodies or residues that must be expelled from the discipline in time. Instead, the errors in a discipline have a positive function in that they play an active and necessary part in the history of the discipline. Secondly, a proposition must fulfil certain conditions in order to belong to a discipline. Foucault (1981a: 60-61) specifies three such conditions.

i. A proposition must refer to **a determinate range of objects**. This specified range of objects changes from one time period to another. For example, propositions regarding the symbolic value or the virtues and properties of plants, as were made during the sixteenth-century and antiquity respectively, were no longer considered 'botanical' in the eighteenth-century. From the end of the seventeenth-century propositions belonging to botany had to concern the visible structure of the plant or the working of its fluids. In the same way propositions that refer to the role of human consciousness in the cause (aetiology) and functioning (pathophysiology) of disease were excluded from the medical discourse of the nineteenth-century and onwards.
ii. A proposition must also use **conceptual tools of a specific type**. For instance, since the nineteenth-century propositions were no longer medical "if it used notions that were at the same time metaphorical, qualitative and substantial (like those of engorgement, of overheated liquids or of dried-out solids)". In fact, such notions acquired the status of an individual illusion or popular imagery. On the contrary, propositions belonging to medicine now had to use concepts that were similarly

[78] I substitute the phrase "a play of rules and definitions" in the original translation, with the corresponding phrase from Sheridan's (1980:126) translation: "a set of rules of definitions".

metaphorical but based on a different theoretical model, namely a physiological model, such as "irritation, inflammation or degeneration of tissues".

iii. Finally, a proposition must refer to **a specific body of theory** in order to belong to a particular discipline. Propositions connected to the humoral theory of disease were excluded from medicine at the end of the eighteenth-century, whereas propositions that refer to the theory of disease were accepted.

Each discipline can distinguish between true and false statements within its own limits. Before a statement can be judged as true or false it has to meet the complex and heavy criteria for inclusion in the discipline, it has to be regarded as being 'in the true'. Yet, a whole field of knowledge is expelled from its borders.

> It is always possible that one might speak the truth in the space of a wild exteriority, but one is 'in the true' only by obeying the rules of a discursive 'policing' which one has to reactivate in each of one's discourses (Foucault, 1981a:61).

Statements regarding the role of consciousness and the social environment in health and illness may be true, but are not 'in the true' of medical discourse. If human consciousness is to be introduced as an object in medical discourse, new conceptual instruments and theoretical foundations are needed.

The discipline is a principle that exercises control in the production of discourse. It determines boundaries for discourse through constant reactivation of the rules. We are used to view the development of a discipline as "so many infinite resources for the creation of discourses". This may be true, but the discipline is nevertheless a principle of constraint. It is very likely that we will be unable to appreciate its positive and multiplicatory role, if we do not also consider its restrictive and constraining function (Foucault, 1981a:59-61; Sheridan, 1980:126).

3.3.3 A rarefaction of the speaking subjects

Foucault (1981a:61-64) describes a third group of procedures that exercise control over discourses. These procedures determine the conditions in which discourses are applied and the rules for those that use a particular discourse, and are therefore rules that limit access to discourses. Put differently, Foucault (1981a:61, 64) is referring here to "a rarefaction of the speaking subjects"; procedures whereby discourse controls speaking subjects.

> None shall enter the order of discourse if he does not satisfy certain requirements or if he is not, from the outset, qualified to do so. To be more precise, not all the regions of discourse are equally open and penetrable; some of them are largely forbidden (they are differentiated and differentiating), while others seem to be almost open to all winds and put at the disposal of every speaking subject, without prior restrictions (Foucault, 1972:61-62).

The most obvious system of restriction can be referred to as **ritual**. Ritual determines the qualifications needed by the speaker; the gestures, behaviour, circumstances and the entire set of signs which have to accompany the discourse; and also the effectiveness of the words spoken, that is their effect on those to whom they are directed, and the limits of their ability to constrain. Medical, as well as religious, judicial and, to a great extent, political discourses cannot be dissociated from the framework of the ritual which determines the characteristics and roles of the speaking subjects.

There are also '**societies of discourse**' whose function it is to protect discourse by distributing it only according to strict rules so that the participants in the discourse are not dispossessed by its circulation. Within a society of discourse the roles of speaker and listener are not interchangeable. Only a limited group has access to the secret discourse, which they can display without revealing the secret. An example of a society of discourse is the castes of poets from archaic times. These groups of bards possessed the knowledge of the poetry to be recited, and they protected this knowledge, often with complex exercises of memory. One could only enter such a group after successfully completing a lengthy apprenticeship. Such closed societies hardly exist in our times. Yet, even if discourses are now communicated in more diffuse structures, these are nonetheless constraining. The way that medical discourse is distributed certainly suggests the notion of a society of discourse.

The final system of restriction of the speaking subjects described by Foucault (1981a:64) exists on a much broader scale. He talks about the cleavages in the **social appropriation of discourses**. Education may be the instrument that gives every individual, in a society similar to France in the late twentieth century, access to any type of discourse. But the distribution of education, that which it allows and that which it prevents, follows the path marked out by social differences, conflicts and struggles (Foucault, 1981a:64; Sheridan, 1980:127). "Any system of education is a political way of maintaining or modifying the appropriation of discourses, along with the knowledges and powers which they carry" (Foucault, 1981a:64).

Speech rituals, societies of discourse and social appropriations do not exist independently of each other. They are often connected to each other and form great edifices that make sure that speaking subjects are distributed into different forms of discourse and that discourses belong to certain groups of subjects.

Foucault (1981a: 64-65) proposes that certain themes in philosophy correspond with the processes of limitation and exclusion discussed above, that is the social and internal procedures of control and the procedures of subjection by discourse. Such philosophical themes correspond to these procedures by suggesting an ideal truth as the law that controls discourse and an immanent rationality as the principle that governs their expression. These philosophical themes also reinforce the systems of control and restriction by denying the specific reality of discourse. It seems to Foucault (1981a:65) that since antiquity Western thought has made sure that discourse occupies "the smallest possible space between thought and speech. Western thought seems to have made sure that the act of discourse should appear to be no more than a certain bridging (apport) between thinking and speaking". It thus seems that the reality of discourse has been elided between thought and speech in Western thought since the Sophists have been questioned. An example of a recent theme in philosophy which acts in this exclusionary manner is "the idea of the founding subject", as found in phenomenology[79]. This theme causes the material reality of discourse to be overlooked. The subject is given the task of bringing the otherwise empty forms of language to life through his/her utterances. (S)he intuitively understands the meaning that is deposited in empty things by moving through their density and inertia. "In his relation to meaning, the founding subject has at his disposal signs, marks, traces, letters. But he does not need to pass via the singular instance of discourse in order to manifest them" (Foucault, 1981a:65).

[79]Young (1981: 49) clarifies some of Foucault's references in *The Order of Discourse*, and specifies that "the idea of the founding subject" comes from phenomenology.

Foucault (1981a: 66) suggests three decisions or tasks that will enable us to break though the traditional conceptual barriers which place limits on what we can say and think. "We must call into question our will to truth, restore to discourse its character as an event, and finally throw off the sovereignty of the signifier". These tasks carry four specific methodological requirements for the study of discourse, namely

i. the principle of reversal,

ii. the principle of rarefaction,

iii. the principle of discontinuity and

iv. the rule of exteriority (Foucault, 1981a:67-68).

In the following section I shall describe these methodological principles.

3.4 Principles for the analysis of discourse

The four principles for the analysis of discourse can each be summarised by a single term, namely the event, the series, the regularity and the condition of possibility. Each of these terms is opposed to another term. The principle of reversal places the notion of the event in opposition to the notion of creation. The principle of discontinuity places the notion of series in opposition to the notion of unity, epoch or theme. The principle of specificity places the notion of regularity in opposition to the notion of originality. And, the principle of exteriority places the notion of the condition of possibility in opposition to the notion of signification (Foucault, 1981a:67). I shall now elaborate on these principles which regulate discourse analysis.

The **principle of reversal** means that which is traditionally regarded as the sources of discourse, such as the author, the discipline and the will to truth, must rather be recognised as performing a negative function of cutting-up (segmenting) and rarefying discourse (Foucault, 1981a:67; Sheridan, 1980:128).

Foucault wants us to treat discourses as sets of discursive events. But what is the philosophical or theoretical status of the notion of a discursive event? The event "is neither

substance nor accident, neither quality nor process; the event is not of the order of bodies". The event is not immaterial either, since it occurs in material elements. It is "produced as an effect of, and within, a dispersion of matter". The event thus has the paradoxical philosophical character of a "materialism of the incorporeal" (Foucault, 1981a:69; Sheridan, 1980:129).

Foucault (1981b:6) refers to this procedure of analysis as "eventalisation". He describes eventalisation firstly as "a breach of self-evidence". Eventalisation wants to show that it wasn't **necessary** for current practices to develop in the way they did. For instance, "it wasn't self-evident that the causes of illness were to be sought through the individual examination of bodies" (Foucault, 1981b:6). Eventalisation is a breach "of those self-evidences on which our knowledges, acquiescences and practices rest" (Foucault, 1981b:6). Additionally, the principle of eventalisation means that a multiplication of causes is produced and that the object of analysis (the event) is then analysed according to the various processes of which it is made up. This second feature of

> eventalisation means rediscovering the connections, encounters, supports, blockages, plays of forces, strategies and so on which at a given moment establish what subsequently counts as being self-evident, universal and necessary. In this sense one is indeed effecting a sort of multiplication or pluralisation of causes (Foucault, 1981b:6).

This method will allow the analyst to identify the material aspects that act "upon and within discourse" and will also make the links between discourse and the operation of power more visible. Analyses that practice the principle of reversal or eventalisation are politically and ontologically stronger than analyses which rely on traditional views regarding the source of discourse (Hook, 2001:531). When discourse is treated as an event it is approached as a practice, or as Hook (2001:532) puts it "as an active 'occurring', as something that implements power and action, and that also *is* power and action". Discourse can then be seen as more than the mere form and signs of language that represent a reality, and rather as reality itself. "We must conceive of discourse as a violence which we do to things, or in any case a practice which we impose on them" (Foucault, 1981a:67). Discourse thus "*is* the thing that is done" (Hook, 2001:531).

When the processes of rarefaction have been noticed through the principle of reversal, we must not assume that an abundance of uninterrupted discourses can be found beneath them.

This is where the other methodological principles must be introduced. The **principle of discontinuity** states that although processes exist which work to control and delimit discourse, it does not imply that

> beneath them or beyond them there reigns a vast unlimited discourse, continuous and silent…which we have the task of raising up by restoring the power of speech to it. We must not imagine that there is a great unsaid or unthought which runs throughout the world and intertwines with all its forms and all its events…Discourses must be treated as discontinuous practices, which cross each other, are sometimes juxtaposed with one another, but can just as well exclude or be unaware of each other (Foucault, 1981a:67).

Foucault's (1981a:67) denial of "a great unsaid or unthought" makes it clear that 'the ultimate truth' cannot be discovered and reinstated simply by pronouncing or thinking what has been excluded, pushed to the boundaries of the reasonable, or repressed by discourse and its systems of control. While Foucault wants to make the sources that are repressed and subjugated by the predominant discourse heard, he does not do so "under the auspices of confronting a great untruthfulness with the force of an indisputable truth" (Hook, 1981:536). He does not want to prove that other forms of knowledge have a greater or purer truth value than the reigning, supposedly true discourse. Rather, Foucault proposes that pointing out discontinuities between the leading discourse and "a strategically organised ensemble of historical knowledges" (Hook, 2001: 536) has a particular power to disrupt dominant discourses that are viewed as continuous, consistent, immobile and unified (Foucault, 1977c:147, as cited in Hook, 2001:534).

Foucault's (1981a:67) third methodological requirement is **the principle of specificity**. Foucault expresses this principle in the following passage:

> We must not resolve discourse into a play of pre-existing significations; we must not imagine that the world turns towards us a legible face which we would have only to decipher; the world is not the accomplice of our knowledge; there is no prediscursive providence which disposes the world in our favour. We must conceive discourse as a violence which we do to things, or in any case as a practice which we impose on them;

> and it is in this very practice that the events of discourse find the principle of their regularity[80].

In the quotation above Foucault refers to discourse as a practice. To "throw off the sovereignty of the signifier" (Foucault, 1981a:66) it is necessary that the analysis of discourse moves beyond textuality to include the physical effects of discourse and the "materiality of its practices" (Hook, 2001: 537). Hook (2001:537) provides the following helpful example: when the utterance by a medical professional that a particular person (patient) is a 'pervert'[81] is regarded as an action, a practice or an event, then the utterance seems to border on the terrain of materiality, and can more easily be connected to the collection of physical actions by means of which such a diagnosis may be arrived at in the first instance. When discourse analysts blur the division between the textual and the material (the discursive and the extra-discursive) with caution they can prevent an underestimation of the material effects of discourse, and the discursive effects of material.

Foucault's final principle for the analysis of discourse is **the principle of exteriority**. With this principle Foucault (1981a:67) argues that discourse analysis should not

> go from discourse towards its interior, hidden nucleus, towards the heart of a thought or a signification supposed to be manifested in it; but, on the basis of discourse itself, its appearance and its regularity, go towards its external conditions of possibility, towards what gives rise to the aleatory series of these events, and fixes its limits.

Usually a text or speech is analysed with a desire to move from the exterior to the interior in search of the intention or utterances of a founding, transcendental subjectivity (Sheridan, 1980:102) that initiated the utterance under analysis. Foucault refers to exteriority in a paradoxical way, since he denies its opposite form of interiority. He wants to recover the status of statements as events. Analysis should seize the irruption of statements in the place and moment of their exact occurrence (Foucault, 1972: 136-137).

Hook (2001:539) views critical readings, searching for meaning within texts, as inadequate for two reasons. The first problem is that of textual relativity which means that any textual interpretation that is reasonably argued for, is just as valid as any other such interpretation.

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[80] Merquior (1985:82-83) criticises Foucault for completely rejecting "so many established ways to knowledge" without offering much sound or solid in the way of an epistemology.

[81] In other words, the diagnosis of 'pervert' is uttered.

Mere textual analyses therefore have limited use outside the scope of the text in question. To increase its utility, it must be possible to validate the findings of discourse analysis against "certain stable reference points outside of the text". Examples of extra-textual dimensions against which the findings of discourse analysis can be corroborated are "space (geopolitics), time (history), architecture or material forms of practice". The second problem with analyses that focus only on discourse at the textual level, is that discourse is only approached as an effect of power, and not also as an instrument of power. Foucault views discourse as both an effect (the result) of power and an instrument (the means) of power and argues that analyses should treat discourse as both: "history constantly teaches us, discourse is not simply that which translates struggles or systems of domination, but it is the thing for which and by which there is a struggle, discourse is the power which is to be seized" (Foucault, 1981a:52-53).

The principle of exteriority places the notion of the condition of possibility in opposition to the notion of signification. Analysis should thus not only concern significations, but should pay attention to a variety of contingent circumstances, including material, institutional and historical circumstances, which allow certain statements, acts and subjects in specific settings. By paying attention to these conditions of possibility the analyst can identify the forms of support which create boundaries for the discourse under study and without which particular statements could not be uttered (Hook, 2001:540). Foucault (1972:32) wants discourse analysis to understand the relation between groups of statements and events with a very different nature, for instance events that are "technical, economic, social, political".

Foucault (1981a: 70-73) states that analyses according to these principles can be divided into two sets or groups, namely the critical set and the genealogical set. Critical analyses apply the principle of reversal by examining procedures of discursive control in terms of their effects and their method of operation. Analyses in the genealogical group apply the other three principles. Genealogical analyses are interested in examining the formation of discourses as influenced by systems of control (that is despite or with the support of systems of control) and the norms and contingent material conditions of their "appearance, growth and variation". Critical and genealogical analyses can never be completely separated from one another. The difference between these two sets of analyses is not so much related to their object or domain of interest, but rather to their relative perspectives and limits. The formation of a discourse can for example include procedures of control in the same way that systems of control can be formed within an established discursive formation.

This is an opportune moment to again clarify the goals of the current project, and I would like to start with what this dissertation does not aim to achieve. Firstly, I do not wish to give a description of the formation of medical discourse. Secondly, I do not wish to establish whether or to prove that the discourse of natural science influences medical discourse. Enough has been written from within and outside the borders of medicine to support the statement that medical discourse is fundamentally influenced by the ontology and epistemology of the natural sciences. In the first chapter I described the nature of the natural science paradigm and the implications of medicine's self-identification as a natural science. The aim of this dissertation is rather to investigate the **effects** of medical discourse, as it is influenced by the natural-sciences, on communication between doctors and patients. With this aim in mind, Foucault's work is valuable in a number of ways. To begin with, Foucault provides a conceptual framework and terminology according to which medical discourse, as a discursive formation with its objects, enunciative modalities, concepts and themes may be studied and understood. Furthermore, Foucault illustrates the factors that are related to the various elements of discourse. Secondly, Foucault's work on the procedures that control and restrict discourse provides a way of understanding and explaining why everything that can be said about sickness and health is not included in medical discourse. It also draws attention to the restrictions on how and by whom medical discourse may be used. Thirdly, Foucault's principles for the analysis of discourse enable one to recognise the specific reality of discourse. Medical discourse is thus not merely the representation of natural and empirical facts by means of language. Medical discourse is a discursive practice that is influenced by power relations and which also brings about effects of power. Up until now power as an element of discourse has only been hinted at. The next section will describe Foucault's view on the nature of power and the relationship between power and discourse.

3.5 Discourse and power

Foucault is credited as the first thinker who introduced the issue of power to the study of discourse at a time when discourse analysis was predominantly concerned with the analysis of texts[82]. In the following section I shall discuss Foucault's view of power and the relationship between discourse, or rather knowledge and truth, and power. I use the subheadings of Foucault's essay titled *The Subject and Power* (1984) to structure my writing.

3.5.1 Why study power

Foucault (1982:208) states that the goal of his work has never been to analyse the phenomenon of power. The general theme of his research was rather the subject. He studied the various methods of objectification that have turned individuals into subjects in the western world. Foucault (1982:209) became aware that humans are placed in complex relationships of power and that no tools for the study of power relations existed. With 'relationships of power', Foucault (1987:11) means the human "relationships in which one wishes to direct the behaviour of another". The only ways of thinking about power was in relation to the law or the state. In other words, it was only questions such as "what legitimises power?" and "what is the state?" that were asked in order to understand power. Foucault (1982:210-211) suggests that "in order to understand what power relations are about, perhaps we should investigate the forms of resistance and attempts made to dissociate these relations". Examples of oppositions to power that have developed in recent years are the oppositions to the power which men exercise over women, parents over their children, psychiatry over those with mental illness, medicine over the population, health professionals over people with disabilities and state governments over the way that citizens lead their lives. The main objective of all of these different struggles is to attack a specific technique or form of power, rather than to attack a specific institution, or group, or social class. The form of power that is resisted is the power that transforms individuals into subjects.

> This form of power applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity,

[82] Alessandra Fontana and Pasquale Pasquino make this statement in a question addressed to Foucault for the interview entitled Truth and Power (1984:57).

> imposes a law of truth on him which he must recognise and which others have to recognise in him (Foucault, 1982:212).

The word *subject* has two meanings. One may be "subject to someone else by control and dependence" or tied to one's own identity "by a conscience or self-knowledge". In both cases a type of power is implied which "subjugates and makes subject to". The struggles mentioned above are thus "struggles against subjection, against forms of subjectivity and submission" (Foucault, 1982:212).

Foucault (1982:216) talks about "universal philosophy" to characterise the work of thinkers like Descartes who asked questions such as "Who am I?" The *I* in this question is unique, but is also a universal and unhistorical subject. The *I* for Descartes may be everyone, in any location and at any moment in history. Foucault (1982:216) contrasts this universal intent with the work of thinkers like Kant, Hegel and Nietzsche who asked "What are we? In a precise moment of history". This latter form of philosophy which takes on the task of critically analysing the world that we presently live in, has become more and more important. Foucault (1982:216) suggests that the aim of contemporary philosophy should be "to refuse what we are", and not only "to discover what we are". What he means is that "we have to imagine and to build up what we could be" in order to free ourselves from the subjection of modern power structures.

Foucault (1976:95-96) wants to study and expose domination. By domination he does not mean the strong and broad type of domination that one person or one group exercises over others. He refers to the many forms of domination that are possible in society. "Not the domination of the King in his central position, therefore, but that of his subjects in their mutual relations". To achieve this Foucault refrains from studying the mechanisms and effects of the controlled and legal forms of power in their focal locations. He rather pays attention and tries to locate power as it is exercised at its periphery, "its ultimate destinations…where it becomes capillary, that is, in its more regional and local forms and institutions…where it is always less legal in character". It is here that power overcomes and extends itself beyond the rules of the law which organise and place limits on it, and "invests itself in institutions, becomes embodied in techniques, and equips itself with instruments and eventually even violent means of material intervention".

Foucault (1976:97) also refrains from conducting an internal analysis of power, at the level of the conscious intention or choice of a subject. His advice is to avoid the complex and unanswerable questions such as 'who has power?'; 'why does (s)he want to dominate?'; 'what do they seek, and by what strategy?'. The external face of power should rather be studied where it stands in a direct and immediate relationship with "its object, its target, its field of application…where it installs itself and produces real effects". We must explore how power operates at the level of continuous subjugation, the level at which on-going and uninterrupted processes subject bodies, dictate behaviours, govern gestures, and so forth. We must question how subjects are "gradually, progressively, really and materially constituted" as a consequence of the effects of power. In short, "we should try to grasp subjection in its material instance as a constitution of subjects".

Power relations thus exist beyond the limits of the state. Although the state's apparatuses are omnipotent, it cannot occupy the entire domain of actual power relations. Furthermore, the state functions on the basis of a range of pre-existing power relations. The state is a superstructure based on a series of power networks regarding for example, "the body, sexuality, the family, kinship, knowledge, technology" (Foucault, 1984:64).

3.5.2 How is power exercised?

When Foucault (1982:217) asks the question "how is power exercised?" he does not mean "*how*" in the sense of the effects of power, as in the question "how does power manifest itself?" He wants to know "by what means is power exercised" and "what happens when individuals exert power over others?" To answer this question it is first necessary to draw a distinction between power relations and two other types of relationship. First there is the power that is exerted over things and that makes it possible to "modify, use, consume, or destroy them". This power stems from aptitudes immediately intrinsic to the body or passed on by external instruments. It may be called a "question of capacity". Conversely, power is also characterised as an influence on the relationships between individuals or groups of individuals. Power relations should also be distinguished from relationships of communication. Relationships of communication transfer information through symbolic systems, such as a language or another system of signs. Although communication is always a particular way of acting upon other individual(s) and may have an objective or consequence(s) related to power, communication is not a particular feature of power.

"Whether or not they pass through systems of communication, power relations have a specific nature" (Foucault, 1982:217).

These three types of relationship, namely relations of power, relationships of communication and "objective capacities" should not be thought of as three separate domains. These relationships "always overlap one another, support one another reciprocally, and use each other mutually as means to an end". Naturally, the interaction between these three forms of relationships varies and is irregular. No general form of equilibrium exists between completed activities, communication systems and relations of power in any society. Yet, one comes across "blocks" in which the three types of relationships "constitute regulated and concerted systems". One may speak of a "capacity-communication-power" blocks. By enlarging the meaning of the word slightly, these blocks may be referred to as disciplines. In disciplines the three relationships are adjusted to each other according to carefully thought-out formulae (Foucault, 1982:218-219). The hospital, for instance makes up a "capacity-communication-power" block through the way that its space is used, the rules that govern its inner life, the various activities which are arranged there, the diverse individuals who exist there and interact with one another, each of whom performs a particular role and possesses a well-defined character. The activity which ensures treatment of diseases is developed there through a whole collection of regulated communications (such as health professional-patient consultations, communication between health professionals from similar and different disciplines, signs that indicate treatment outcomes and adherence to treatment, labels that distinguish patients according to the type and severity of disease and treatment, signs which differentiate health professionals based on their role and position in the institution) and through a chain of power processes (such as enclosure, surveillance and the pyramid-shaped hierarchy)[83].

Disciplines thus illustrate how systems of objective capacity, communication and power may be welded together. They also show different models for the expression of these relationships. In some disciplines the completion of activities are the most important feature (such as in hospitals), in others relationships of communication are the most important (as is the case in disciplines of apprenticeship), where power relations are given pre-eminence in disciplines with a monastic or penitential character. Some disciplines emphasise all three

[83] I've adjusted Foucault's (1982:218-219) example of the educational institution as a "capacity-communication-power" block, to illustrate how the hospital constitutes such a block, as medical institutions are directly relevant to the subject of this dissertation.

types of relationship, such as the military discipline "where a plethora of signs indicates, to the point of redundancy, tightly knit power relations calculated with care to produce a certain number of technical effects" (Foucault, 1982:219).

3.5.3 What constitutes the nature of power?

Studies of power in the 1960s described power in terms of prohibition and repression. When power is defined as repression it is seen in a purely juridical manner. Power is identified with a law that forbids, as something that prevents individuals from doing certain things. From this narrow perspective power is seen as something bad that can only have a negative function. Foucault has a much more complex view of power. Studies of power must not make an *a priori* connection between power and repression (Foucault, 1984: 60-61; Foucault, 1978:102). The notion of repression does not capture the productive feature of power (Foucault, 1984:60).

> If power were never anything but repressive, if it never did anything but say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms of knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression (Foucault, 1984:61).

Foucault's conception of power also breaks with previous conceptions of power in that Foucault does not view power as a possession (Sheridan, 1980:218). Foucault (1976:98) advises that power should not be seen as something that belongs to one person or one group who then exercises that power over others. For Foucault power is a result of the working of relationships between social groups and between individuals (Sheridan, 1980:218). Sheridan (1980:218) explains this aspect of Foucault's notion of power:

> [Power] is not unitary; it has no essence. There are as many forms of power as there are types of relationship. Every group and every individual exercises power and is subjected to it. There are certain categories of person – children, prisoners, the 'insane' – whose ability to exercise power is severely limited, but few members of these groups do not find some means of exercising power, if only on each other.

Foucault (1976:98) views power "as something which circulates, or rather as something which only functions in the form of a chain". Power is never in a specific location, never anybody's instrument or possession. Power establishes a net-like organisation through which it is freely circulated and exercised. Individuals not only circulate between the threads of this net, they are also always in the position of concurrently undergoing and exercising this power. Ells (2003:215) expresses this idea neatly with the statement that Foucault conceptualises people as "both subject *to* power and subjects *of* power". Individuals must not be thought of as the numerous and passive adhesive material for power, or the surface against which power strikes and as a consequence crushes or brings individuals under its control. It is rather the case that power constitutes individuals who then act as the elements of its articulation. One of power's main effects is that "certain bodies, certain gestures, certain discourses, certain desires, come to be constituted as individuals…The individual which power has constituted is at the same time its vehicle.. Individuals are the vehicles of power, not its points of application" (Foucault, 1976:98).

Foucault does not view people as "individuals", in the sense that the word is used in the current liberal understanding of persons. The liberal view holds that people are discrete entities capable of making autonomous decisions according to abstract rules or principles. It is assumed that all people are similarly situated. Foucault's description of people differs sharply from the liberal view. He views people as living bodies who are entangled in a matrix of power relations. These relationships are not only with other individual persons, but also with institutions. Foucault acknowledges that differences exist between people and that people are influenced and controlled by various social institutions, for instance race, class and gender. A person, or what Foucault refers to as a subject, is fundamentally influenced by a particular network of power relations. Foucault thus views a person's identity and interests as socially constructed according to the person's position within the power network (Ells, 2003: 218-225). In his view a person, or the self, "*can only* be a subject; selfhood does not exist outside of being subjected". For Foucault consciousness does not exist outside of social systems that unavoidably subject. "There is no self without being a subject, and no being a subject without being subjected" (Frank & Jones, 2003:183). Yet, the Foucauldian subject is not merely shaped by the power matrix, (s)he also shapes the power network in at least some respects (Ells, 2003:225).

Two important notions regarding Foucault's conception of power are illustrated in the paragraphs above. The first is that power relations are dispersed throughout the entire social

body. Power relations are thus not only located in specific institutions, such as the central government of a nation (Mills, 2003:35). Since the power relations that operate on people are so diffuse and ensnare people, their effect may not be noticed (Ells, 2003:215, 218). Secondly, power is envisaged as a productive force. It does not only restrict, but it opens up a range of possible behaviour and attitudes. Importantly, power produces knowledge and discourse. Foucault (1980:52) argues that modern humanism mistakenly views knowledge and power as independent of each other. Instead "knowledge and power are integrated with one another". When power is exercised knowledge is continuously created, and in contrast knowledge constantly causes power effects. The effects of power that are connected to knowledge are "diffused, entrenched and dangerous" and operate throughout society. Foucault (1980:52) argues that it is pointless to dream about a point in time when knowledge will be independent of power.

> It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power. 'Liberate scientific research from the demands of monopoly capitalism': may be a good slogan, but it will never be more than a slogan.

Mills (2003:69-70) suggests that to illustrate the relationship between power and knowledge one may think about the wealth of information and investigations regarding groups that are politically and economically marginalised in Western societies, compared to information about more privileged groups. For instance, many books and scientific studies exist on the subject of women, homosexuality, non-white races and the working class, whereas relatively little information can be found in libraries and scientific databases regarding men, heterosexuality, whites and the middle class. Knowledge about disadvantaged groups may work in complex ways to maintain the existing distribution of power. Similarly knowledge produced by disadvantaged groups themselves, may be a very powerful tool for change of the status quo.

It is also important to recognise the relationship between power and truth. Power relations cannot be formed, strengthened or implemented without discourses of truth which work through and on the basis of their association with the exercise of power. "We are subjected to the production of truth through power and we cannot exercise power except through the production of truth" (Foucault, 1976:93). In societies with capitalist economies and democratic governments the highly specific organisation of the relationship between power and truth is such that individuals *must* speak and discover the truth that society demands and

needs in order to function. Power institutionalises, professionalises and rewards the pursuit of truth.

> In the last analysis, we must produce truth as we must produce wealth, indeed we must produce truth in order to produce wealth in the first place…In the end we are judged, condemned, classified, determined in our undertakings, destined to a certain mode of living or dying, as a function of the true discourses which are the bearers of specific effects of power (Foucault, 1976:94).

Foucault's thesis that power produces knowledge is contrary to the accepted idea that "an almost uncrossable line" exists between knowledge, regarded as the domain of truth and liberty, and the domain where power is exercised. Foucault's understanding of power "deprives knowledge of its apparent objectivity. It denounces the illusion of truth. Knowledge is not so much true or false as legitimate or illegitimate for a particular set of power relations" (Sheridan, 1980:220). For Foucault (1978:106) the development of the human sciences cannot be separated from the exercise of power. The fact that societies or human behaviour became objects of scientific study is closely connected to mechanisms of power. In psychology for instance human behaviour became a problem to analyse and resolve.

The institutions and organised activities which accompany scientific discourses possess power. This power has certain effects. Science exercises power in that it literally forces one to make particular statements in order to escape disqualification for being wrong or for being a charlatan (Foucault, 1978:106-107). A "scientific hierarchisation of knowledges" seems to exist which disqualifies certain types of knowledges. A set of *subjugated knowledges* exist that rank low on the hierarchy and are unqualified and disqualified because they do not have the sufficient level of scientificity. An example is the voices of the patient, nurse and doctor that are parallel and marginal to the powerful voice of medical knowledge. Subjects of knowledge and experience are thus seen as unimportant in scientific discourses. These low-ranking discourses involve a popular knowledge, not in the sense of general common-sense knowledge, but knowledges that are local, regional, differential and incapable of unanimity (Foucault, 1976: 82-85).

Truth is thus also a form of power. "Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its 'general politics' of truth". A society's regime of truth includes the types of discourse that are accepted and made to function as true; the mechanisms that are used to differentiate between true and false statements; the techniques and procedures that are regarded as valuable in gaining truth as well as the status of those who are given the responsibility to say what is accepted as true (Foucault, 1984:72-73). Foucault (1984:74) states that "there is a battle 'for truth' ". Truth here does not mean "the ensemble of truths which are to be discovered and accepted", but rather, "the ensemble of rules according to which the true and the false are separated and specific effects of power attached to the true". It is also "not a battle 'on behalf' of the truth, but a battle about the status of the truth and the economic and political role it plays". Foucault (1984:74; 1976:93) suggests that a circular relationship exists between power and truth. Systems of power produce, transmit and sustain truth and the effects of truth, which in their turn produce and extend the effects of power.

Foucault (1982:219-220) argues that power is "a set of actions upon other actions". "The exercise of power is not simply a relationship between partners, individual or collective; it is a way in which certain actions modify others". Power, in the sense of a noun, does not exist. There is not something called power or Power that exists universally in a condensed or diluted form. "Power exists only when it is put in action" (Foucault, 1982:219). Power is thus a verb and not a noun. Power is "something that does something, rather than something which is or which can be held onto" (Mills, 2003:35).

Power must be differentiated from consent and violence. Although consent may be an instrument or an effect of power, power "is not by nature the manifestation of a consensus". Power differs from violence in the sense that violence is exercised upon a body or things. Power is not directly and immediately exercised on others; instead it is exercised upon their actions: "an action upon an action, on existing actions or on those which may arise in the present or the future" (Foucault, 1982:220). Another difference between violence and power is that violence has passivity as its opposite pole. When violence is met with resistance its only option is to attempt to minimise it. In contrast, a power relationship is dependent on two elements in order to exist. The first indispensable element of a power relationship is that "'the other' (the one over whom power is exercised) be thoroughly recognized and

maintained to the very end as a person who acts". The second necessary element for the expression of a power relationship is that "faced with a relationship of power, a whole field of responses, reactions, results, and possible interventions may open up". It is in this sense that power is productive and not only repressive and negative. Similar to consent, violence may be an instrument or result of power, yet it does not constitute the basic nature of power.

> The exercise of power can produce as much acceptance as may be wished for: it can pile up the dead and shelter itself behind whatever threats it can imagine. In itself the exercise of power is not violence; nor is it a consent…It is a total structure of actions brought to bear upon possible actions: it incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely; it is nevertheless always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action. A set of actions upon actions (Foucault, 1982:220).

The exercise of power is thus to structure the potential field of action of other individuals. The element of freedom is included in this definition. "Power is exercised only over free subjects, and only insofar as they are free". Free subjects are individuals or groups of subjects who have a field of options open to them from which various forms of behaviour and reaction may be accomplished. Where no freedom exists, as in the case of slavery, a physical relationship of constraint exists, rather than a power relationship. Power and freedom are thus not mutually exclusive, but have a much more complicated relationship. Freedom is the precondition and the condition for the exercise of power. Power can only be exercised where freedom exists, and freedom is also power's constant support, as power would amount to physical determination without the possibility of resistance. "At the very heart of the power relationship, and constantly provoking it, are the recalcitrance of the will and the intransigence of freedom. Rather than thinking of freedom as essential for the exercise of power, one should think of the relationship between power and freedom as reciprocal incitation and struggle; "less of a face-to-face confrontation which paralyzes both sides than a permanent provocation" (Foucault, 1982:221-222)[84].

[84] Foucault (1982:222) refers to this relationship with a neologism, namely "agonism". The translator's note on this term states that the neologism is based on a Greek word that means combat. The translator writes that "the term would hence imply a physical contest in which the opponents develop a strategy of reaction and of mutual taunting, as in a wrestling match".

3.6 Conclusion

In this chapter I provided a relatively detailed account of Michel Foucault's work on discourse. I also explained towards which end I will use these theoretical ideas. Foucault's work on discourse makes us aware that discourse does not merely represent the social order but rather forms an essential part of the social order (Kuipers, 1989:103). Foucault's conception of discourse as a configuration of knowledge, power and truth (Mills, 1997:17) makes powerful analyses and critiques of systems of power, such as modern medicine, possible. However, for some scholars Foucault's very abstract understanding of discourse is too remote from the "real world" (Kuipers, 1989:112). His notion of discourse is removed from the particular context(s) wherein it appears and where power is exercised[85]. Foucault's ambiguous conception of discourse makes it very difficult for (empirical) researchers to link linguistic forms with their social functions in real life encounters (Kuipers, 1989:105-106).

The abstract nature of Foucault's theorising about discourse is very suitable for the purpose of my general philosophical enquiry. I do not want to analyse a sample of particular doctor-patient interactions. My aim is rather to broadly investigate the influence of modern medicine's intellectual self-image on communication between doctors and patients. Foucault's understanding of discourses as regulated practices is very valuable to my project. I want to investigate how the positivist worldview regulates medical discourse and by what procedures this discourse is controlled. I perform these analytical tasks in Chapter 6. In Chapter 7 I shall critique the appropriateness of modern medicine's scientific self-image. However, before I apply Foucault's (and Habermas') ideas, I shall describe doctor-patient communication in the next chapter.

[85] Foucault's abstract notion of discourse stands in stark contrast to the approaches to discourse within the fields of linguistics and sociology that radically ground discourse "in its context of interaction". Scholars from these fields often study discourse by analysing transcripts of real life interactions in much detail (Kuipers, 1989:106). I described such types of research in the Introduction of this dissertation.

Chapter 4

Doctor-patient communication

"…perhaps the story you finish is never the one you begin"

Salman Rushdie (1991:491)

4.1 Introduction

Chapter 4 is devoted to a description of doctor-patient communication based on the praxis and discourse literature on this subject. The aim of this dissertation is to examine the influence of medicine's self-understanding as a natural science on the nature of communication between doctors and patients. In chapter 1 I described the nature of medicine's intellectual self-image. In chapter 2 I described Jürgen Habermas' research on Universal Pragmatics. Following the current chapter which describes doctor-patient communication, I shall attempt to analyse this form of communication with the help of Habermas' universal pragmatics.

Ainsworth-Vaughn (2003:453) divides the literature on doctor-patient encounters into two separate categories which she terms "praxis literature" and "discourse literature". In this chapter I shall first describe the praxis literature and thereafter the discourse literature. Praxis literature represents the majority of research on doctor-patient interaction. The research studies that form praxis literature are mostly directed towards medical praxis or the consultation process and focus on the structure of the consultation "from greeting to closure" and describe and measure concepts such as patient and doctor centeredness (Elwyn & Gwyn, 2006:186). The praxis literature is atheoretical about language and thus regards language as merely expressive, as a transparent vehicle of meaning and communication. Tanenbaum (1998:207) refers to praxis literature as "positivist social-psychological literature". Discourse literature refers to research that is interested in the "analysis of talk itself" as informed by theories of discourse (Ainsworth-Vaughn, 2003:453). The term 'discourse' indicates a critical view of language. The structuralist and post-structuralist view of language as a system "with its own rules and constraints, and with its own determining effect on the way that individuals think and express themselves" is adopted in discourse literature of clinical communication (Mills, 1997:8). Discourse literature is generated from the perspective of "qualitative social science and literary studies" (Tanenbaum, 1998:207).

4.2 A description of the praxis literature on doctor-patient communication

Scholars working in different intellectual traditions repeatedly comment on the importance of communication in the practice of medicine (Tanenbaum, 1998:207). Sandra J. Tanenbaum (1998:207) who conducts research on health services management and policy writes that despite the strong technological nature of contemporary health care, the "basic unit" of clinical medicine remains one doctor and one patient talking to each other. According to Mishler (1984:5, 12), a respected psychiatrist and qualitative researcher at the Harvard Medical School, the talk between doctors and patients forms a significant component of the daily practice of clinical medicine and is central to the work of clinical medicine. In their review of the praxis literature on doctor-patient communication, Ong *et al*. (1995:903) write that communication can be viewed as the main ingredient of clinical medicine (Ong *et al*., 1995:903).

Modern medicine is a diverse discipline with many branches, such as family medicine, internal medicine, surgery, paediatrics *etcetera*. Pellegrino and Thomasma (1982:62-64) suggest that the feature common to all the branches of medicine is the clinical event. The authors regard the clinical event as **the medical** event, and suggest that this event is produced by clinical interaction. They support the latter idea with the following comments. The goal of modern medicine is to restore patients to well-being. A large body of evidence exists which indicates that health and disease, the central concepts of medicine, are not merely defined in terms of the state of organ systems, but that the concepts are also evaluative, that is, the values of patients, societies and cultures are included in their meanings. Therefore the clinical relationship must be taken into consideration in any attempt to understand modern medicine. The healing relationship into which the doctor and patient jointly enter provides the moral nature of modern medicine. The healing relationship is also the source from which doctors and patients derive rights, obligations, privileges and other forms of societal approval. Pure scientists, such as physicists, chemists and biologists do not have the same duties and rights.

Effective communication is vital for the delivery of quality patient care. Not only does effective communication between doctors and patients make the benefits of medical advances available to patients, but it provides a sense of professional satisfaction to the doctor. Effective or adequate doctor-patient communication includes a variety of components, such as the disclosure of medical and social information by patients, the development of doctor-patient relationships characterised by mutuality and comfort, shared decision-making, provision of medical information that patients can understand and responsiveness by doctors to patients' requests for information. Yet it is well-known that effective communication is challenged by "the intrusion of business into the patient-doctor relationship, the pressures of limited time for office visits, the culture of medicalization, and the sometimes all-consuming focus on technology" (Teutsch, 2003:1115-1116). This dissertation investigates the effect of medicine's understanding of itself as an alleged natural science on doctor-patient communication.

Communication between doctors and patients has been studied with increasing frequency over the past 40 years[86], resulting in a vast body of research belonging mostly to the category of praxis literature. The growth of this research field can be attributed to at least two factors. Firstly, the development of technology, particularly the videotape, which made observation of doctor-patient encounters easier and more valid and reliable and which therefore has increased the quality of empirical research in this field[87] (Roter *et al.*, 1988: 99-100; Kurtz, 2002:S24). The second factor that is related to the growing research interest in doctor-patient encounters is the shift in attention that occurred during the past four decades from biomedicine to humanistic medicine (Ong *et al.*, 1995:12). Unfortunately, the immense body of praxis literature does not constitute a coherent whole. Researchers who study the communication behaviour of doctors and patients during clinical encounters according to the

[86] A search on 11 February 2013 of the Scopus (online) database based on the keywords "doctor-patient communication" delivered a total of 20007 (twenty thousand and seven) results of which 13261 were original research articles, 2761 were review articles, 797 were letters, 598 were short surveys, 550 were conference papers and 26 results referred to articles in press (the remainder of the results belonged to the following document types with the number of results per document type indicated between square brackets: editorials [895], notes [836], and erratum [1]). This impressive body of research grew exponentially over time with less than 500 studies published per annum in the period between 1965 and 1996; more than 500 studies published per annum between 1997 and 2002, and more than a 1000 reports published per annum between 2003 and 2012 (with the exception of the year 2010 in which 986 documents on the subject were published in scholarly journals).

[87] Studies that aim to describe the communication behaviour of doctors and patients during clinical encounters through observation generally make use of tape-recordings, video-recordings or direct observation by a researcher physically present in the consultation. Researchers analyse the written transcriptions of the observed interactions according to a particular interaction analysis system (IAS).

praxis literature tradition "are relatively unencumbered by broadly accepted theoretical models or methods" (Roter *et al.*, 1988:111). The published research studies in this field focus on a wide variety of aspects related to the doctor-patient relationship and a broad range of (often self-invented) tools are used to analyse doctor-patient interactions. Furthermore, the doctor-patient relationship has many facets and dimensions and is considered to be one the most complex forms of human interaction. The factors mentioned above result in a body of knowledge that is poorly integrated and fragmented (Roter *et al.*, 1988:111; Ong *et al.*, 1995:912). A systematic theory explaining the nature of doctor-patient communication has not been developed yet (Ong *et al.*, 1995:915).

Due to the diversity and size of the praxis literature on doctor-patient communication the best way to describe what is known about the behaviour of doctors and patients during clinical encounters may thus be to refer to review articles in this field. In the discussion which follows I will mostly rely on the reviews by the following authors: Roter *et al.*, (1988); Ong *et al.* (1995); Willems *et al.* (2005) and Schouten & Meeuwesen (2006). It must be noted that only studies published in English-language books or journals were included in these reviews.

In their review of the research on doctor-patient communication, Ong *et al*. (1995:903-905) draw the conclusion that doctor-patient communication serves three purposes, namely to create a good inter-personal relationship, to exchange information and to make decisions about the treatment of the patient's disease. **Information exchange** is one of the most researched aspects of doctor-patient communication (Ong *et al.*, 1995:906). Despite the availability of sophisticated technology to assist in medical diagnosis and treatment, the primary means of information exchange between doctors and patients remains talking (Street, 1991:541). Erzinger (1991:95) suggests that doctors and patients each have certain communicative tasks to fulfil during clinical communication. Patients need to describe their concerns, clarify the information expressed to the doctor, obtain adequate explanations and develop a personal relationship with the doctor. Doctors' communicative tasks are to explore the patient's symptoms, to interpret and to provide feedback regarding follow-up information in the patient's medical record, to adequately explain information to patients (using repetition as necessary), to give them advice and finally to understand the patient on a personal level. The overall success of a clinical interaction is determined by the manner in which the doctor and patient assist each other in the completion of their respective communicative tasks. Information-giving and information-seeking underlie the communicative tasks of both partners in clinical interactions. Ong *et al*. (1995:904) describe information exchange during

clinical encounters in terms of needs. Doctors need information to arrive at the correct diagnosis and an appropriate treatment plan. Patients have to fulfil two needs during communication with a doctor, namely 'to know and understand' (for instance what is wrong with his/her body) and 'to feel known and understood' (to know that (s)he is accepted and taken seriously by the doctor). Doctors' and patients' needs can only be adequately addressed when both parties alternate between information-giving and information-receiving. However, information exchange between doctors and patients during clinical encounters is often fraught with difficulty (Street, 1991:541). Research indicates that in almost all circumstances patients desire as much information as possible from their physicians, yet doctors appear to underestimate patients' need for information. Kurtz *et al*. (2005:15) cite two research studies which claim that doctors overestimate the amount of time that they spend on explanation and planning in the consultation by as much as 900%. Advocates of the patient-centred approach to clinical communication encourage doctors to elicit patients' views of their illness as well as their feelings and expectations related to the disease in order to accomplish effective exchange of information (Ong *et al*., 1995:904-905).

Medical decision-making is another very important purpose of doctor-patient communication. Whereas paternalism was traditionally regarded as the ideal model for the doctor-patient relationship, shared decision-making by doctors and patients regarding the patient's medical care has been the goal for the last 30 years. In order to make decisions about their health care, patients need information from their doctors (Ong *et al.*, 1995:905). As public expectations regarding access to medical information increase, the doctor's role shifts from "keeper of information to interpreter and integrator of information for patients" (Teutsch, 2003:1116).

Roter *et al*. (1988) and Ong *et al*. (1995) also discuss the empirical research on doctor-patient communication by referring to the specific **communication behaviours** that are reported in the praxis literature. Roter *et al.*. (1988:101-102) grouped the aspects of doctor-patient communication that researchers study most frequently into six categories. These categories are:

i. information-giving, which implies offering any material which might promote understanding and knowledge;

ii. information-seeking, which refers to all requests for information, clarification or greater understanding;

iii. social talk, which refers to all varieties of non-medical and social communication, such as greetings and casual conversation;

iv. positive talk, which includes all conversations with a positive affective tone or intention;

v. negative talk, which includes all conversations with a negative affective tone or intention;

vi. partnership-building, which includes two types of exchanges namely exchanges in which the doctor facilitates participation by the patient, and exchanges which indicate the role of the doctor as interpreter and synthesizer, such as when the doctor reflects on the patient's message. Although it is possible to think of communication behaviours by patients which may fit the category of partnership-building, researchers have only studied this variable in relation to the communication behaviour of doctors.

The average length of medical consultations is estimated as 12.35 minutes when practice characteristics such as whether the consultation took place in a private versus public health care setting, have been taken into account. Furthermore, it is estimated that on average doctors' contribution to the speech of the consultation is 60% while patients contribute an average of 40% to the consultation. It is not clear from the research whether the amount that each partner contributes to the talk of the conversation is uniformly spread across the different phases of the interaction or whether one partner dominates during a specific phase of the consultation (for instance during history taking or during the closing segment) (Roter *et al.*, 1988:108; Ong *et al.*, 906). Roter *et al.* (1988:108-109) provide profiles of doctor and patient interaction which indicate the frequency of the various types of communication behaviour in

doctors' and patients' conversation. The median percentages[88] that doctors spend on the different communication behaviours during a consultation are as follows: information giving, 38.5%; information seeking, 22.5%; positive talk, 14.5%; partnership building, 10%; social conversation, 5% and negative talk, 1%. The median percentages for patients are as follows: information giving, 54%; question asking, 6%; positive talk, 20.5%; social conversation, 7% and negative talk, 7%. These results are summarised in Figure 4.1 below.

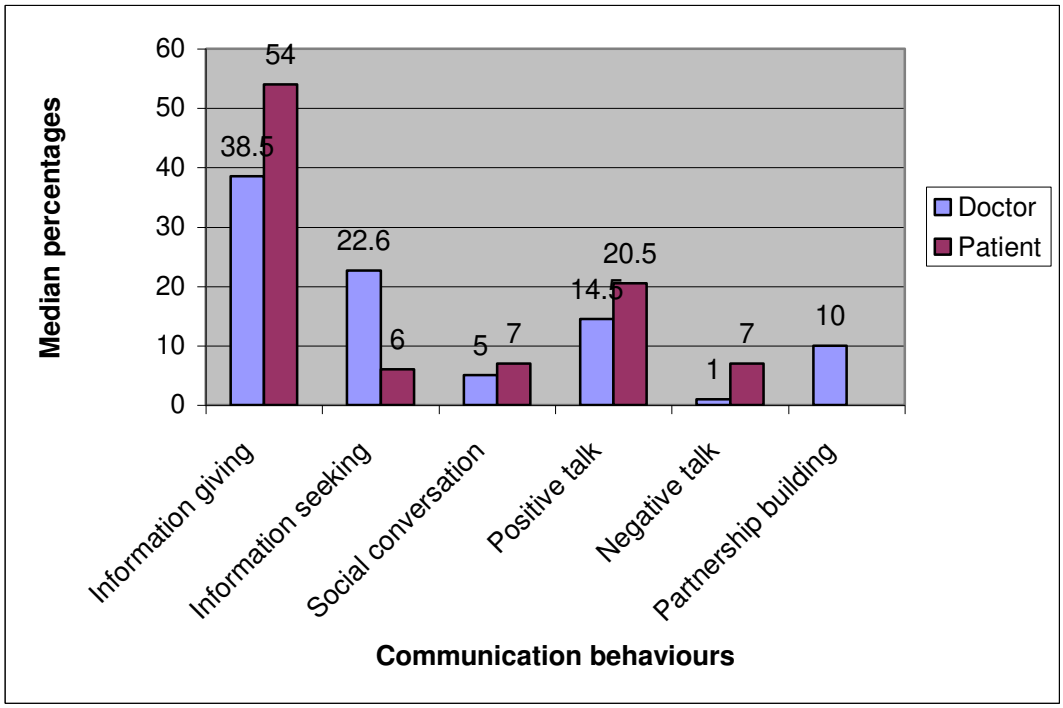

Figure 4.1: A comparison between doctors' and patients' interaction profiles (adapted from Roter *et al*. [1988:108-109])

It is clear that doctors' and patients' interaction profiles differ from each other. Utterances that aim to elicit information from the conversational partner are much more frequent among doctors than patients. It is also clear that patients perform more information-giving behaviours during clinical encounters compared to doctors. Research studies across various cultural groups found that doctor-patient encounters are often extremely asymmetrical

[88] The median is a value that indicates an average. Specifically it refers to the middle point in a distribution of data values. It is also known as the 50th percentile, meaning that it is the point "at which half the cases are above it and half the cases are below it" (Neuman, 1997:299-300). If doctors spend a median percentage of 38.5 of their time during communication with patients on information seeking, it means that 50% of doctors spend more than 38.5% of their time on information seeking and 50% of doctors spend less than 38.5% of their time on information seeking.

interviews which are primarily made up of questions by doctors and responses from patients (Ainsworth-Vaughn, 1998:6-7). Various research studies have found that patients are reluctant to pose questions to doctors during consultations (Ong *et al.*, 1995:908). Street (1991:541,546) found that the amount of information that patients receive from their doctors is influenced by the patients' communicative styles (that is the nature of their question-asking, opinion-giving and expression of concern) as well as their personal and social characteristics (that is age, gender, levels of education and anxiety). Roter *et al.* (1988:109,112) performed a comparison between empirical studies on doctor-patient communication as part of their description of this literature. They found that white patients received more information and positive talk and less questions during consultations compared to non-white patients. The authors comment that it is possible that the differences in doctor-patient communication as a function of patients' race may reflect differences in communication between doctors and patients from different socio-economic groups. Studies have found that working-class patients ask fewer questions to and receive less information from doctors compared to middle-class patients. I shall later discuss in more detail the influence of patients' socio-economic and cultural backgrounds on their communication with doctors.

Roter *et al.* (1988:109-112) found no difference in visit length among patients from different race groups. Visit length was however associated with the doctor's experience and the health care setting in which the communication took place. Doctors with more experience conducted shorter consultations than doctors in training. In private health care settings consultations were shorter and doctors sought less information and made fewer partnership-building statements, compared to consultations in public health care settings. Roter *et al.* (1988:112) argue that these findings may mean that experienced doctors are more efficient in seeking information from patients and may have more confidence in their ability to diagnose disease compared to doctors in training. Experienced doctors may therefore spend less time eliciting information from patients and conduct more efficient consultations than junior doctors. Furthermore it can be argued that doctors in private settings have a financial incentive to limit the length of patient visits.

Another interesting difference between the interaction profiles of doctors and patients is the occurrence of negative talk. This is a rare communication behaviour for doctors, whereas it is more frequently used by patients. Roter *et al.* (1988:108,115) describe negative talk as statements that indicate disagreement, confrontation, antagonism and tension. However, confrontation was only observed in doctors' (and not patients') communication by empirical

researchers. Roter *et al*. (1988:109) mention that the literature on doctor-patient communication does not pay sufficient attention to partnership-building statements by doctors. The reviewers state that such statements may serve as critical markers for interactions with an egalitarian character, or it may point to difficult encounters in which patients seem withdrawn, reserved or uncomprehending.

Researchers of doctor-patient encounters typically focus on verbal communication, and in doing so tend to neglect **non-verbal communication** in their scholarly activities. Communication regarding emotions occurs mostly through non-verbal means. A variety of factors are regarded as expressions of the emotional tone of interpersonal clinical encounters, such as "tone of voice, gaze, posture, laughter, facial expressions, touch and physical distance". Two interesting remarks regarding non-verbal clinical communication were made by researchers. The first is the observation that patients are very sensitive and attentive regarding their doctors' non-verbal communication behaviour. This may be explained by the fact that illness is usually accompanied with emotions such as fear, anxiety and emotional uncertainty. Patients may therefore pay attention to subtle cues in the doctor's behaviour to determine what they should feel and/or think. The second observation regarding non-verbal communication is that during clinical interactions the majority of patients also actively seek information about different aspects of their disease, such as its severity, course and prognosis. Messages that are not intended to be sent may leak out through non-verbal communication. Patients are very aware of such messages and to discrepancies between a doctor's verbal and non-verbal messages (Ong *et al*., 1995:908-909).

Doctor versus patient **controlling behaviours** receive much attention in the doctor-patient communication literature. A 'high control style' of communication may include frequent question asking, interruptions, verbal exaggerations to emphasise a point, dramatization, argumentation and frequent gesturing. Traditionally the doctor-patient relationship involved high control by the doctor and low control by the patient, meaning that the doctor is the dominant partner who makes decisions in what (s)he regards as the patient's best interest. In 1989 Steward and Roter[89] wrote that such paternalistic doctor-patient relationships were still the most common type of interaction between doctors and patients. The difference between the degree of control that doctors and patients exercise during clinical communication

[89] Steward, M.A. & Roter, D.L. 1989. *Communicating with medical patients*. Newbury Park CA: Sage Publications. This book is cited by Ong *et al*. (1995).

probably stems from patients' restricted understanding of medical issues and their intense uncertainty, "doctors' control of medical information and the institutional roles prescribed for the doctor and patient" (Ong *et al.*, 1995:909-910).

The praxis literature on doctor-patient communication has not paid much attention to the **vocabulary** that is used in clinical encounters. Yet, vocabulary is an "'ingredient' of the communication process" and is active during all interactions between doctors and patients (Ong *et al.*, 1995:910). Korsch *et al.* (1968:862) describe doctors' use of medical terminology as an "outstanding barrier" to clinical communication. Bourhis *et al.* (1989:339) view doctors as bilingual; "they speak at least their native everyday language (EL), and they also are fluent in a highly specialised register, namely medical language (ML)". Conversely, patients are only fluent in EL and usually do not understand much of the specialised terminology of ML (Bourhis *et al.*, 1989:342). Bourhis *et al.* (1989) conducted a survey of communication in a Canadian hospital setting focussing specifically on the use of ML and EL. In this study the participating patients perceived themselves as using their limited ML 35% of the time that they conversed with doctors. The doctors who participated in the study conducted by Bourhis *et al.* (1989:342-344) estimated a much lower percentage of ML in the patients' talk during clinical interactions, and reported that patients use ML only 7% of the time. The doctors also estimated that ML makes up 23% of their conversations with patients, whereas patients estimated that 49% of doctors' talk was delivered in ML during the consultation. The doctors and patients agreed that it is more appropriate for doctors to use EL to communicate with patients compared to ML. Both groups of participants also perceived ML as a frequent cause of communication difficulties between doctors and patients. In their view the use of EL seldom led to such difficulty.

Researchers interested in doctor-patient communication do not only focus on communication behaviours, such as those discussed above, but are also interested in the influence of doctors' communication behaviour on patients' behaviour and welfare. The following four patient outcomes[90] are frequently used to indicate the effectiveness of clinical communication: patient satisfaction, patient adherence to treatment, patient recall and understanding of information and patients' health and psychological outcomes (Ong *et al.*, 1995: 910-912).

[90] The term outcome, as used in the health sciences, can be defined as "an observable consequence of prior activity occurring after an encounter, or some portion of the encounter, is completed" (Beckman *et al.*, 1989 as cited in Ong *et al.*, 1995: 910).

Patient satisfaction was the most recognised and frequently used outcome measure in the praxis literature reviewed by Ong *et al*. (1995: 910-911). The reviewers report the following findings regarding patient satisfaction with clinical communication. Patients are often dissatisfied with the information communicated by doctors. Part of the reason is that doctors frequently underestimate patients' need for information. A strong relationship exists between patient satisfaction and doctors' information-giving behaviour. Patient satisfaction is also related to the length of the consultation, with longer consultations resulting in greater patient satisfaction. Patients are less satisfied with a dominant and high control style of doctor communication compared to doctors who use more affective communication behaviour. Affective communication behaviour aims to address the patient's need to feel known and understood and to form and maintain a positive doctor-patient relationship. This type of communication includes statements and non-verbal behaviour with definite socio-emotional content and intent. Furthermore patients' satisfaction with the clinical encounter increases when their requests are met (Ong *et al.*, 1995:906).

Patient compliance or **adherence to treatment** is also frequently used to study the effectiveness of doctor-patient communication. Yet, research results do not show a clear relationship between doctor-patient communication and later patient compliance. Patients often do not follow their doctor's advice (Ong *et al*., 1995:911). Willems *et al*. (2005:139) state that increased information-giving, positive talk and a participatory style as well as empathy by doctors lead to patient compliance. Patients also often do not **recall** or **understand** the information that they receive from doctors. Patient understanding is significantly related to the amount of time that the doctor spends on providing information and medical opinions. Furthermore patients often cannot recall much of the information that a doctor provided during the consultation. The communication that takes place at the start and at the end of a consultation are the most salient and are therefore better remembered by patients, compared to information imparted during the middle-section of the interaction. It is also known that when upsetting information is communicated, such as the diagnosis of a life-threatening condition, most patients are too shocked to take note of any information provided to them thereafter. Patient recall is also strongly associated with the amount of information that the doctor provides to the patient, and with the doctor's information-giving behaviour (Ong *et al.*, 1995:911-912).

Certain aspects of doctors' communication are associated with better **health outcomes** for patients, such as reduced controlling behaviours (and more control by patients), more affective communication and more information-giving to patients in response to effective information seeking on the patient's behalf (Ong *et al*., 1995:912). Furthermore, doctors' communication behaviour may affect patients' psychological well-being. Patients' psychological morbidity as a function of the doctor-patient relationship is a frequent topic in psychosocial oncology research. Various psychological difficulties may arise for patients during the diagnosis and treatment of cancer, such as uncertainty, anxiety, depression and coping problems. These difficulties appear to be related to a lack of information (Ong *et al*., 1995:912). Coyle and Sculco (2003:214) found that doctors' missteps in communication may harm the patient with cancer by causing a loss of hope, a sense of abandonment and reduced feelings of dignity and self-worth.

I mentioned before that patients' socio-economic and cultural backgrounds may influence their communication with doctors. Willems *et al*. (2005) conducted a review of empirical research studies to determine whether patients' socio-economic status (SES) influenced doctor-patient communication[91]. The authors found a difference in the nature of doctor-patient communication based on the patient's SES. Patients with a lower SES receive less verbal affective communication and less diagnostic and treatment information from doctors. Furthermore doctors use a more directive and less participatory consulting style, more biomedical talk and question asking and more physical examination during interactions with patients from lower social classes. These patients also have less control over communication with doctors. The differences in doctors' communication behaviour can partially be explained by differences in the patients' communication behaviour. A patient's communicative style is directly influenced by his/her personal and social characteristics such as age, level of education and gender. Patients with a higher level of education generally are active communicators, that is, they ask questions and are opinionated and use affective communication behaviour during interactions with doctors. This active communicative style elicits information from doctors. A smaller cultural gap also exists between doctors and patients who received tertiary education, which may help such patients in their interactions with doctors. In contrast, patients with a low SES ask fewer questions, do not frequently express their opinion, do not often display affective communication behaviour and have a

[91] The authors included all doctor-patient communication studies that directly mentioned patients' SES, or any of the following determinants of SES: level of education, income level or occupation (Willems *et al.* 2005:140).

lower preference for decision-making during clinical interactions. Such a communicative style distances the doctor from the patient and leads to fewer partnership building statements by doctors, which further discourages the patient's active participation in the clinical encounter. It thus seems that doctors and patients from lower social groups are caught in a vicious cycle (Willems *et al*., 2005:143-144).

However, Willems *et al*. (2005:142-144) found that doctors communicate differently with different groups of patients, regardless of the patients' communicative style. Doctors provide more diagnostic and health information to patients with more education and a higher SES. This might be due to an inaccurate assumption by doctors that patients with low levels of education and income are not interested in information about their health, or that they will not know what such information means. There is also evidence that doctors do not involve patients from lower social classes in treatment decisions to the same extent that patients with a higher SES are involved. Doctors perceive patients with a low SES to have a limited interest in and ability to participate in their health care. Although such perceptions are not necessarily accurate, they have a profound influence on doctors' behaviour. Patients with lower levels of education are thus doubly disadvantaged: first by their passive communication style, and secondly by doctors' misperceptions of their need for information. Willems *et al*. (2005:144) emphasise that variation exists between the communication styles of individual doctors, and that exceptions to the generalisations mentioned above are reflected in the literature.

Schouten & Meeuwesen (2006) conducted a review of observational, doctor-patient communication studies with the aim of gaining insight into the effects of doctors' and patients' cultural background on communication during clinical encounters. Fourteen research studies were included in their review of which 11 were conducted in the USA, two in The Netherlands and one in Australia. In these studies intercultural doctor-patient communication meant that the doctors belonged to the main-stream culture (they are referred to as white), and that patients belonged to ethnic minority groups[92] (Schouten & Meeuwesen, 2006:23-25). The reviewers found considerable differences and difficulties to be present in the communication between doctors and patients from different cultural groups, compared to monocultural clinical interactions. Doctors display less affective communication behaviour

[92] In the American studies ethnic minority groups were described as Hispanic, Latino, Asian or African American. The two Dutch studies described the ethnic minority patients as Surinamese, Turkish or Moroccan, whereas the Australian study described ethnic minority patients as Aboriginal.

and provide less information in interactions with patients from ethnic minority groups. Patients from ethnic minority groups also speak less and appear less assertive and affective compared to white patients. Very few research studies on inter-cultural clinical communication investigate the reasons for and the effects of these differences (Schouten & Meeuwesen, 2006:28).

A number of remarks can be made regarding doctor-patient communication as it was described in the preceding pages of this chapter. Firstly, despite the wealth of praxis literature on doctor-patient communication our understanding of this subject remains limited. Ong *et al*. (1995:903) attribute this to the complexity of the doctor-patient relationship. There are also problems with the theoretical foundation and methodologies of many of the studies which form the praxis literature on doctor-patient encounters. Secondly, it is clear that doctor-patient communication is central to the practice of medicine, and a very important aspect of the patient's illness experience. Thirdly, it is evident that substantial problems occur in the communication between doctors and patients (Kurtz *et al.*, 2005:14)[93]. It is clear that many of these problems are related to factors that may lead to difficult inter-personal communication in settings other than health care, such as educational settings. Examples of such factors are differences between the social class and level of education and/or culture of communication partners.

In the next section I shall describe some important insights from the discourse literature on doctor-patient encounters. The discourse literature is younger and much smaller than the body of praxis literature (Ainsworth-Vaughn, 2003:453). I pay specific attention to the work of Hunter (1991; 1992), Mishler (1984), Barry *et al*. (2001); Ainsworth-Vaughn (1998) and Anspach (1988). These authors pay attention to the narratives of the clinical encounter and to what we can learn about biomedicine and medical discourse by studying medical case presentations.

[93] I also referred to these problems in the Introduction of the dissertation.

4.3 Insights from the discourse literature on the doctor-patient encounter

4.3.1 Medicine's narratives

Kathryn Montgomery Hunter (1939-) has been teaching courses in humanities to North American medical students since the mid-nineteen seventies. Her formal education was in English. In 1983 she undertook an ethnographic research study aimed at "describing the customs and habits and assumptions of medicine's teachers and learners" by observing them in an academic medical centre[94] (Hunter, 1991: xxi). The book and articles that resulted from her qualitative research project are highly original and instructive and are often cited in the discourse literature on the doctor-patient encounter.

Hunter (1992:116) claims that "medicine is fundamentally narrative…and its daily practice is filled with stories. Most important are the opening stories that patients tell their physicians". These are the stories by which patients gain entry into "the world of the ill". The patient describes and explains his/her illness to the doctor, in terms of its events, their chronology and its common-sense aetiology or cause (Hunter, 1992:116). Hunter (1992:116) provides the following example of such an autobiographical account: "I'd been feeling pretty good, even with the bursitis – I'd been doing some overtime – but then today, almost every step I took, it hurt something awful".

The doctor then interrogates and expands the patient's story by questioning the patient directly and collecting data through physical and special examinations of the functioning of the patient's body (Hunter, 1992:116). Poirier & Brauner (1988:5) state that when the doctor starts to question the patient, (s)he also starts to manipulate the patient's story by the questions that (s)he asks and the manner in which (s)he organises the information according to the prescribed format of the medical report. The doctor thus transforms the patient's story into medical information. Later the doctor returns the story to the patient in the form of a diagnosis, "an interpretive retelling that points toward the story's ending". Patients' stories are thus not the only narratives in medicine. In fact, Hunter (1992:116) observes that "the space between the patient's first words to the physician's closing recommendation to the patient is filled with medicine's narratives". The doctor's discourse about illness also has the

[94] An academic medical centre is affiliated with a university which trains medical doctors and other health care professionals.

structure of a story. Medical diagnoses and treatment plans are narrative in the sense of being organized in space and time, with one thing resulting in another (Frank, 2010:52). Medical stories have long been a successful manner of managing difficulties in diagnosis and treatment. After the patient has told his/her story, the doctor locates the chronological ordering of the illness' details in "a narrative taxonomy of similar cases" (Hunter, 1992:116-117). The medical narrative enables the doctor to construct a more or less coherent unity from the welter of clinical facts about the individual patient (Hunter, 1992:118).

Hunter (1992: 128) draws a comparison between the nature and rationality of clinical medicine and literature. She uses the metaphor of reading to illustrate the process by which doctors interpret the conditions of individual patients.

> The patients are the texts to be examined and studied and understood by the physician…Physicians are the readers of these texts, and like all readers, they read by understanding the signs and fitting them together into a recognisable, communicable whole (Hunter, 1992:118-119).

The patient-as-text is constituted by the patient's report of his/her subjective experience of illness (the symptoms), his/her answers to the doctor's specific questions, the noticeable signs of the body's dysfunction which the doctor discovers during the physical examination, and finally the results of diagnostic tests which the doctor may have ordered or performed (Hunter, 1992:119). The doctor is a sophisticated reader of this text, comparable to the literary critic. The doctor arrives at the text loaded with theoretical knowledge, assumptions and hypotheses. (S)he has expectations about what will be read, how it should be read and how its meaning will be understood. The doctor's status as an expert reader is based on his/her familiarity with a wide variety of comparable texts, his/her understanding "of the genres (or taxonomy) of those texts" and the traditions from which these texts developed (Hunter, 1992:119).

The doctor's medical narrative, for instance the one that is recorded in the patient's folder or presented to colleagues during hospital ward rounds, does not bear a resemblance to the patient's experience of the illness (Hunter, 1992:117). The doctor only reports on those details of the patient's life that reflects medicine's methods and values (Poirier & Brauner, 1988:5) The doctor does not ask the patient questions about the matters that may trouble him/her most, such as the patient's pain, the impact of the illness on his/her work and/or

family life or his/her anxiety about the severity of the illness. Instead the doctor asks questions regarding other matters, some of which appear unrelated to the patient's concerns. The doctor pieces together the patient's story and his/her answers to the doctor's questions and translate these into pathophysiological concepts. Medical students are taught that case presentations[95] should be concise and relevant. For the purposes of case presentations during (academic) hospital rounds, medical trainees are instructed to leave out a detailed chronology of the patient's history. Instead they are taught to focus on the history of the patient's medical problem and its management and to provide a summary of the problems present in the patient's various organ systems (Anspach, 1988:360,362). The official record of the doctor's story sounds official and bureaucratic since the narrator is removed and the tone is "prescribed and objective". Medical narratives use a "self-enclosed dialect" and follow strict rules "that define the genre" (Hunter, 1992:118). The medical narrative has a strict order and uses narrowly descriptive language that does not express emotion. In the doctor's account "irrelevancies" are eliminated and abnormal physical details are highlighted. The medical narrative takes this form in order to separate the patient's subjective account of discomfort and abnormality from the doctor's more objective perspective of the case. The flatness also establishes the "emotional detachment" that is regarded as necessary for the on-going and ingenious care of the patient. Furthermore, the style of the medical narrative accentuates the pattern of the evidence so that the doctor can identify the "intellectual puzzle posed by the illness" without difficulty. The medical narrative may sound "chillingly unrecognisable and scientific", yet this is precisely the reason for the patient's visit to the doctor: "to have his story retold as a medical story as a part of the effort to determine the meaning of the events he reports" (Hunter, 1992:117). A physician-reader is required to transform the ill person into a patient with a disease which can be attended to. "Like the tree that falls in the forest unheard, the readerless text has a dubious existence" (Hunter, 1992:122).

Who is the author of the patient-as-text? When one considers the active and forceful role of the doctor in cases of serious and extended illness, and the doctor's centrality in the treatment of disease, one might agree with the doctors who see themselves as the authors of the text that is the patient. Yet, Hunter (1992:121) argues, this is a simplistic view which also ignores the

[95] Case presentation refers to a doctor's or student-doctor's recounting of a case, namely a "medical account of a malady constructed from the patient's words and body", to a medical audience (Hunter, 1991:51). Case presentation may take place orally or on paper and may take place on a number of occasions including formal conferences (such as morbidity and mortality conferences) or daily rounds, that is when a new patient is admitted to a hospital ward or when a new doctor takes charge of a specific hospital ward (Anspach, 1988:360). I make a further comment on doctors' usage of the word "case" in a footnote within section 4.3.3 of this chapter.

significance of the patient and his/her story. One may then argue that the doctor and patient act as co-authors of the same narrative. Again Hunter (1992:121) objects:

> As a model for the relationship between physician and patient…co-authorship accords the physician a much too central role in the life drama of the person who is ill. It is interpretive work that the physician is doing, not original composition, nor even (except in rare cases) co-composition. Physicians who have attended the funeral of one of their patients have this brought home to them in a striking manner. The discovery that neither the physician nor the disease has been the strongest force in a patient's life comes as a surprise and a relief.

The following reflections of two doctors serve as examples:

> ...the funeral helps me bring "living" and "medicine" into proper perspective. In a special way it gives me perhaps my best understanding of how that person fit into his or her community, and how medical care fit into that life – on the patient's own ground – away from the demeaning patient gowns, the sterile professional uniforms, and the white lights of the intensive care unit. The funeral brings that person back home to the community to rest; we are part of that community too (Irvine, 1985:1705)[96].

> Contrary to common thinking, attending the funerals of special patients does not give me closure; rather, attending the funerals provides lasting memories. My dead patients have come to life in ways that I had never known. Learning about their personal and professional accomplishments, I came away from each funeral or memorial service wondering whether this was the same person I actually took care of in life (Sherman, 2002:11).

After listening to and augmenting the patient's story of his/her illness and observing signs of the disease in the patient's body, the doctor returns to the patient a transformed and medicalized version of the story in the form of a diagnosis. The doctor's story may be foreign to the patient: "strange, depersonalised, unlived and unlivable[97], incomprehensible or terrifyingly clear" (Hunter, 1992:122). It is important that the doctor's story is reintegrated in the form of an interpretation of events into the patient's continuing life story – "whether that

[96] I first encountered Irvine's striking observation in Hunter (1991:12).

[97] Where I made use of direct quotations, I have preserved the author's original spelling, in favour of the British English spelling of my own writing.

story is one of health or illness, successful treatment, physical limitation, or approaching death" (Hunter, 1992:122). This may be difficult since the patient's story of his/her illness experience is distorted, flattened and almost obliterated in its medical version. When the doctor's story is laden with medical language it may be nearly unrecognisable to the patient, and may have almost no use as an explanation of the patient's experience (Hunter, 1992:122).

> A silent tug-of-war over the possession of the story of illness is frequently at the heart of the tension between doctors and patients, for that tension is in part a struggle over who is to be its author and in what language, a struggle for the interpretation of life (and death) events (Hunter, 1992:122).

Despite the fact that the doctor's story partly derives from the story of the patient, and that these two narratives each give an account of the same events, the two stories must be distinguished. The stories are told from different perspectives and have different motives and themes. The difference between these narratives is seldom admitted in medicine, yet it is vital for the care of the individual patient. The illness is owned by the person who is ill. The patient's experience and story of his/her illness is the fundamental fact in clinical medicine. The illness events do not exist for the doctor's story, even if the doctor's story gives them a medical meaning. Two separate stories thus exist (Hunter, 1992:122-123).

> The patient's narrative is a simple chronology, with an implicit aetiology, of the events of illness. The physician's narrative, constructed from this report and the findings of the physical examination, tells the story of the discovery of the diagnosis. Thus it is not strictly chronological but, beginning with the immediate past, delves into "history" and then, by means of tests, moves on into the not yet known (Hunter, 1992:123).

Individuals who seek health care from doctors trained in biomedicine have often adopted the language of scientific medicine into their beliefs and lore about health and disease. This is generally true for members of Western communities. When such persons feel ill, they interpret their symptoms according to the language of the Western folk belief which developed from modern medicine, and this preliminary understanding leads them to visit the doctor. They want an expert reader, one with knowledge of these issues and what they mean, to provide them with an objective understanding of their illness. "Patients often seek in the physician's story the deconstruction of their own interpretation of these symptoms. 'Is it serious?' the patient asks. 'It's not cancer, is it?'" The formation of the doctor's story, the

medical story, is the immediate aim of the consultation. Despite the importance of this reinterpretation for the doctor's task and for the patient, the doctor's story cannot change the precedence of the experience of the patient (Hunter, 1992:122-123).

4.3.2 The voices of doctor-patient interviews

Elliot G Mishler (1924-) studied doctor-patient encounters during his tenure as professor and psychologist at the Harvard Medical School. He produced one of the first major books on this topic from the perspective of discourse. In his book on doctor-patient encounters Mishler (1984:121) argues that the discourse of medical interviews is a dialectic between two separate voices and that it entails "conflict and struggle between two different domains of meaning". The two voices that Mishler refers to are the voices of medicine and of the lifeworld. In this section I shall briefly reconstruct Mishler's argument.

Mishler (1984:5, 60) aimed to describe the characteristic or typical structure of medical interviews[98]. He uses the term "unremarkable interviews" to refer to interviews that researchers, doctors and patients with a shared culture intuitively recognise as appropriate or "normal and unproblematic". This sense of appropriateness is dependent on shared understandings and implicit assumptions about the style and content of talk during doctor-patient encounters (Mishler,1984:59-60). Mishler (1984:67-68) discovered a "basic structural unit of discourse" in unremarkable interviews between doctors and patients. This unit occurs regularly and routinely in unremarkable medical interviews. The unit consists of three consecutive utterances, namely

i. a request or question from the doctor;

ii. a response by the patient; and

iii. an assessment or acknowledgement of the patient's response by the doctor.

[98] Mishler (1984) uses the term 'medical interview(s)' to refer to doctor-patient interaction(s). The term medical interview was therefore added to the list of synonyms for doctor-patient communication in this dissertation.

The doctor then adds a new request or question to this third utterance, and so the next cycle of discourse begins. Medical interviews which are recognised and accepted as standard and appropriate tend to be made up of a connected series of these structural units. The dual function of doctors' questions, namely to terminate the existing discourse cycle and to simultaneously set the next cycle in motion, provides an impression that the medical interview possesses coherence and continuity (Mishler, 1984:95).

The primary function of the basic three-utterance discourse unit is that it allows the doctor to control the development and the content of the medical interview. By being the first as well as the last speaker in each discourse cycle, the doctor is in control of the turn-taking system of the interaction. The doctor determines when the patient takes a conversational turn. The doctor also controls the content of the interview through the questions that (s)he asks and the assessments that (s)he makes. All new topics are initiated by the doctor. The doctor's questions and assessments selectively pay attention to some particulars in the patient's responses, while dismissing other details. A "systematic bias" occurs in the focus of the doctor's attention. Only physical signs that are possibly related to the patient's symptoms and physical details of symptoms receive attention in the doctor's speech. Any mention in the patient's account of the role that symptoms play in his/her life is systematically ignored by the doctor. The doctor also maintains control of the interview by means of the syntactic structure of the questions s(he) poses. Doctors tend to ask patients closed-end questions which restrict the "range of relevance for patient responses" (Mishler, 1984: 69-70, 75-76).

The clear pattern of unremarkable interviews implies that the discourse of the medial interview expresses a specific voice. Since the doctor dominates the interview Mishler (1984:71) refers to this voice as the "voice of medicine". The voice of medicine refers to the perspective of the biomedical model (Mishler, 1984:90). The standard diagnostic examination, or the unremarkable interview, is a practical application of the biomedical model (Mishler, 1984:120).

Another voice appears in the medical interview, namely "the voice of the lifeworld". Patients may make an effort to interrupt the dominant voice of medicine by using the voice of the lifeworld (Mishler, 1984:77). Patients use this voice when they speak about problems that they experience in life which are related to or resulting from their symptoms (Mishler, 1984:91). The voice of the lifeworld describes "the patient's contextually-grounded experiences of events and problems in her life". The temporal characteristics and significance

of lifeworld events depend on the patient's life situation and his/her social position (Mishler, 1984:104). Doctors tend to regard information in the voice of the lifeworld as irrelevant. In unremarkable doctor-patient encounters the doctor is fast to suppress the voice of the lifeworld and to reinstate the voice of medicine as the dominant voice in the discourse. It is the dominance of the voice of medicine that brings about the intuitive impression that an interview represents standard clinical practice (Mishler, 1984:77). When patients make an effort to sustain the voice of the lifeworld the medical interview appears less typical. Patients may disrupt the routine order of the interview, and thus the voice of medicine, by introducing a new topic in the voice of the lifeworld (Mishler, 1984:86-87). A struggle for control of the interview between the voices of medicine and the lifeworld may then occur (Mishler, 1984:91). In the words of Arney & Bergen (1984:1-2):

> When the self begins to speak about its experience of suffering an illness, it confronts a rule that we all learned governed the traditional medical encounter: "You shall speak only about things the physician designates important to the medical encounter; otherwise, keep silent." When the self speaks of the experience of being or becoming a patient, it speaks about what is important to it, not necessarily about what is important to the physician. And there lies a potential conflict.

As most studies of doctor-patient interaction, the discourse analysis that has led to Mishler's (1984:98) findings presented above was based on the 'silent' assumption of physician dominance. Problems are encountered when discourse analysis which is based on the identification of the basic three-utterance discourse unit, is applied to interviews where the voice of the lifeworld attempts to interrupt the voice of medicine (Mishler, 1984:88). Mishler (1984:97) argues that although the findings of traditional analytic efforts implicitly criticises medical practice by creating an impression of doctor coerciveness and dominance, the analysis itself remains located in the voice of medicine.

> The salience of the voice of medicine in the analysis, the findings of physician dominance and control, the description of the patient's lifeworld concerns as "interruptions" – all these ways of formulating and analysing the structure of the discourse and its problems function to maintain and reaffirm the dominance of the medical voice. In other words, the analysis remains confined within the phenomenon. It does not question the assumptions of the voice of medicine. In the end, the power of

> medicine and the dominant role of the physician are intact and untouched (Mishler, 1984:97).

Prompted by the realisation of the medical orientation of his former analytic efforts, Mishler (1984:99) attempted a fresh approach to the analysis of unremarkable medical interviews. His new approach is based on the assumption that "the patient's account is primary". During the medical interview the patient must tell a story with the theme of a lifeworld problem. The telling of the patient's story is interrupted by the doctor's speech in the voice of medicine. Mishler's reanalysis, which he also refers to as 'the interruption analysis' (Mishler, 1984:106), produced new insights into the doctor-patient encounter.

In his reanalysis Mishler (1984:105-112) investigated the manner in which the medical interview is shaped and structured through the interaction between the voices of medicine and of the lifeworld. Based on the assumption that the patient's account is primary, the structure of medical interviews appears to be fragmented and discontinuous, whereas medical interviews seemed coherent and continuous from the perspective of physician dominance. The impression of fragmentation is created by shifts in the content of the interview as the doctor interrupts the voice of the lifeworld and takes up a conversational turn in the voice of medicine. The apparent coherence of the medical interview that was revealed through the first method of analysis is achieved by the doctor's systematic exclusion of the voice of the lifeworld. Patients also make shifts between the two voices, but this usually occurs within the patient's conversational turn. Shifts from the voice of medicine to the voice of the lifeworld may occur in the patient's speech as (s)he answers the doctor's question and then adds lifeworld content, perhaps in an attempt to introduce a new topic. Such utterances by patients, wherein shifts between the two voices are made, may be seen "as efforts by the patient to maintain coherence and continuity" in the telling of his/her story and over the disruption of his/her story by the doctor.

Again the power of questions in the doctor's discourse is evident. Previously it was mentioned that doctors use questions to control the turn-taking system and the structure of medical interviews in terms of the sequences of speakers and the length and type of utterances. Mishler's (1984:110-112) interruption analysis shows that doctors also use questions to control "the flow of content toward the lifeworld or toward medicine". The doctor's questions are almost always in the voice of medicine and they function as "points of return from any other utterance".

> Every utterance, by either physician or patient, and in either voice, can be followed by a question from the physician…All roads lead back to the physician's question. In contrast, lifeworld topics introduced by the patient lead only to self-elaboration of the topic, at best; the discourse is then returned to point zero by the physician's question in the voice of medicine (Mishler, 1984:110-112).

Mishler's (1984: 112-120) reanalysis of medical interviews not only attempted to describe the structure of the interviews, but also the meaning of the voice of medicine and the voice of the lifeworld. The structure of meaning expressed in the voice of medicine may be characterised as follows. The primary and exclusive emphasis of the voice of medicine is on the description of reality based on its objective, physical characteristics, in other words "an 'objective' reality that has standard physical properties for all persons". Events are given meaning through abstract rules which remove the events from their specific personal and social contexts. This process is referred to as decontextualization.

The doctor introduces various topics throughout the medical interview. These topics mostly concern the patient's symptoms or different stages of the patient's life. The doctor makes no connection between the topics that (s)he initiates throughout the interview. (S)he may ask the patient a number of questions related to a particular topic, moving in direction from the general to the specific. The increase in the specificity of the doctor's questions pertaining to individual topics is aimed at an objective, physical description of the patient's symptoms. Patients may be confused by questions which are disconnected from the previous conversational topic. Yet, patients attempt to answer the doctor's questions, even when some questions may appear inappropriate. It is probable that patients and observers who belong to Western cultural groups assume that doctors have good reasons for the questions which they ask. We assume that the doctor uses a specific underlying model of causality which specifies relationships between separate symptoms (Mishler, 1984:120). As Arney & Bergen (1984:8) observe, the patient cannot understand the intentions behind the doctor's actions. The patient has no language or dictionary to consult in order to make sense of what the doctor does. The structure and content of the doctor's questions reflect the biomedical model which regards symptoms as significant and the relations between symptoms as indicators of specific disease processes. Yet, no evidence of this model appears in the discourse. The doctor's reasoning process remains invisible and inaudible in the medical interview (Mishler, 1984:120; Ten Have, 1991:141; Groopman, 2007:8).

A vastly different structure of meaning belongs to the voice of the lifeworld. Meaningful causal links exist among the events that patients experience and recount. These events are also self-centered. Furthermore the patient's account in the voice of the lifeworld is coherent. This coherence may be achieved by repeated mention of certain states or actions, by connections made between the past and the present (for instance by mention of symptoms that occurred earlier and which are again experienced at the present time) or by temporal organisation of the events described. However, the coherence of meanings in the voice of the lifeworld is difficult to discern in the medical interview due to the doctor's disruption of the flow and organisation of the patient's story. The patient has to work actively to express an account that (s)he finds coherent and meaningful, because (s)he is constantly interrupted by the doctor who verbalizes the voice of medicine. The structure of the doctor's questions differs greatly from the structure of the patient's account. The doctor's questions aim to define and classify separate symptoms one after the other, and are not directed at the relations among symptoms. Furthermore, the relations between symptoms which may be inferred from the doctor's questions have no connection with the causal relations between the life events that the patient talks about.

The doctor's interruptions of the patient's story remove the contexts in which the patient experiences his/her problem. The doctor is likely to ignore the causal and temporal connections between the events that the patient describes. The doctor pays attention to only one element in the patient's story, namely the symptom, and removes it from the context of the patient's life and isolates each symptom from the others. Mishler (1984:121) concludes that

> the discourse of medical interviews is not to be understood primarily as one dominated by physicians speaking in the voice of medicine with patients intruding their concerns, thereby disrupting its smooth flow. Rather, discourse is revealed as a dialectic between the voices of the lifeworld and of medicine; it involves conflict and struggle between two different domains of meaning.

Seventeen years after the publication of Mishler's (1984) study Barry *et al*. (2001), a group of British social scientists, published a study which is in many ways similar to Mishler's (1984) research. Some differences between the study by Barry *et al.* (2001:493) and Mishler's research are the following. Mishler's data were collected in the middle of the 1970's in North America from research participants from hospital outpatient departments as well as private

practices. Barry *et al.*'s (2001:493) data were collected in England in the late 1990's in general practice settings. Only white, male doctors participated in Mishler's research while 50% of the doctors in Barry *et al.*'s (2001:493) sample were female and 15% of the participating doctors were Asian. Furthermore, Barry *et al.* (2001:493) followed a more complex methodology compared to Mishler. Mishler's data included only transcripts of recorded medical interviews whereas Barry *et al.* (2001: 493) conducted interviews with doctors and patients before and/or after their clinical interactions which were also recorded and later transcribed and analysed. Both Barry *et al.* (2001:492) and Mishler analysed the recorded consultations by means of discourse analysis.

Barry *et al.* (2001:487) found four different communication patterns between doctors and patients compared to the two-part typology described by Mishler. The British authors credit their more complex data collection strategy with their more complex findings. Barry *et al.*'s (2001:493) four-part typology is organised around which voice was used, the voice of medicine or the voice of the lifeworld; and by whom, patient or doctor. The four patterns of doctor-patient communication are labelled and described as follows (Barry *et al.*, 2001:487; 493-499):

i. Strictly Medicine: Doctors and patients speak exclusively in the voice of medicine. This communication pattern was observed in consultations regarding acute single physical conditions, such as tonsillitis and ear infection, presented by patients in emergency health care settings[99].

ii. Lifeworld Blocked: Patients' utterances in the voice of the lifeworld are blocked. The voice of the lifeworld is blocked by the doctor's use of (medical) questions which allows the doctor to control the turn-taking system and the content of the interview. In these consultations only glimpses of the lifeworld can be observed[100].

[99] Emergency or unbooked consultations take place in emergency clinics and are different in quality from consultations by appointment (pre-booked consultations). Emergency consultations typically have a shorter duration compared to pre-booked consultations and doctors focus on efficient throughput of patients in emergency health care settings.

[100] The first two communication patterns correspond with the patterns reported by Mishler (1984).

iii. Lifeworld Ignored: Patients' utterances in the voice of the lifeworld are ignored. Patients' utterances are either entirely or predominantly in the voice of the lifeworld. Doctors completely ignore these utterances and speak exclusively in the voice of medicine. The previous two communication patterns were observed in consultations regarding chronic physical conditions, such as angina, arthritis and asthma.

iv. Mutual Lifeworld: Both doctors and patients predominantly speak in the voice of the lifeworld and doctors do not block the voice of the lifeworld in patients' communication. This communication pattern was observed in consultations with patients who presented with psychological problems, most of whom also presented with a physical problem, for instance stress and indigestion or anxiety and vertigo.

Apart from discourse analysis Barry *et al*. (2001:492) also analysed how much of each participating patient's agenda was voiced in each recorded consultation as well as the outcomes of the consultation. They found paradoxically that the consultations with the best outcomes were those in which both parties communicated either in the voice of medicine (Strictly Medicine) or in the voice of the lifeworld (Mutual Lifeworld) (Barry *et al.*, 2001:501). Interestingly, the Mutual Lifeworld pattern of communication was not restricted to specific doctors. All of the doctors who responded to and communicated in the voice of the lifeworld also used the other communication patterns in which they communicated entirely in the voice of medicine. Based on this finding Barry *et al.* (2001:499) suggest "that the communication behaviours are situation specific, or constructed in interaction rather than fixed dispositions of individual doctors". It seems that doctors choose their communication strategy based on their perception of the patient's problem as physical or psychological (Barry *et al.*, 2001:503).

The consultations in which the Lifeworld Ignored and Lifeworld Blocked communication patterns were used had the poorest outcomes. These consultations all involved patients with chronic physical conditions. In these consultations the doctors did not pay attention to or responded to the patients' need to feel known and understood. The researchers observed many instances of doctors side-stepping, ignoring or avoiding the lifeworld issues raised by their patients in these consultations and interpret this as a failure on the doctors' part to recognise each patient as unique. The Lifeworld Ignored consultations were the most

problematic. The authors observed active dialectical struggles between the voices of medicine and the lifeworld in these interactions. "Here patients repeatedly returned to the concerns of the lifeworld and doctors repeatedly ignored them". The patient's repetition of a lifeworld issue in the face of the doctor's disregard might suggest that the patient has strong feelings about the issue and the patient wants his/her needs to be heard. In the Lifeworld Ignored and Lifeworld Blocked communication patterns doctors do not view the lifeworld concerns of patients with chronic, ostensibly, physical problems as valid or relevant to the consultation. Instead, the patient's condition is regarded as a physical problem in need of the voice of medicine (Barry *et al*., 2001:495, 502-504). Ironically, the experiences of the patient with a chronic disorder provide the physician with reliable and important evidence for the formulation of a treatment plan and the patient's personality codetermines the treatment outcome. Furthermore, the patient with a chronic disorder mainly carries out his/her own treatment and even diagnostic actions are mainly dependent on his/her consent and cooperation (Szasz & Hollender, 1956:587; Burger, 2001:81)[101]. The lifeworld concerns of patients with chronic problems are thus in fact of critical importance to the consultation.

The Mutual Lifeworld consultations all involved patients with psychological conditions, although most of these patients also reported physical problems. Barry *et al*. (2001:497) comment that it seems as though the lifeworld can legitimately enter the consultation only when patients report psychological problems such as "sleep problems due to anxiety, unexplainable psychosomatic symptoms, bereavement depression and anxiety, and depression due to job stress". The researchers describe Mutual Lifeworld consultations as relaxed and similar in some ways to ordinary conversations between friends[102]. In these consultations there are evidence of doctors' recognition of and respect for patients' unique situations as well as "a sense of shared humanity". The impression is also created of the patient as an equal partner with expertise to offer regarding the diagnosis and treatment of psychological difficulties. In Mutual Lifeworld consultations the patient's experiences and emotions are allowed and are validated as relevant to the medical world (Barry *et al*., 2001:496-499). Strauss *et al.* (1982:263) report that oncologists might share aspects of their own lives (and

[101] Paradoxically, doctors often view patients who are unwilling or unable to carry out a prescribed treatment plan as troublesome, noncompliant and jeopardising "*actual useful* therapy". Such a judgement probably stems from the biomedical worldview that does not regard the patient's psychological and social situation as relevant in treating disease, which is seen as material and unconnected to the psycho-social realm (Burger, 2001:81).

[102] Barry *et al*. (2001:497) note that perhaps the Mutual Lifeworld consultations were in some way conversations between friends. With the exception of one, all of the patients in this group had been consulting their doctor for more than two years, and in three cases the patient has been visiting the doctor for eight, 10 and 15 years respectively.

thus use the voice of the lifeworld) with patients suffering from cancer in hospital settings. The authors point out that the reason for this "sentimental work"[103] by the specialists is "primarily to further the therapeutic work". The oncologist needs much information about the patient's lifeworld in order to set the speed of the prescribed treatment. The doctor also needs to communicate in the voice of the lifeworld to monitor the impact of the treatment on the patient's life. Strauss *et al*. (1982:274) suggest that much of the work that health professionals do surrounding medical equipment (such as "X-rays, scanners, monitoring machines, respiratory equipment, dialysis machines") in hospitals cannot be performed with ease, efficiency or at all if not accompanied by the required sentimental work.

Barry *et al*. (2001:500-501) offer the following explanations for the predominance of the voice of the lifeworld in psychological consultations. Firstly, psychological difficulties "are more rooted in the lifeworld". Although voice of medicine is involved in discussions about the causation of psychological conditions (such as the role of the neurotransmitter Serotonin in depression), the definitions of these conditions as well as the outcomes of their treatments are discussed in the voice of the lifeworld. Secondly, a person with an acute physical condition such as a broken leg can be decontextualized and nevertheless be successfully treated. In the case of psychological conditions such as anxiety the whole person has to be studied in context in order to diagnose, understand and treat. Psychiatry is also the branch of medicine in which talking and listening are most openly thought of as therapeutic (Launer, 1998 as cited in Barry *et al*., 2001:500). Thirdly, general practitioners who are not specifically interested in psychiatry have less structured routines and pre-set medical formulas to rely on when confronted with psychiatric conditions compared to psychiatrists or interactions with patients presenting with unitary physical problems. General practitioners may therefore view the voice of the lifeworld as legitimate discourse for the psychological consultation. In the absence of any pre-set medical formulas to follow, the general practitioner depends on his/her everyday communication and life skills.

Barry *et al*. (2001:501) also make some interesting comments regarding the Strictly Medicine pattern of communication. In the post-consultation interviews with the researchers these patients reported that they were satisfied with their consultations. Barry *et al*. (2001:493,501)

[103] Strauss *et al.* (1982:254) define sentimental work as "an ingredient in any kind of work where the object being worked on is alive, sentient, reacting – an ingredient either because deemed necessary to get the work done effectively or because of humanistic considerations. Sentimental work has its source in the elementary fact that any work done with or on human beings may have to take into account their response to that instrumental work (as with medical work); indeed their responses may be a central feature of that work."

also found the Strictly Medicine consultations to be successful in terms of outcomes. The authors did not observe any hints by the patients in these consultations to indicate that they wanted to shift the consultation to the voice of the lifeworld. The patients, who visited emergency surgeries without prior appointments for the treatment of single acute physical problems might have been quite pleased to communicate in the voice of medicine. The patients were aware of the time-pressures under which doctors work in emergency medical settings. Unless patients had needs for the consultation apart from simple diagnosis or treatment, Barry *et al*. (2001:501) found no evidence in the interview transcripts of objections from patients to "being treated as less than unique [in] this type of consultation". Barry *et al*. (2001:501) suggest that there may be "certain types of simple physical problems for which the patients can be seen as all the same with no adverse consequences". The patients in the Strictly Medicine consultations might have been goal-oriented with the wish to achieve their goal as efficiently as possible. It is of course also possible that these patients have learned through experience that the voice of the lifeworld is not acceptable in emergency consultations regarding acute physical problems (Barry, 2001:501).

Nancy Ainsworth-Vaughn (1998:41-43), whose ethnographic study and analysis of medical discourse have greatly contributed to the discourse literature on doctor-patient encounters, agrees with Mishler's view of power in doctor-patient interactions. Ainsworth-Vaughn (1998:50-51) disagrees with the frequent description of patients as passive during clinical interactions in the research literature on doctor-patient communication. Similar to Mishler, she regards the view of the doctor as the dominant party with all the power and the patient as the completely powerless participant as a misinterpretation of the complexity of the dynamics of the clinical encounter (Ainsworth-Vaughn, 1998:33). Ainsworth-Vaughn (1998:42-43) discovered that during clinical encounters decisions about future actions (for instance, which course of treatment to follow) were negotiated between doctors and patients. She views power in medical encounters as a process. "Power is constructed moment-to-moment during interaction, with all participants being involved, in turn, as either its claimers or its ratifiers". This view corresponds with Foucault's (1976:98) view of power as something which freely circulates between individuals who are always in the position of concurrently undergoing and exercising power.

Ainsworth-Vaughn (1998:43) describes the ways in which power is constructed in doctor-patient encounters. One way in which power is constructed is through discourse actions which seek to "control the emerging discourse". Ainsworth-Vaughn (1998:43) is here

referring to the "successful claims to speaker rights" by participants in the medical interview. Speaker rights include the right to take a conversational turn, to hold the floor for an acceptable period of time, to introduce and pursue a conversational topic and to bring a topic of conversation to an end. Another way in which power is constructed in the clinical encounter is through actions which seek to control "plans, decisions, and physical actions", for instance treatment plans. Doctors and patients use a number of discourse actions to claim power during interactions, such as to interrupt or to ask questions (Ainsworth-Vaughn, 1998:51).

Control over the emerging discourse and the outcomes of the interaction are available to the doctor and to the patient. However, the doctor may have greater access to and ease in securing control. Doctors claim power during interactions with patients, based on their official connection with the social institution of medicine. Doctors also have a high social standing, which provides them with a basis for control of the medical interview (Ainsworth-Vaughn, 1998:42-43). The doctor's role in the clinical interaction, namely to diagnose and treat disease, provides him/her with the right to question the patient. Patients are aware of the bases of doctors' claims for power and as a result patients have a need to demonstrate deference towards medical practitioners. "Deference is a universal cultural phenomenon whereby speakers acknowledge others' socially conferred authority". Ainsworth-Vaughn (1998:47) refers to the techniques that patients use to demonstrate deference as "mitigation". The social norms for biomedical encounters allow patients to ask doctors for their opinion. It may however be hard for patients to propose a course of action to the doctor, since the doctor is culturally viewed as the party who makes treatment suggestions. When a patient wishes to make a proposal during a clinical interaction (s)he may need to present it in a heavily mitigated manner. Patients may show deference in a number of ways during medical interviews, for instance by presenting proposals in the form of questions, by asking indirect rather than direct questions to the doctor, by answering the doctor's question(s) before attempting to introduce a new topic for discussion, by using hesitations, by refraining from interrupting the doctor's speech or by using the respect term 'doctor'. Patient's deference must not be mistaken for passivity, which refers to a refusal to claim power. "Deference is not the same as acquiescence". Mitigation may however dilute the patient's claims to his/her

speaker rights and his/her attempts to control the outcomes of the interaction[104] (Ainsworth-Vaughn, 1998:44-47).

An acknowledgement of patients' active role in the construction of the discourse and the outcomes of medical encounters does not deny that doctors often abuse their positions of power (Ainsworth-Vaughn, 1998:33). Doctors often interrupt patients' speech. This means that the doctor takes a conversational turn before the patient has finished his/her turn. Ainsworth-Vaughn (1998:33-34) views such interruptions as violations of the patient's speaker right to complete his/her point while holding the floor. It also reflects disrespect for the patient and a failure on the doctor's behalf to view his/her relationship with the patient as a partnership. Often doctors' interruptions are not necessary in order to achieve the medical aims of the interview. When doctors interrupt patients' conversational turns, the patient has to work hard to implement his or her agenda. Not all patients may be up to this task, and may be totally silenced and disenfranchised by a doctor's controlling communicative style (Ainsworth-Vaughn, 1998:50-51). My earlier description of the communication behaviour of patients with a low socio-economic status, show that these patients are especially vulnerable to domination by the powerful voice of medicine.

4.3.3 The language of case presentations

The extensive research literature on doctor-patient communication has not paid much attention to a very important social phenomenon, namely the formal case[105] presentations that doctors deliver to each other in hospital settings. While many studies aim to describe the communication between doctors and patients, very few researchers have paid attention to doctors' discussions of patients with other doctors (Donnelly, 1986:81; Anspach, 1988:358). The sociologist, Renee Anspach (1988) conducted a study of the language of case

[104] Patients may of course also exercise power over future plans by non-verbal means, such as a decision not to hand in a doctor's prescription for medicine at a pharmacy, or a decision not to return to the same doctor for a follow-up appointment (Ainsworth-Vaughn, 1998:43).

[105] Donnelly (1986:84) reminds us that the word "case" was used for the first time in the eighteenth's century to refer to "an instance or condition of disease in a patient". Yet, over time doctors have come to use the word to refer to patients (as opposed to diseases). The latter use has become so frequent and institutionalized that some recent dictionaries explain the word accordingly. The latter usage of the word "blurs the distinction between the patient and his disease" and in my view is a symptom of biomedicine's prioritization of disease at the expence of concern about the person suffering from illness.

presentation[106]. She argues that case presentation does more than simply convey information about patients from one doctor to his/her colleagues. Anspach (1988:357) argues that case presentation "is an arena in which claims to knowledge are made and epistemological assumptions are displayed, a linguistic ritual in which physicians…enact fundamental beliefs and values of the medical world". Case presentations also provide insight into the dynamics of medical discourse (Poirier & Brauner, 1988:6). In this section I report some of Anspach's (1988) remarks about the language of case presentation and what this reveal about the nature of modern medicine's knowledge and culture.

De-personalization occurs in the lexicon and syntax of case presentations. For instance, a disease or organ system often occurs in the subject position of sentences, as in "the bruit (murmur) has decreased significantly…" Doctors certainly know that the diseases or organs they refer to are experienced by or belong to particular individuals. Yet, the language of case presentation suggests that one can separate biological processes from the individuals who experience them. The conception of mind-body dualism in medical knowledge is thus reflected in the language of case presentation[107] (Anspach, 1988: 366). What also becomes evident is the way that the medical culture treats patients as objects and devalues patients' subjective experiences. Medical treatment is mostly understood to be directed at diseases and organs, and not at patients. Although the format of the case presentation may include room to mention some aspects of the patient's social circumstances[108], this information is seldom integrated with the biomedical elements of the patient's story. The format of the case presentation does not lead to a holistic understanding of the patient's condition or a holistic approach to the care of the patient (Poirier & Brauner, 1988:6). "In its most extreme form, the language of case presentation treats the patient as the passive receptacle for the disease rather than as a suffering subject" (Anspach, 1988:372).

It is not only the patient's personal identity that is not mentioned during case presentations. The identities of the health care professionals who performed the procedures or made the

[106] After the publication of Anspach's (1988) study a number of analyses of the medical case history has appeared (Fleischman, 2001: 477, 494-495). However, Anspach study differs from these subsequent studies in its clear and perceptive analysis of medical case histories as well as Anspach's attempt to discover the epistemological assumptions that influence this written genre of medical discourse (Fleischman, 2001:477, 479).

[107] Anspach (1988:366) points out that the conception of mind-body dualism is also evident in the general Western culture. The disease is separated from the subject when we speak of a person "having a disease".

[108] The aspects of the patient's social history that are usually included in the case presentation are "the patient's marital status, occupation, family size and situation, and smoking and drinking habits" (Poirier & Brauner, 1988:6)

observations that are discussed in the case presentation, are also omitted. Case presenters often make use of the "agentless passive voice" when they refer to clinical observations that were made or when they make claims to knowledge. Some examples are: "both babies were noted to have respiratory problems on examination" and "the baby was noted to have congestive heart failure" (Anspach, 1988:366-367). Anspach (1988:367) argues that failure to mention the person who made the observation suggests that the observer is immaterial to what (s)he observed or 'noted', or that any person would have made a similar observation or would have 'noted' the same 'thing'. "Using the passive voice while omitting the observer seems to imbue what is being observed with an unequivocal factual status".

When doctors do use the active voice during case presentations, they often place various medical technologies in the subject position of sentences, that is as the agents. One of the examples that Anspach (1998: 367) uses to illustrate this is: "ausculation of the head revealed a very large bruit, and angiography showed a very large arterio-venous malformation in the head…" In statements like this neither the person who performed the procedure, nor the process of interpretation of the data delivered by the diagnostic instrument is mentioned. Furthermore, the use of verbs such as 'revealed' and 'showed' seems to suggest that the data gathered by means of measurement instruments "was obtained by a process of scientific revelation, rather than equivocal interpretation". The language of case presentation point to a view of knowledge which regards instruments rather than people as the creators of data (Anspach, 1988:368).

While doctors regard the data obtained from measurement instruments as fact, they treat patients' reports with scepticism, "as subjective accounts with tenuous links to reality" (Anspach, 1988:368). During case presentations doctors often treat patients' accounts of their symptoms as subjective narratives made up of statements and reports. Anspach (1988:368) provides this example: "the patient reports she was seen in the emergency room and states that she has been having uterine contractions". On the contrary doctors present information obtained from physicians as factual, using verbs such as 'note', 'observe' or 'find'. "Physicians 'note', 'observe', or 'find'; patients 'state', 'report', 'claim', 'complain of', 'admit' or 'deny'. The first verbs connote objective reality (i.e., only concrete entities can be noted or observed); the second verbs connote subjective perceptions". Medical students are taught to make a distinction between the subjective symptoms that are perceived only by

patients, and objective signs that can be perceived by experts. The SOAP[109] system for the clinical evaluation of patients and the recording of progress notes is widely used in teaching hospitals. According to this system medical information provided by the patient is classified and recorded as subjective, whereas data produced by physicians or measurement instruments are regarded as objective (Anspach, 1998:368-369). Anspach (1988:371) notes that a "clear epistemological hierarchy" exists in the language of case presentation in which diagnostic technology has more value than the observations made by physicians, which again carry more value than patients' accounts.

4.3.4 Summary remarks

I shall now make some summary remarks regarding what can be learned about the doctor-patient encounter from the discourse literature on this topic. The discourse literature makes us aware of a silent or submerged conflict which can be found beneath the linguistically atheoretical descriptions of doctor-patient encounters of the praxis literature. The conflict is between two stories or two voices: the patient's story and the doctor's story; the voice of the lifeworld and the voice of medicine. The struggle "is over the possession of the story of illness" (Hunter, 1992:122). It is a conflict over the meaning of illness and disease. We are reminded of Foucault's (1981:52-52) words that discourse "is the thing for which and by which there is a struggle, discourse is the power which is to be seized".

The voice of medicine, the medical discourse which is the focus of this dissertation, bears the characteristics of biomedicine. It speaks and moves in a language that the patient often does not understand. The medical voice values and speaks only of the physical aspects of disease. Of that which can be observed directly or by means of diagnostic technology. It is interested only in the diseased body. Neither the person who suffers the disease nor the health care professional, the learned reader of the signs of disease, is seemingly important.

[109] SOAP stands for: subjective, objective, assessment, plan (Kibble *et al.*, 2006:230).

4.4 Conclusion

The mind and soul and social network of the patient also suffer disease. The patient and those close to him/her may be harmed by an approach to healing that ignores these fundamental aspects of human existence. The doctor, who entered the medical profession based on charitable reasons, either faces daily conflict between his/her humane aspirations and the demands of biomedicine, or has lost contact with those initial caring impulses in the process of his/her one-dimensional and rigorous training in the method of modern medicine.

Despite the many and great successes that modern medicine has achieved in the cure and treatment of disease, it seems that its conception of mind-body dualism comes at a cost to both patient and healer. In this chapter I aimed to describe the communication between doctors and patients during clinical consultations by means of a discussion of the praxis and discourse literature on this topic. In the next chapter I apply Habermas' universal pragmatics to this description.

Chapter 5

Universal pragmatics and doctor-patient communication

Science has purchased its very great success by the modesty of its ambition.

Science does not seek to answer every sort of question.

Sir John Polkinghorne[110]

…in order to accomplish any public or private goals, people have to talk to each other, and in more and more cases, the people come from more or less different cultural backgrounds.

Deborah Tannen (1985: 203)

5.1 Introduction

Up to the current chapter, this dissertation has been merely descriptive. In Chapter 1 I described modern medicine's intellectual self-understanding. Thereafter I described Habermas' universal pragmatics as well as Foucault's theory on the nature of discourse. The preceding chapter was devoted to a description of the empirical research literature on doctor-patient communication. The current chapter introduces the analytical work of my project. In this chapter I describe doctor-patient communication, as it was portrayed in the previous chapter, in terms of Habermas' universal pragmatics. I shall describe doctor-patient communication against the background of Habermas' model of linguistic communication and thereafter I shall discuss the validity claims in doctor-patient interactions. I start, however, with a few notes on the context of clinical communication. At this stage my aim is not to critique modern medicine's intellectual self-image. I undertake the task of criticism in the penultimate chapter.

[110] This quotation is from the transcript of a talk by Polkinghorne that appears in a book edited by Eric Metaxas (2011:9).

5.2 The context of doctor-patient interactions

Doctor-patient interactions take place in a particular social world which allows the two parties to understand each other's utterances (Skirbekk, 2004:247-248; Tanenbaum, 2006:200). In Habermas' terminology this social world forms the **background consensus** of doctor-patient interactions. The background consensus of doctor-patient communication includes shared understandings of the goal and the rationale of biomedicine, the social status of modern medicine as well as the public image and the self-image of biomedicine. In this section I shall briefly describe these elements of the background of the doctor-patient encounter.

The primary **goal and rationale of biomedicine** is to promote the welfare of patients (Beauchamp & Childress, 2009:205). More specifically the goal of medicine is to restore well-being (Pellegrino & Thomasma, 1981:62) and to care for those who are sick and disabled (Van Leeuwen & Kimsma, 1997:104). When medicine is unable to cure disease its goal is to restore well-being by managing a patient's illness or, when this is not possible, to reduce suffering (Pellegrino & Thomasma, 1981:62). An implicit assumption of beneficence exists in the medical profession and its institutional contexts. The moral requirement of beneficence, that is the requirement to contribute to the welfare of others, demands more from doctors than merely to avoid harm to their patients (that is the moral requirement of non-maleficence) (Beauchamp & Childress, 2009:197). Doctor-patient interactions occur against the background of the assumption of beneficence and non-maleficence. Patients therefore expect that doctors will attempt to help them and that doctors will act in the patients' best interests (Skirbekk, 2004:246).

The **social status of modern medicine** is another important element of the background of clinical consultations. Patients and their caregivers are likely to invest a lot of authority in doctors (McDougall *et al.*, 2006:36) due to modern medicine's successes in discovering cures for diseases and to prevent or ameliorate suffering and disability (Barry *et al.*, 2001: 490-491; Le Fanu, 1999:xv), the association between modern medicine and science (Montgomery, 2006:39; Miles, 2007:548), as well as the decline in organised religion in many Western societies (Helman, 2007: 125-126). This is particularly true in times of crises when patients are seriously ill and/or confronted with disability. Patients "have been taught that medicine and science can, or should be able to, fix almost everything" (McDougall *et al.*, 2006:33,36). It is probably due to the association between modern medicine and science, and the standard image of science that is prevalent among the general public, that patients expect certainty and

very few errors from doctors (Pellegrino & Thomasma, 1981:58). Patients expect that doctors will be able to cure disease, or at the very least will be able to make sense of what is happening to the patient (McDougall *et al.,* 2006:33, 36; Frank, 2010:54). Yet, as McDougall *et al*. (2006:37) warn, "there is always the danger…that a doctor held in such high esteem may fall – he has, indeed, a long way to fall". The reality is that doctors cannot cure everything and do not always have (satisfactory) answers to patients' questions. Patients' faith in modern medicine and in doctors may thus go beyond the rational and the expectations of and pressures on doctors are often unfair. What happens when doctors cannot deliver on patients' expectations? Patients and/or their caregivers may feel frustrated and angry at doctors' uncertainty and may blame doctors for the uncertainty that they themselves feel. Doctors again may feel like failures (McDougall *et al.*, 2006:33, 35, 37; Waymack, 2009: 228).

> They may heroically try to do more and more investigations to find a cause or a cure when they suspect – or even know – that this quest is hopeless. They may protect themselves from their own sense of helplessness and despair at not being able to help by trying to cut off emotionally, and by retreating into the position that because modern medicine is scientific, emotions are irrelevant to the best care of patients…All these reactions, though not ideal, are human and understandable. It requires an enormous change not only on the part of doctors themselves, but also in what we expect of them, for doctors to behave differently under very difficult circumstances (McDougall *et al.*, 2006:33).

The final element of the background of clinical communication that I want to describe is the **public and the self-image of biomedicine**. It is probably fair to say that similar to medical doctors (Kriel, 2000: 10; Simon, 2010:337), at least the majority of patients with a Western background have an image of medicine as a (natural) scientific enterprise (Montgomery, 2006:30). The patient who views modern medicine as scientific expects his/her subjective account of illness to be translated into an objective medical story by the doctor so that the patient can determine the meaning of his/her story (Hunter, 1992:117). It is probably also fair to say that biomedical doctors are respected and have authority in most communities due to their superior knowledge (Måseide, 1991:554; Van Niekerk, 2002a:261) and their commitment to deliver important services to patients and their caregivers (Beauchamp & Childress, 2009:7). For these reasons patients are likely to answer doctors' questions and to do what is requested of them during consultations and to follow doctors' treatment advice

(even if the doctor's advice goes against the patient's wishes[111]). These patients assume that doctors have good reasons for the questions that they ask and the requests and recommendations that they make (Mishler, 1984:120) and may even assume that "the doctor's word [is] law" (Barry *et al*., 2001:493). This assumption is closely linked with the assumption of beneficence and with Western communities' faith in science.

It is important to consider the question of whether it is appropriate to examine doctor-patient communication through the lens of universal pragmatics, since Habermas' (1979:4) aforementioned research project takes only consensual speech actions into consideration. A consensual speech action is an "idealized case of communicative action…in which participants share a tradition and their orientations are normatively integrated to such an extent that they start from the same definition of the situation and do not disagree about the claims to validity that they reciprocally raise" (Habermas, 1979:208-209). Later in this chapter I argue that doctors and patients do not always accept the validity claims that underlie the other party's utterances during the medical interview. The description of doctor-patient communication in Chapter 4 made it clear that medical discourse is often problematic. Yet, a case can be made that the background consensus against which doctor-patient communication occurs, as described in the paragraphs above, makes doctor-patient interaction an "idealized case of communicative action" in the sense indicated by Habermas (1979:208) in the quotation above. For this reason I regard it as appropriate to view doctor-patient communication in terms of universal pragmatics. Other scholars (Tanenbaum, 1998; 2006; Skirbekk, 2004; Greenhalgh *et al.*, 2006)[112] have used universal pragmatics in the study of doctor-patient communication with success and I shall refer to some of their ideas in this chapter. The next section is a discussion of doctor-patient communication based on Habermas' (1979) universal pragmatics.

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[111] Some of the patients who participated in the research of Barry *et al*. (2001:493) followed doctors' treatment advice (of using antibiotic treatment) even though this was against the patients' wishes. The patients did not find room during the (emergency) consultations to discuss their treatment preferences with their doctors. However, there is also evidence to the contrary. When patients' need for information is not satisfied and they feel the doctor did not take their concerns, requests and beliefs regarding treatment seriously, they may decide not to follow the doctor's treatment advice (Stevenson *et al.*, 2000:834, 836).

[112] Greenhalgh *et al*. (2006:1171-1172, 1184) drew on Habermas' work on communicative action in their study of interpreted primary care consultations, that is consultations between general practitioners, patients and interpreters. They found Habermas' theory useful for their purposes. Although Greenhalgh *et al*.'s (2006) paper provided me with insight into the application of Habermas' universal pragmatics to the study of doctor-patient communication; I do not refer to it in this chapter, since my focus is on doctor-patient dyads as opposed to the triads studied by these scholars.

5.3 Universal pragmatics and doctor-patient communication

5.3.1 A description of doctor-patient communication based on Habermas' model of linguistic communication

I want to describe doctor-patient communication against the background of Habermas' (1979:65-68) model of linguistic communication (see Table 2.1 for a tabular description of this model). Some general characteristics of the medical interview are the following. Doctors' and patients' communication behaviour are asymmetrical in terms of information seeking and information giving. Research indicates that doctors spend more time seeking information during consultations than providing information. The opposite is true of patients. Furthermore, it is estimated that on average doctors' contribution to the speech of the consultation is 60% while patients contribute an average of 40% to the consultation (Roter *et al.*, 1988:101-102, 108). The medical interview consists of different phases which correspond to the stages of the clinical method[113]. The initial phase of the medical interview is aimed at discussing the nature of the patient's symptoms. After the doctor has performed the physical examination and, if indicated, the appropriate special investigation(s), (s)he communicates the diagnosis to the patient. The third phase in the medical interview is aimed at discussing the treatment plan for the identified disease. The asymmetry and three-phase process of the medical interview makes it a special form of interaction compared to the interactions of everyday life. The unequal balance of power in the doctor-patient relationship is another factor that makes doctor-patient interactions unique.

5.3.1.1 Doctors' communication

Doctors mostly communicate in the cognitive mode of language use. The theme of this mode of communication is the contents of utterances as statements about experiences and states-of-affairs, expressed as knowledge claims that can be either true or false (Habermas, 1979:53). The doctor's utterances refer to the domain of reality that Habermas (1979:66) terms "external nature". External nature refers to the segment of reality which the subject can perceive and manipulate. This includes inanimate nature as well as all objects and situations which can directly or indirectly be accessed through sense experience. Constative speech acts belong to the cognitive mode of communication. In the cognitive mode of language use the

[113] The clinical method is described in section 4 (*Clinical biomedicine*) of Chapter 1.

validity claim of truth is stressed. The pragmatic function of speech acts in the cognitive mode of language use is to represent facts. A speaker who wants to fulfill this pragmatic function must be able to produce a grammatical sentence and "to select propositional content in such a way that he represents…an experience or fact (so that the hearer can share the knowledge of the speaker)" (Habermas, 1979:29)[114]. The achievement of this pragmatic function is assessed against the validity conditions for truth (Habermas, 1979:33).

Doctors' dominant use of the cognitive mode of communication stems from the positivist ontology of modern medicine[115]. As Mishler (1984:71, 90) remarked, the doctor speaks in the "voice of medicine" which refers to the perspective of the biomedical model. This is the perspective of the natural sciences which includes monistic materialism, the belief that "everything that exists is physical" (Blackburn, 2005:238). Modern medicine's positivist ontology prescribes a positivist epistemology. In this epistemology an empiricist assumption exists namely that all real or reliable knowledge stems from sense observation. Empiricism further claims that there is a reality that can be known objectively without being influenced by observer or theoretical bias. It is thus assumed that knowledge gained empirically is objective, which means that this type of knowledge is viewed as a reflection of the nature of reality as it truly is, unclouded by the personal reactions of the knowing subject to that which (s)he experiences (Rossouw, 1980:3; Nel, 1981:89; Van Niekerk, 1992:49). Another principle of positivist epistemology is the principle of verification. This principle states that a statement can only be accepted as true if it is known by which observations of reality the statement could be verified (Kriel, 2000:15). The validity conditions for the truth of a statement from a positivist perspective are that the observations on which the statement is based can be identified and that these observations can be described in quantifiable terms. In the positivist world-view all immaterial phenomena, that is phenomena that cannot be measured through objective observation are regarded to be outside the realm of science and are awarded a lower status. The positivist world-view of biomedicine thus only includes one of the domains of reality listed by Habermas (1979:66-67), namely 'the' world of external nature. I mentioned in Chapter 1 that modern medicine's approach to problems of the mind or abnormal behaviour is to focus almost exclusively on the biological or physiological

[114] This quote is from Habermas (1979:29). I used McCarthy's 1978 translation (McCarthy, 1978:280) in favour of the somewhat less lucid 1979 version.

[115] It is necessary to briefly repeat some of the issues discussed in Chapters 1, 2 and 4 to provide a context for the upcoming discussion of doctor-patient communication based on Habermas' (1979) universal pragmatics.

aspects of such disorders. Psychotherapy or 'talking' to the patient as a means of treatment is not a well-integrated intervention in the medical discipline of psychiatry.

5.3.1.2 Patients' communication

Modern medicine's positivist world-view has a definite impact on the way that it understands its three central concepts, namely patient, disease and therapy. In modern medicine the patient is very often reduced to a biological organism composed of loosely connected parts or organs. This biological system is believed to exist and function independently of the mind. Similarly disease and its causes are understood as biological and mechanical in nature. Disease is regarded as the necessary and sufficient reason for malfunction of the body. Following from the conceptualisation of disease as a physical phenomenon, biomedical treatments are all physical in nature, taking the form of for instance, pharmaceutical products, surgery or radiation therapy (Kriel, 2000:23-25; Marcum, 2008:394-397).

A description of patients' utterances according to Habermas' (1979:68) model of linguistic communication will refer to a different domain of reality, a different mode of communication, different validity claims, and a different theme and pragmatic function than was the case in the above description of doctors' utterances. Patients communicate in the voice of the life-world[116]. Patients use the voice of the lifeworld when they speak about problems that they experience in life which are related to or resulting from their symptoms (Mishler, 1984:91). The voice of the lifeworld describes "the patient's contextually-grounded experiences of events and problems in her life" (Mishler, 1984:104). Patients mostly communicate in the expressive mode of language use. The theme of this mode of communication is the speaker's intention. Patients' utterances refer to the domain of reality that Habermas (1979:67) terms "internal nature". Internal nature refers the to the subject's own subjectivity which (s)he communicates or conceals "in a first person attitude". This domain includes all desires, feelings, intentions and so forth "to which an 'I' has privileged access and can express as its own experiences before a public". Representative speech acts belong to the expressive mode of communication. In the expressive mode of language use the validity claim of truthfulness is stressed. The pragmatic function of speech acts in the expressive mode of language use is to express intentions. A speaker who wants to fulfll this pragmatic function must be able to

[116] Throughout this dissertation I use the term 'lifeworld' as it is defined by Mishler (1984:91). I do not attach Husserl's meaning to this word.

produce a grammatical sentence and "to express his intentions in such a way that the linguistic expression accurately renders what is meant (so that the hearer can trust the speaker)" (Habermas, 1979:29)[117]. The achievement of this pragmatic function is assessed against the validity conditions for truthfulness (Habermas, 1979:33). The consequences of the speaker's actions have to prove that the intention (s)he expressed is truly the intention which guided his/her behaviour (Habermas, 1979:64).

Patients thus speak about their subjective experiences and feelings regarding illness. Yet modern medicine is the prevailing approach to health care in many Western and other developed countries. Biomedicine is also rapidly developing into the main approach to health care in the developing and Eastern world (Marcum, 2008:393). Patients who visit biomedical doctors have often adopted the language of scientific medicine into their beliefs and lore about health and disease. This is generally true for members of Western communities. When such persons feel ill, they interpret their symptoms according to the language of folk beliefs which developed from modern medicine, and this preliminary understanding leads them to visit the doctor (Hunter, 1992:122). The distinction between medicine and the lifeworld is problematic in the light of the role of biomedical language in modern societies and the manner in which this language has become part of modern subjects' accounts of themselves (Silverman, 1987 as cited in Barry *et al*., 2001:501). However, mutual misunderstanding may occur when either the doctor or the patient uses a medical term as these two parties often do not interpret medical terms in similar ways (Helman, 2007:151). As Hunter (1992:122-123) puts it:

> The use of the same terms for the same events suggests (especially to those who use them daily) that physician and patient are talking about the same thing, telling the same story. But often only the physical signs and their diagnostic labels are the same; the understanding and the concerns are entirely different.

[117] This quote is from Habermas (1979:29). I used McCarthy's 1978 translation (McCarthy, 1978:280) in favour of the somewhat less lucid 1979 version.

Patients also do not understand the doctor's behaviour. The doctor's actions and speech are based on the biomedical model which is not accessible to patients. It remains invisible and inaudible in the medical interview (Mishler, 1984:120). Patients have no language or dictionary to consult in order to make sense of what the doctor does (Arney & Bergen, 1984:8).

It would be wrong to paint a picture of doctor-patient interactions wherein the doctor always and only communicates in the voice of medicine and the patient always and only communicates in the voice of the lifeworld. Barry *et al*. (2001:493-494, 496-499) found that (some) doctors at times speak in the voice of the lifeworld and that some patients speak exclusively in the voice of medicine and that these consultations generally have good outcomes and lead to patient satisfaction. Doctors and patients tend to speak exclusively in the voice of medicine during consultations regarding acute single physical conditions such as tonsillitis and ear infection presented by patients in emergency health care settings. Conversely, both doctors and patients tend to speak predominantly in the voice of the lifeworld during consultations which involve psychological problems.

5.3.1.3 The interactive mode of communication in doctor-patient interactions

According to Habermas (1979:42) communication in language is only possible when the speaker and hearer simultaneously become involved in two levels of communication when communicating with each other regarding a particular topic, namely "the level of intersubjectivity" and "the level of propositional content", or "the level of experiences and states-of-affairs"[118] (Habermas, 1979:41-42; McCarthy, 1978:282). Speakers and hearers must simultaneously reach an understanding on both communicative levels if they wish to communicate their intentions to each other. Every speech act explicitly raises one particular validity claim in accordance with the mode of communication that it belongs to, yet it is also

[118] "*The level of intersubjectivity*" is the communicative level on which speaker and hearer, by means of illocutionary acts, set up the relations which allow them "to come to an understanding with each other". The "*level of propositional content*" is "the level of *experiences and states-of-affairs* about which they want to reach an understanding in the communicative function determined by" the communicative level of intersubjectivity (Habermas, 1979:41-42; McCarthy, 1978:282) (this quotation is from McCarthy's 1978 (p. 282) translation).

implicitly inhabited by the other two validity claims. Each speech act thus fulfills all three of the pragmatic functions, namely to "represent something in the world, to express the speaker's intentions, and to establish legimate interpersonal relations" (Habermas, 1979:33; Tanenbaum, 1998:206). The doctor and patient therefore create their relationship (the so-called doctor-patient relationship) with their utterances, which are mostly constative and representative speech-acts.

It is not only constative and representative speech acts that occur in doctor-patient interactions. Regulative speech acts are also present, such as **commands** or **requests** (as when the doctors command or request patients to perform certain actions during the physical examination or as part of a treatment plan, or when either of the two parties request information from the other); **warnings** (for example by doctors against patients' unhealthy behaviours); and **recommendations** and **advice** (for instance by the doctor regarding the treatment for the diagnosed disorder). Regulative speech acts belong to the interactive mode of communication. The theme of this mode of communication is the relation between the speaker and the listener. The interactive mode of communication is connected to the domain of reality which Habermas (1979:66) terms "society". "Society" refers to an environment or "symbolically prestructured segment of reality" that the subject "conforms to or deviates from in the ego-alter attitude of…a participant in a system of communication". Valid interpersonal relations, institutions, cultural values, traditions and so on belong to this domain of reality. In the interactive mode of language use the validity claim of rightness is stressed. The pragmatic function of speech acts in the interactive mode of language use is to establish interpersonal relations. A speaker who wants to fulfill this pragmatic function must be able "to carry out a speech act in such a way that it satisfies recognized norms or accepted self-images (so that the hearer can agree with the speaker in these values)" (Habermas, 1979:29)[119]. The achievement of this pragmatic function is assessed against the validity conditions for rightness (Habermas, 1979:33). In the interactive use of language a "speech-act-immanent *obligation to provide justification*" is offered by the speaker. Regulative speech acts include only the offer to point to, if needed, "the *normative context*" from which the speaker obtains the "*conviction*" that his/her utterance is correct, in other words that "the speech action performed fits an existing normative background"(Habermas, 1979:64).

[119] This quotation is from Habermas (1979:29). Again I used McCarthy's 1978 translation (McCarthy, 1978:280) in favour of the somewhat less lucid 1979 version.

The question that now arises is "What does a legitimate doctor-patient relationship look like?" This legitimacy can be described in terms of the status of each party's right to perform the various types of speech acts. The right to perform a particular type of speech act depends for example on the speaker's role or status, accepted norms and conventions, established relational patterns and recognised values (McCarthy, 1978:289). One can also use the concept of "speaker rights" to describe the legitimate doctor-patient relationship. Speaker rights include the right to take a conversational turn, to hold the floor for an acceptable period of time, to introduce and to pursue a conversational topic and to bring a topic of conversation to an end (Ainsworth-Vaughn, 1998:43).

The doctor-patient relationship does not resemble everyday relationships between equals. Due to doctors' knowledge, skills and power over disease and the authority that society has bestowed upon them because of it, the practitioners of scientific medicine have become accustomed to **unilaterally** shape the structure of their relationships with patients. The medical profession argues that the powerful benefits that modern medicine can bestow on patients depend on the condition that doctors have the freedom to determine the nature of the doctor-patient relationship. The doctor-patient relationship is viewed as a contract into which the doctor enters with the patient. The patient can benefit from the doctor's scientific knowledge and skills if the doctor determines the contractual terms and supervises the patient's (and/or the patient's caregiver's) compliance with these terms. The nature of the doctor-patient relationship is thus determined by the doctor based on the physician's special knowledge and the assumption of his/her benevolence towards the patient (Jonsen, 1990:87-94).

The doctor's unilateral construction of the doctor-patient relationship is evident in the structure of the unremarkable medical interview described by Mishler (1984). Mishler uses the term "unremarkable interview" to refer to interviews that researchers, doctors and patients with a shared culture intuitively recognise as appropriate or "normal and unproblematic" and thus fitting the normative context (Mishler, 1984:59). A "basic structural unit of discourse" occurs regularly and routinely in unremarkable medical interviews. The unit consists of three consecutive utterances, namely

i. a request or question from the doctor;

ii. a response by the patient; and

iii. an assessment or acknowledgement of the patient's response by the doctor.

The doctor then adds a new request or question to this third utterance, and so the next cycle of discourse begins. Medical interviews that are recognised and accepted as standard and appropriate tend to be made up of a connected series of these structural units (Mishler, 1984:68).

From the structure of the unremarkable interview it appears that **only the doctor has the right to perform certain regulative speech acts**. The doctor's role and status gives him/her the right to question the patient. The social norms for biomedical encounters allow patients to ask doctors for their opinion. It may however be difficult for patients to suggest a course of action to the doctor, since the doctor is culturally viewed as the party who makes treatment suggestions. When a patient wishes to make a suggestion during a clinical interaction (s)he may need to present it in a manner that demonstrates deference towards the doctor. For instance by presenting suggestions in the form of questions, by asking indirect rather than direct questions to the doctor, by answering the doctor's question(s) before attempting to introduce a new topic for discussion, by using hesitations, by refraining from interrupting the doctor's speech or by using the respect term 'doctor' (Ainsworth-Vaughn, 1998:42-47).

In unremarkable interviews the doctor controls the development and content of the interaction. The patient is not afforded the right to take the first turn in a discourse cycle. The doctor is the first and the last speaker in each discourse cycle and is thus in control of the turn-taking system of the interaction. **The doctor determines when the patient takes a conversational turn**. The patient is thus also not allowed to introduce and to pursue a conversational topic and to bring a topic of conversation to an end. The doctor controls the content of the interview through the questions that (s)he asks and the assessments that (s)he makes. **All new topics are initiated by the doctor** (Mishler, 1984: 69, 76).

In the unremarkable interview the doctor communicates in the voice of medicine. His/her questions and assessments are focussed on the concerns of biomedicine, namely the symptoms experienced and the signs presented by the patient. The doctor ignores content in the voice of the lifeworld in the patient's utterances. Should a patient raise lifeworld issues in the interview, the doctor is fast to suppress the voice of the lifeworld and to reinstate the voice of medicine as the dominant voice in the discourse. **It is the dominance of the voice of medicine that brings about the intuitive impression that an interview represents standard clinical practice** (Mishler, 1984:77). Medical interviews in which patients initiate and attempt to sustain conversational topics in the voice of the lifeworld appear less typical (Mishler, 1984:86-88). A struggle for control of the interview between the voices of medicine and the lifeworld may then occur (Mishler, 1984:91).

I stated earlier that although doctor-patient interaction may be described as an idealized case of communicative action which takes place against a particular background consensus, the problems of communication between doctors and patients are well documented. In the next section I will pay attention to the validity claims that are raised and responded to during doctor-patient interactions in an attempt to understand the problematic character of doctor-patient interaction.

5.3.2 Validity claims and doctor-patient communication

A speaker who wants to bring about understanding has to use an utterance that is comprehensible, true, sincere and right. Furthermore, the speaker has to suppose that these claims to validity can be justified. A speaker and hearer have reached understanding if the hearer accepts the validity claims raised by the speaker (Habermas, 1979:3). When the hearer accepts the validity claim that was raised by the speaker, the hearer "acknowledges the validity of symbolic structures; that is, he acknowledges that a sentence is grammatical, a statement true, an intentional expression truthful, or an utterance correct" (Habermas, 1979:4-5). The four validity claims which are implicitly raised and reciprocally recognised constitute the background consensus of communicative action in everyday contexts. This background consensus is crucial for reaching understanding (Habermas, 1979:3-4; Thompson, 1984:262; Van Niekerk, 1992:190). The validity claims may thus also be thought of as "four different dimensions in which communicative interaction can break down or suffer disturbances" (McCarthy, 1978:288).

In the next section I follow Skirbekk (2004:246-247) in discussing how doctors and patients may respond to each other's utterances and the validity claims underlying these utterances. However, whereas Skirbekk focussed on hypothetical doctor-patient interactions regarding chronic lower back pain, an illness for which no specific cause can be identified and which cannot be observed objectively, I will discuss hypothetical interactions about acute and chronic physical disorders, as well as interactions about psychological conditions (which are often accompanied by physical problems). I structure my discussion around these different types of disorders based on Barry *et al.*'s (2001:439-499) finding that different patterns of doctor-patient communication exist and that these patterns seem to correspond with the type of disorder that the patient suffers from. I will first consider likely consultations about single acute physical disorders. I divide this discussion according to (some of) the different phases of the medical interview, namely history taking, communication about the diagnosis and communication about the treatment plan. Each phase is directed at a particular consecutive task and is therefore somewhat different in character from the other phases of the interview (Ten Have, 1991:139).

5.3.2.1 Consultations about single acute physical disorders

A doctor will most likely open and continue the **history taking phase** of the interview with questions regarding the patient's reason(s) for attending the consultation (Ten Have, 1991:142) (such as "Tell me what is the reason for your visit"), the nature of the patient's symptoms and factors that might be related to the "still-to-be-diagnosed disease" (Kriel, 2000:22) such as the history of disease in the patient's family, the patient's work history and lifestyle. The doctor thus performs regulative speech acts during the history taking which stresses the validity claim of rightness. The patient is likely to accept the doctor's questions since the doctor's role in the clinical interaction, namely to diagnose and treat disease, provides him/her with the right to question the patient (Ainsworth-Vaughn, 1998:42-43). The doctor's tasks are to investigate the case and to listen to the patient's complaints, while it is the patient's task to report his/her symptoms and to answer the doctor's questions (Ten Have, 1991:140). As Hunter (1992:117) notes, the patient's reason for visiting the doctor is to have his story transformed into a biomedical story as part of his attempt to discover the meaning of his symptoms.

Barry *et al.*'s (2001:493) research shows that patients with acute physical disorders are likely to communicate in the voice of medicine. The patient is thus likely to report his /her physical symptom(s) to the doctor in response to the latter's questions. The patient's utterances about his/her symptom(s) are representative speech acts which refer to the subjective world of the patient and which stress the validity claim of truthfulness. Skirbekk (2004:247) states that the doctor may respond in one of two ways to the patient's validity claim of truthfulness. The doctor either believes that the patient is truthful or not. The doctor's response to the truthfulness of the patient's representative speech acts regarding his/her illness is probably greatly influenced by what the doctor observes by means of the physical and other examinations. If the doctor finds physical evidence to explain the patient's symptoms (s)he will regard the patient's report of his/her symptom(s) as truthful. Conversely, when no observable evidence can be found for the patient's complaint(s), the doctor may not take the patient's subjective experience seriously. When the doctor's examination provides no physical evidence to explain the patient's symptoms it does not necessarily mean that there is no pathophysiologic cause for the symptoms. It may also mean that biomedical science has not yet discovered the pathophysiologic cause of the symptoms and therefore the doctor does not know what to look for or how to look for it.

The patient may attempt to suggest a cause for his/her symptoms to the doctor. The utterance may be in the form of a statement or may be mitigated (Ainsworth-Vaughn, 1998:47) by the question form. The patient cannot explain his/her symptoms according to the biomedical model. (S)he uses folk belief (which for the Western patient may be largely based on the biomedical model) to explain his/her subjective illness experience. How might a doctor respond to the validity claims underlying a suggestion regarding the cause of the illness by the patient? The doctor will not regard the utterance as true before (s)he can verify it by means of the clinical method. Whether or not the doctor believes that the patient is truthful about his/her understanding of the cause of the illness is probably not of much importance. Yet, a patient may be seen as violating the norms of doctor-patient interaction by suggesting a cause for his/her symptoms. It is not the patient's role to make (uninvited) suggestions during the consultation. Instead it is the patient's role to cooperate with the doctor (Ten Have, 1991:140), for instance by answering all questions as truthfully and thoroughly as possible and to cooperate in the doctor's examination of his/her body so that the disease may be biomedically identified and treated. Since patients typically do not take initiative during the

medical interview, doctors tend to reach treatment decisions that are mainly based on the medical professional's perspective on the case (Ten Have, 1991:141).

Following the history taking phase of the interview and examination process, the doctor will communicate the identified **diagnosis** to the patient. The doctor will do this with a constative speech act (for example "You have otitis media[120]"). This utterance stresses the validity claim of truth and has a connection with "the" world of external nature (Habermas, 1979:68). The diagnosis is the outcome of the clinical method according to which the doctor formulates and confirms a specific hypothesis in biomedical terms and by biomedical methods (Kriel, 2000:22-23). The diagnosis that the doctor pronounces is based on a link between the symptoms reported by the patient and the physical signs of disease in the patient's body as found by the doctor. The patient will most likely accept the doctor's validity claim[121] since (s)he wants a biomedical explanation for his/her subjective illness experience. The patient typically trusts the doctor as an expert regarding (scientific) knowledge and examination of the body and disease (Heritage & Maynard, 2006:364). Furthermore, the doctor's utterance validates the patient's subjective illness experience and allows the patient to take on the rights and benefits of the "sick role", such as to temporarily avoid his/her obligations towards the social groups that (s)he belongs to (for example family and colleagues) and to receive care from these social groups (Helman, 2007:128).

After the doctor has communicated the diagnosis to the patient the **treatment plan** needs to be discussed. **Shared decision-making** is supported more and more as an ideal model of decision-making about treatment in the clinical consultation[122] (Ong *et al.*, 1995:905; Charles *et al.*, 1997:681). Charles *et al.* (1997:685-688) suggest that shared treatment decision-making has four key characteristics, namely:

[120] Otitis media refers to an infection of the (middle) ear.

[121] In a review of the literature on doctor-patient interaction in primary health care settings, Heritage (2005:98) found no reports of patients that explicitly disagreed with the diagnoses that were made by their doctors.

[122] Shared decision-making is not the only treatment decision model that receives attention in the literature. Other models include the paternalistic, the informed and the physician-as-agent decision-making models (Charles, et al., 1997:682-683).

i. At least two participants are involved, namely the doctor and the patient;

ii. Both parties (doctor and patient) take steps to participate in the decision-making process about treatment;

iii. Both parties must share information;

iv. A treatment decision is taken and both parties agree to the decision.

According to the shared decision-making model a doctor and patient can thus reach agreement about the treatment option to follow by means of an open discussion about each party's preferences (Charles *et al.*, 1997:688; Stevenson *et al.*, 2000:838). This view parallels Habermas' (1979:3) description of agreement as the outcome of communicative action, or action aimed at understanding.

Empirical research indicates that all patients desire information regarding their illness and the treatment options available (Charles *et al.*, 1997:683; Guadagnoli & Ward, 1998:337). However, patients have diverse preferences in terms of participation in treatment decision-making. Informed patients may prefer to make the treatment decision independently or may want to delegate or share this responsibility to or with the doctor (Charles *et al.*, 1997:683). Guadagnoli and Ward (1998:329) reviewed the empirical research literature on patient participation in decision-making about medical care. Due to the methodological limitations of the reviewed research these reviewers found it difficult to draw clear conclusions about whether patient involvement in medical care and treatment decision-making results in improved medical outcomes "such as reduced pain and anxiety, quicker recovery, and increased compliance" (Guadagnoli & Ward, 1998:332-335). However, they argue that

> patient participation in decision-making is justified on humane grounds alone and is in line with a patient's right to self-determination…although not all patients will want to take control of their medical care, it is still important that their concerns, desires, and values be incorporated into decisions about their care (Guadagnoli &Ward, 1998:329, 337).

Despite the research findings mentioned above and the advocacy of the use of shared decision-making, empirical research indicates that shared decision-making is not the norm in practice (Stevenson *et al.*, 2000:838; Stevenson, 2003:291). Ten Have (1991:141) writes that the discourse literature on doctor-patient communication supports the conclusion that there is

> a tendency for decisions that are mainly based on the doctor's perspective on the case, guided by his questioning and relative lack of knowledge of the relevancies stemming from the patient's orientation to the problem…it takes specific efforts on the part of patients to counter tendencies leading to such a result, unless physicians take steps to provide them with occasions to influence the proceedings.

I will now make some comments about the types of speech acts that patients may (want to) use during the second half of the medical interview and how doctors may respond to such speech acts. After the doctor has communicated the diagnosis to the patient (s)he will talk about the treatment of the disorder. In the case of single acute physical disorders the doctor will most likely want to prescribe medication. Research performed in various countries shows that most clinical consultations entail the doctor writing a prescription (Stevenson *et al.*, 2000:830). Whether or not the treatment decision (for instance whether or not to use medication(s), or which medication(s) to use) will be jointly reached generally depends on the doctor. As Charles *et al*. (1997:687) write:

> By and large, physicians set the norms of interaction in the medical encounter. If the physician is not motivated to share decision-making, the patient cannot force this to happen. Her only option is to seek out another physician whose expectations about how the decision-making process should occur is similar to hers.

A doctor may thus simply declare, with a regulative speech act, that (s)he recommends or prescribes a specific treatment for the patient's disease ("I am giving you something to help with your cold/infection " or "I will give you _____ for your _____")[123]. A doctor with a less paternalistic style may phrase his/her treatment advice more tentatively or interrogatively and collaboratively. For instance: "I think we should treat this with _____". The doctor's regulative speech act(s) stresses the validity claim of rightness and is connected to the social domain of reality. Patients are likely to accept the doctor's structuring of the decision-making process. According to the norms of doctor-patient interaction, the doctor

[123] These examples are based on the findings of Stevenson *et al*. (2000:833).

determines the rules of the interaction and the patient should comply with this arrangement in order to benefit from the doctor's special knowledge and skills (Jonsen, 1990:90).

The doctor thus determines the norms of interaction in the medical interview (Charles *et al*., 1997:687). What do we know about information exchange during the final phase of the medical interview? Research has found little evidence of information sharing between doctors and patients and of patient participation in decision-making in general practice consultations (Stevenson *et al*., 2000:839). Doctors are mostly willing to answer patients' questions aimed at clarification of topics such as how the prescribed medication should be taken ("How much should I take of this medicine?") and what the patient can expect of the medication ("Are there side-effects?")[124] (Ten Have, 1991:149; Stevenson *et al*., 2000:836). Questions such as these stress the validity claim of rightness. Doctors typically accept and answer such questions from patients since sharing the requested information with patients is connected with the doctor's professional role of treating disease. Furthermore, such questions from patients do not bring the doctor's treatment advice into question and are thus not a threat to the doctor's authority. The doctor probably assumes that the patient asks such questions to better comply with the dispensed advice. Finally, these questions are related to the external world – the only world that biomedicine is comfortable to speak about.

However, research shows that doctors underestimate patients' need for information and generally do not give patients enough information (Kurtz *et al.*, 2005:15). Patients whose information needs have not been met might not adhere to the prescribed treatment. Doctors are often not aware of patients' non-adherence to prescribed treatment. Doctors also often do not adequately respond to patients' concerns regarding the prescribed treatment or requests regarding treatment (Stevenson *et al.*, 2000:833-834, 836). Voiced concerns or requests regarding the prescribed treatment by patients contravene the norms of doctor-patient interaction. The doctor is culturally viewed as the party who makes treatment suggestions and the patient's role is to comply with the doctor's suggestions. Patients are thus likely to present their concerns and requests regarding treatment in a mitigated manner during the medical interview (Ainsworth-Vaughn, 1998:48-49). Doctors often do not notice patients' voiced concerns in the interaction, or may interrupt or ignore patients' requests (Mishler,

[124] It must be kept in mind that patients from lower socio-economic groups and patients from cultural minority groups ask fewer questions to and receive less information from doctors compared to wealthier patients from mainstream cultural groups (Roter *et al.*,1988:109, 112; Schouten & Meeuwesen, 2006:28). I discussed the influence of patients' socio-economic and cultural backgrounds on their communication with doctors in Chapter 4.

1984:105-112; Stevenson *et al*., 2000:834,836; Kurtz *et al.*, 2005:14-15). When patients' concerns and requests are not attended to during the medical interview, they may decide not to follow the doctor's treatment advice (Stevenson *et al*., 2000:834, 836). In addition, doctors are unlikely to elicit patients' beliefs regarding medicine during the medical interview. It is very difficult for patients to volunteer their beliefs regarding medicine to the doctor (for example: "I do not like to use antibiotics"). Doing so may entail rejecting the prescribed treatment (Stevenson *et al.*, 2000:836-838), which contravenes the norms of doctor-patient interaction, as explained above[125].

The above shows that doctors frequently do not share enough information with patients, nor do they elicit or pay attention to patients' (attempts to express) concerns, requests and beliefs regarding treatment. Doctors probably do not recognise the validity claim of rightness that underlies patients' uttered concerns, requests and perceptions regarding treatment. Voiced concerns and requests regarding the prescribed treatment by patients contravene the norms of doctor-patient interaction. The doctor is culturally viewed as the party whose special knowledge, skills and experience allow him/her to make good treatment suggestions and the patient's role is to comply with the doctor's suggestions[126]. Yet, I want to argue that there are more reasons for doctors' dismissal of patients' concerns, requests and beliefs. Reasons closely connected to modern medicine's intellectual self-image. Stevenson *et al*. (2000:838-839) questioned doctors on their views regarding shared decision-making. The British general practitioners who participated in Stevenson *et al*.'s research did not regard patients' perceptions regarding medicine as relevant to their professional task. Patients' perceptions belong to the world of internal nature and express patients' subjective feelings, desires *etcetera* (Habermas, 1979:67). Biomedicine's positivist worldview does not accommodate subjective knowledge. To my mind this goes a long way towards explaining why doctors tend to regard patients' perceptions about treatment as irrelevant. Stevenson and her colleagues (2000:838-839) also found that doctors might not regard patients as requiring

[125] Ironically, doctors seem to assume that patients will voice their opinions regarding medication on their own initiative during the medical interview when they are uncomfortable with the doctor's treatment suggestion (Stevenson *et al*., 2000:837). This possibly indicates that doctors are not sufficiently sensitive or have become desensitized to the power and knowledge divide between doctor and patient and the implication thereof for patients' communication behaviour during the medical interview.

[126] However, it seems that doctors' perceptions of patients' (with single acute physical conditions) expectations regarding prescription medicine play an important role in doctors' prescription decisions. Cockburn & Pitt (1997:521-522) found that if a doctor perceives that a patient with a single acute physical disorder expects a prescription, (s)he is 10 times more likely to prescribe medication to that patient. I noted at the start of this chapter that patients often have high expectations of modern medicine and that doctors may indeed feel pressured to live up to patients' expectations.

information about medicine. The doctors who participated in their study were also of the opinion that patients do not have the will or ability to take part in decision-making regarding their health care, since patients do not generally understand medical language and medical problems. In my view doctors' frequent apathy towards sharing information and treatment decisions with patients stems to a great extent from biomedicine's understanding of its three central concepts, namely patient, disease and therapy, as merely physical in nature. **The doctor is mainly interested in physically treating the observable disease located in the patient's body.** Mastery of biomedicine is necessary to achieve this aim. According to the biomedical tradition the patient's mind has no role to play in the treatment of disease. This explains why doctors may not think that patients need information about treatment or that patients should participate in treatment decisions.

The first two characteristics of Charles *et al.*'s (1997:685-688) model of shared decision-making are thus not generally present in doctor-patient communication. As a result the third and fourth characteristics do not usually appear either (Stevenson *et al.*, 2000:839). Even when doctors and patients share information, doctors may not take patients' contributions seriously. If information **is** shared between doctor and patient, it is often not used as a basis to develop a consensus regarding the preferred treatment or to reach an agreement on the treatment to be carried out (Stevenson *et al.*, 2000:839; Stevenson, 2003:292). It thus appears that doctors and patients do not reach agreement in the Habermasian sense, that is by means of communicative action, regarding the treatment to be implemented. Habermas (1979:3) states that communication partners can reach agreement if the speaker raises four validity claims (comprehensibility, truth, truthfulness and rightness) "and suppose that they can be vindicated" and the hearer can accept these validity claims. Agreement in this sense is not possible since doctors typically do not allow or regard patients' speech acts concerning treatment as important. Doctors therefore also do not accept the validity claims underlying such utterances by patients. The consequence of doctors' failure to communicate with patients with the aim of reaching agreement regarding treatment, is that patients may not adhere to doctors' treatment advice (and often the doctor will not be aware of this non-adherence). The financial cost of non-adherence is high considering the cost of unused or wrongly used medication, as well as the cost of additional medical consultations, laboratory tests, medication and so forth (Kurtz et al., 2005:16).

It can thus be said that doctors do not generally act communicatively in their interactions with patients. On the contrary, a case can be made that doctors act strategically during medical

interviews[127]. Strategic action is not aimed at achieving understanding, but wants to achieve self-determined goals, for instance by using power (Van Niekerk, 1992: 182; Skirbekk, 2004:246). The doctor does not attempt to rationally motivate the patient regarding the doctor's treatment advice. Nor does the doctor allow him/herself to be rationally motivated by the concerns, requests and beliefs of the patient. The doctor does not respond to the patient as an autonomous and rational being. The doctor also doesn't reveal his/her full humanity in interactions with patients. The biomedical doctor acts as a technician of the machine called the human body. (I am referring here to a hypothetical biomedical doctor and not a specific individual. The behaviour of this hypothetical doctor fits the descriptions in the research literature of doctors' seemingly typical communication behaviour during consultations. I do not suggest that all doctors disregard the rationality and autonomy of their patients or that the doctors who do so, always act in this way. I also do not imply that doctors who interact minimally with their patients do not care about them.)

5.3.2.2 Consultations about chronic conditions

Consultations regarding chronic conditions generally have poor outcomes and particularly problematic communication between doctor and patient (Salmon, 2000: 110-111; Barry *et al*., 2001:502; Ariss, 2009:909). The term 'chronic conditions' includes patients with physical symptoms for which a physical pathology can be identified as well as patients with physical symptoms for which no physical pathology can be found. The latter group of patients are considered as having psychosomatic disorders and are referred to as 'somatising patients' (Salmon, 2000:107). Patients with chronic disorders are often described as "frequent attenders" in the literature on general medical practice and doctor-patient communication (Salmon, 2000:105). Frequently attending patients pay 10 or 12 visits per year to their general practitioners, compared to the average rate of one to three visits to the general practitioner per year among the majority of the population (Ariss, 2009:909). Ariss (2009:909) mentions research findings which indicate that although frequent attenders constitute a small percentage of the general population (approximately 3%) they roughly

[127] Hyde *et al*. (2005:69) found evidence in nursing records of strategic communication by nurses towards patients. Their analysis of patients' nursing records in four Irish hospitals revealed little evidence of communicative action by nurses. The authors conclude that nursing records display a biomedical view of the patient's body, disease and treatment and that the promotion of "notions of partnership, autonomy and self-determination" contained in current nursing theory is not reflected in the nursing records analysed. The authors acknowledge that nursing documentation may not be a valid representation of actual nursing practice (Hyde *et al*., 2005: 71,73).

make up a fifth of general practitioners' total consultations. Patients with chronic disorders may have significant knowledge and opinions about the state of their health and the treatment and management of their illness due to their frequent contact with health care professionals and their experience of living with illness (Ariss, 2009:909). I shall first discuss clinical consultations regarding chronic disorders with identifiable physical aetiologies and thereafter I shall focus on consultations regarding chronic disorders for which no physical pathology can be identified. I refer to the first category of patients as patients with **physical chronic conditions** in order to make a distinction between these two groups.

Barry *et al*. (2001:494-496) found that patients with chronic conditions mainly or exclusively (attempt to) speak in the voice of the lifeworld throughout the medical interview, yet these contributions are blocked or ignored by doctors who conduct the interview in the voice of medicine. Patients may persist in raising lifeworld issues despite the doctor's failure to pay attention to such utterances. In interviews of this kind dialectical struggles between the voice of medicine and the voice of the lifeworld, "two different domains of meaning" (Mishler, 1984:25), occur. A patient's repetition of a lifeworld issue in the face of the doctor's disregard suggests that the patient has strong feelings about the issue and that the patient wants his/her needs to be heard (Barry *et al*., 2001:495). Doctors probably disregard patients' utterances in the voice of the lifeworld since these utterances are connected to the subjective, inner world of the patient. Biomedicine views the patient, disease and its treatment exclusively in physical and objective terms. This is probably an important reason why the doctor does not consider patients' subjective experiences as valid or relevant to the consultation (Barry *et al*., 2001:504). However, patients with chronic physical conditions commonly have "poorly understood or non-improving symptoms and undiscovered or undiagnosed problems" (Ariss, 2009:909). The experiences of such patients may provide the doctor with reliable and important evidence for the formulation of a treatment plan. Furthermore, the patient with a chronic disorder also mainly carries out his/her own treatment (Szasz & Hollender, 1956:587). The lifeworld concerns of patients with chronic problems **are** thus of critical importance to the consultation and are wrongly dismissed by the biomedical doctor.

Ariss (2009:909) made an interesting finding in a recent study that investigated doctor-patient communication regarding physical chronic disorders in general practice settings in northern England. He found that doctors accept the knowledge claims of patients with physical chronic disorders regarding topics such as "illness management, medication and test results".

Such knowledge claims "are associated with the long-term nature of patients' conditions" (Ariss, 2009: 916,918). Below are two examples of this from Ariss' (2009: 916-917) paper:

- The patient states the result of a blood test ("My ESR was 26 in September" [128]) and the doctor agrees with this statement[129];
- The patient explains how he used prescribed steroids to treat a recurrence of symptoms of chronic pulmonary disease ("I took six steroids and then weaned myself off") and the doctor's reply indicates agreement ("That's fine. You know your chest").

Yet, none of the doctors who participated in Ariss' (2009:918) study accepted utterances from patients that attempted to **interpret or describe the patients' problems** from a biomedical perspective. Discussion and debate about these topics were strongly avoided. In instances where overt disagreement about such issues occurred, this was quickly resolved as each party 'retreated' to his/her "realm of epistemic authority" (Ariss, 2009:918). For instance, one patient communicated the following opinion to her doctor regarding the treatment of her back pain: "I know nowadays they do tell you not to do bed rest, don't they. But I have to say in all honesty, unless I have some bed rest it's no. I can't walk." The doctor did not engage with this topic raised by the patient. Instead he changed the topic and commenced to the next phase of the consultation with the following utterance: "Okay. I have given you back exercise chart before"[130] (Ariss, 2009:913). Ariss (2009: 918) comments that this finding indicates that doctor-patient "interactions are characterised by a style of participation which minimises the need for rational debate in order to continue on the grounds of an established consensus or the acknowledgement of contrary positions". I earlier made a similar comment. It seems that the doctor's biomedical perspective may withhold him/her from acting communicatively in the consultation. The doctor usually does not attempt to reach understanding with the patient. The doctor-patient interaction often does not terminate in agreement, which means "reciprocal understanding, shared knowledge, mutual trust, and

[128] I do not directly quote from the transcripts included in Ariss' (2009) paper in these two examples.

[129] The doctor could confirm this statement by consulting the patient's chart which the doctor had in front of him.

[130] The last two quotations in this paragraph were taken directly from Ariss' (2009:913) transcripts.

accord with one another" (Habermas, 1979:3). Both doctors and patients have knowledge that has relevance to the consultation. The doctor has scientific and technical knowledge regarding the diagnosis and treatment of disease. The patient has the experience of illness and preferences regarding its treatment (Stevenson *et al.*, 2000:830). A patient with a chronic condition often has considerable knowledge regarding his/her disorder due to its long-term nature and the patient's regular contact with health care workers (Ariss, 2009:918). In the typical biomedical interview knowledge is not exchanged in a manner that facilitates understanding, agreement and shared decision making (Charles *et al.*, 1997:687-688; Stevenson *et al.*, 2000:839). Biomedical doctors rarely regard patients' descriptions and interpretations of their illness conditions and treatment preferences as valid. According to modern medicine's positivist world-view only verifiable, objective knowledge gained by suitably qualified individuals through biomedical techniques are acceptable to describe disease, interpret symptoms and formulate treatment plans. The consequence of doctors' neglect to reach agreement with patients may be that patients do not adhere to doctors' treatment advice without doctors' knowledge of this non-compliance.

I now turn my focus to consultations regarding **chronic disorders for which no physical pathology can be identified**. It is believed that somatising patients' symptoms reflect heightened sensitivity to ordinary bodily sensations or social or emotional causes (Salmon, 2000:106). Disagreement between doctors and patients frequently occurs, probably at least as often as instances of non-compliance by patients. Yet, such disagreement is seldom overt. **Overt conflict** may however occur in consultations with somatising patients when the patient demands physical treatment that the doctor is not able or willing to provide. Somatising patients also seem to seek doctors to validate their symptoms and to allow them to adopt the sick role (Salmon, 2000:108). Interactions between patients and doctors in the absence of identifiable physical pathology may be "a kind of 'tug-of-war', in which each party [attempts] to resolve the encounter by pulling it into their own territory" (Salmon, 2000:110-111).

The patient will state his/her symptom(s) to the doctor (for example "I have pains in my back"[131]). The doctor will be left uncertain about the validity claim of truth that underlies the patient's initial complaint when his/her examination of the patient's body cannot identify a physical cause for the patient's symptom(s). The doctor can only state to the patient what (s)he knows (for instance "We can't find anything wrong"). If the doctor accepts the validity

[131] The examples of utterances by a patient and a doctor in this paragraph are directly quoted from Skirbekk (2004:245-246).

claim of truthfulness that underlies the patient's initial complaint, the doctor may also answer the patient in the expressive mode of communication with an utterance that discloses the doctor's subjectivity (for instance "I understand you're in pain –back pains can hurt a lot") (Skirbekk, 2004:245-247). The patient may accept neither an utterance by the doctor that denies evidence of his/her symptoms in the objective world, nor an utterance that refers only to the subjective world (Salmon, 2000:110; Skirbekk, 2004:247). When such disagreement occurs between the communication partners in a medical interview each party may attempt to influence the other "by emphasising the area over which [(s)he has] privileged knowledge". For the doctor this is the "world inside the patient's body" to which the doctor has exclusive access through biomedical tests and instruments. The patient's domain of privileged knowledge is the unpleasant or unbearable nature of his/her symptoms and the psychosocial suffering that (s)he experiences because of these bodily symptoms (Salmon, 2000:110). Somatising patients may therefore continue (to attempt) to communicate in the voice of the lifeworld while the doctor blocks or ignores such utterances and communicates solely in the voice of medicine (Barry *et al*., 2001:494-496). Doctors may experience a sense of failure and pressure when they do not satisfy patients' expectations. In response to these feelings they may zealously attempt to find the cause and to treat the patients' symptoms (McDougall *et al.*, 2006:33). Somatising patients frequently undergo physical investigation and treatment, which include invasive procedures and long-term treatment that are often ineffective, risky and costly (Salmon, 2000:105).

It is clear that medical interviews regarding chronic conditions with no identifiable physical cause may be among the most problematic doctor-patient interactions. Here the doctor, who has been taught according to the biomedical tradition to perceive all disease as physical, is uncertain about the cause and appropriate treatment of the patient's illness, since the doctor can find no physical pathology with the usual biomedical techniques. The biomedical doctor may therefore deny the reality of the patient's symptoms. The patient may be desperately upset by this outcome, since (s)he wants the doctor's authoritative validation of his/her symptoms, "something to refer to in the objective world" (Skirbekk, 2004:247). In the modern Western world one is allowed the rights and benefits of "being sick" only after a biomedical doctor has pronounced one sick. It seems that the biomedical model is ill-suited to deal with chronic disorders for which no physical pathology can be identified. It leaves the doctor uncertain and helpless and may harm patients. Once again a Foucauldian view of power in the medical interview appears. It is not only the doctor who possesses and exercises

power. Patients can exercise significant power over doctors (Salmon, 2000:111)[132]. I shall further discuss power in doctor-patient interactions in the following chapter which describes medical discourse based on the work of Foucault.

5.3.2.3 Consultations about psychological problems (accompanied by physical disorders)

Interesting comments can be made about the influence of doctors' biomedical intellectual self-image on doctor-patient communication when one considers the empirical research findings on doctor-patient interactions regarding psychological problems (that are accompanied by physical disorders). Barry *et al*. (2001: 496-499) described interactions between general practitioners and patients who presented with psychological problems[133] as "Mutual Lifeworld" consultations. In this pattern of communication both partners predominantly communicate in the voice of the lifeworld and doctors do not block the voice of the lifeworld in patients' communication. One of the explanations that Barry *et al*. (2001: 500-501) offer for this finding is the following. General practitioners who have a limited interest and training in psychiatry may have less structured routines and pre-set medical formulas to rely on when confronted with psychiatric conditions compared to psychiatrists or interactions with patients presenting with single, physical problems. General practitioners and medical (as opposed to psychiatric) specialists may therefore view the voice of the lifeworld as legitimate discourse for psychological consultations. In the absence of any pre-set medical formulas to follow, the doctor depends on his/her everyday communication and life skills.

It thus seems that when a doctor (who is not a psychiatrist) becomes aware that a patient experiences a psychological problem, the doctor sets aside his/her biomedical perspective and methods since these are irrelevant to emotional problems. For instance when the patient uses an utterance such as "I had a problem earlier in the year…you know my daughter was ill" [134].

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[132] Greenhalgh *et al*. (2006:1172, 1182) found that even socio-economically deprived patients from "Black and Minority Ethnic populations" in London (United Kingdom) who communicated through interpreters with their doctors, developed strategies to control aspects of their interactions with general practitioners in the National Health Service (NHS).

[133] In most such cases patients also reported a physical problem, such as indigestion or vertigo (Barry *et al*. 2001:497). Vertigo is a symptom that results from a disorder in the inner ear. A patient with vertigo has the sensation of "whirling or spinning" (Martin, 1994:282).

[134] This example is quoted from a transcript included in Barry *et al*.'s (2001:498) paper.

In such cases the doctor accepts the patient's representative speech act and the validity claims it raises. The doctor is likely to continue communication regarding the emotional problem in the voice of the lifeworld. The following reply by a doctor to the complaint quoted earlier in this paragraph is an example from Barry *et al.*'s (2001:498) research: "How is that sorting itself out?" Barry *et al*. (2001:497-499) found that Mutual Lifeworld consultations have good outcomes and lead to patient satisfaction. It thus seems that patients accept doctors' communication regarding patients' emotional problems in the voice of the lifeworld. Barry *et al.* (2001:496-499) remark that in some ways Mutual Lifeworld consultations resemble everyday conversations between friends. The authors noticed "a sense of shared humanity" and equality in these consultations. The doctors allowed the patients to talk about their experiences and emotions and treated these as relevant to the medical interview. There **is** thus evidence of doctors communicating with patients as equals and as human beings. It seems that this style of communication emerges when patients complain of emotional problems and the doctor cannot follow his/her usual biomedical formula of behaviour and interaction.

Researchers have noted that medical students' interviewing skills change as they progress through their training programmes. First year medical students typically use their natural interaction skills to communicate with patients and collect more psychosocial information than organic-factual information during the medical interview (Helfer, 1970:623-627; Preven *et al.*, 1986:843-844). Helfer (1970:626) offers the following explanation for this observation: "…freshmen do not have the experience, understanding, or vocabulary to obtain many of the organic-related facts. Therefore, they must talk about something so they interact at a more interpersonal level."

As students progress to the more senior years of study and become more versed in biomedicine, their style of interaction with patients change. Senior medical students tend to obtain more factual, biological information from patients and to ask more leading questions during the medical interview compared to junior students who collect more psychosocial than biologic information from patients (Helfer, 1970:625). It thus seems that the biomedical model has a definite influence on doctors' communication skills. As doctors become more practiced in modern medicine, their natural ability to interact with patients and to gather information from them is suppressed and they rely on the routines and formulas of biomedicine to interact with patients (Barry *et al*., 2001:501; Helfer, 1970:625). Helfer (1970:626) makes the comment that "…it [is] not infrequent, after watching a few senior [medical students'] interviews, to gain the impression that one [is] observing two computers

talking to each other. The senior had been programmed to ask specific questions in a specific order and manner…"

5.3.2.4 Intelligibility

Thus far in my discussion of validity claims in doctor-patient communication I have taken the **validity claim of intelligibility** for granted. According to Habermas (1979:2) one of the conditions for reaching understanding is that the speaker has to use an utterance that is **comprehensible** in order for the speaker and the hearer to understand each other. From my description of doctor-patient communication in Chapter 4 it is clear that doctors' utterances are often not intelligible to patients. Doctors' use of medical language (ML), the specialised terminology of modern medicine, causes communication difficulties between doctors and patients. In effect, misunderstanding may occur when either of the two parties uses medical terminology, since doctors and patients often do not attach the same meaning to medical terms (Helman, 2007:151).

When misunderstanding occurs the hearer should indicate this to the speaker. That is the hearer must call the validity claim of intelligibility into question, so that the misunderstanding can be solved within the interactive context "such as through explication, elucidation, paraphrase, translation, semantic stipulation" (McCarthy, 1978:288). However, due to the power and knowledge assymetry between doctors and patients as well as the insufficiency of time in the standard medical interview, the patient may not indicate his/her problem with understanding to the doctor and/or request clarification. Doctors are not inclined to pay attention to patients' problems with understanding during the medical interview. Firstly, due to their frequent usage of ML, it may be problematic for doctors to distinguish between everyday language (EL) and ML. As Bourhis *et al.*, (1989:345) explain:

> After years of medical practice, it may be difficlt for doctors to clearly differentiate between medical and everyday language when discussing medical issues with their patients. Terms commonly used within medical language may be perceived by doctors as everyday language. Words and expressions classified as belonging to the ML corpus may only be those used least frequently by doctors themselves.

Secondly, doctors may not regard it as important that patients understand all that is discussed during the medical interview. Doctors may even have the percepion that patients are not interested in or able to take part in decision-making regarding their health care (Stevenson *et al*., 2000:839) and therefore doctors may not take the trouble to ensure that patients understand all that is said during the medical interview. Biomedicine concentrates on the patient's body and the physical aspect of disease. The patient's mind, and therefore his/her understanding of the issues related to his/her health care, are not important in the biomedical consultation.

5.4 Conclusion

I explained in the Introduction of this dissertation that my aim is not to perform a discourse analysis of doctor-patient communication. My aim is rather to use the thoughts of philosophers regarding communication (Habermas) and discourse (Foucault) to gain insight into the influence of modern medicine's intellectual self-image on communicatively effective care to patients. In this chapter I made comments about doctor-patient communication based on Habermas' (1979) universal pragmatics. I concluded that it is appropriate to use Habermas' ideas about communicative action to comment on doctor-patient interactions.

Doctor-patient communication takes place against a particular background consensus which includes shared understandings of the goal and the rationale of biomedicine, the social status of modern medicine as well as the public image and the self-image of biomedicine. Yet, doctors and patients communicate from different perspectives. The doctor's professional perspective is turned to the world of external nature. (S)he mostly communicates in the cognitive mode of language use. The patient mostly communicates about his/her world of internal nature in the expressive mode of communication. Due to their different perspectives, doctors and patients may not accept the validity claims that underlie each other's utterances about the nature, causes and treatment of disease. When either member of a doctor-patient dyad does not accept the validity claim(s) implicit in the other's speech act(s), their "communicative interaction can break down or suffer disturbances" (McCarthy, 1978:288). It is not only the different perspectives of the doctor and patient that threaten the success of their communicative interaction. The social domain of reality dictates the status of each party's right to perform the various types of speech acts as well as the speaker rights of each party.

The norm states that the doctor determines the rules of the medical interview. Shared decision-making about the treatment of the patient's disease can only happen if the doctor feels so inclined (Charles *et al.*, 1997:687). The different perspectives of the doctor and patient and the dominance of the doctor are not necessarily problematic, as in the case of consultations regarding single acute physical conditions. However, it often causes (mostly covert) disagreement in consultations regarding chronic disorders.

It seems that doctors and patients seldom reach agreement through communication in their formal interactions. Communicative partners achieve agreement and understanding through mutual recognition of each other's rationality, that is when the speaker attempts to rationally motivate the hearer with his/her speech act(s). Generally speaking the doctor, influenced by the biomedical model, does not focus on the patient's rationality and thereby impedes communicative action in the medical interview. The doctor tends not to respond to the patient as an autonomous and rational being. The doctor also tends not to reveal his/her full humanity in interactions with patients. It appears that doctors and patients neither discuss problematic validity claims with each other in the interactive context of the medical interview nor at the discursive level. This means that they are left with the alternatives of breaking off communication altogether or changing to strategic action (Habermas, 1979: 3-4; McCarthy, 1978:288-289). It is important to remember that the patient is not a powerless participant in the doctor-patient relationship. Although it may be difficult for the patient to secure control over the emerging interaction, (s)he may also exercise power over the outcomes of the consultation by non-verbal means. The patient may for example decide not to follow the doctor's treatment advice, or not to return to the same doctor for a follow-up appointment, or to seek help outside the realm of biomedicine, for instance from a homeopath (Ainsworth-Vaughn, 1998:42-43; Skribekk, 2004:247). A failure to reach understanding in the medical interview may harm the patient and/or the doctor and may waste resources.

In Chapter 7 of this dissertation I take on the task of critiquing the appropriateness of modern medicine's intellectual self-image. There I want to discuss the validity claims of truth and rightness in doctor-patient communication. I want to consider what appropriate conceptions of truth and rightness would be for modern medicine. Such conceptions have to acknowledge the rationality of patients and the proper relation between modern medicine and science.

Chapter 6

An application of Foucault's thoughts on discourse to medical discourse

What gets us into trouble is not what we don't know,

it's what we know for sure that just ain't so.

Mark Twain[135]

Professions tend to be right in what they affirm, and wrong in what they ignore.

Anthony R. Moore (1978:3)

The dream of reason did not take power into account.

Paul Starr (1982:3)

6.1 Introduction

This chapter continues the analytical work of the dissertation that was started in the previous chapter. In the preceding chapter I described doctor-patient communication in terms of Habermas' universal pragmatics. In the current chapter I apply Foucault's thoughts on the nature of discourse to medical discourse. The structure of the current chapter resembles the structure of Chapter 3, in which I describe Foucault's theory about the nature of discourse. Chapter 3 has two main parts. The first part deals with Foucault's understanding of discourse and the second with Foucault's view of power. The current chapter, in which I apply Foucault's thoughts on the nature of discourse and power to medical discourse, follows the two-part structure of Chapter 3. In the first part of this chapter I describe medical discourse as a discursive formation and a discursive practice. I also describe (some of) the procedures of limitation and exclusion that have an effect on medical discourse. In the second part I describe the nature of power in doctor-patient relationships. As in the introduction to the previous chapter I point out to the reader that the task of critiquing modern medicine's intellectual self-image is reserved for the final chapter and is thus not undertaken in this chapter.

[135] As cited in Tilburt & Geller (2007:819).

6.2 Medical discourse

When I use the word medical discourse in this dissertation I am referring to the discourse of the medical profession and specifically the discourse surrounding the interaction between a doctor and a patient in a clinical setting, such as a hospital ward or consulting room. Foucault (1972:90) considers the term discourse in at least three ways in his work: "sometimes as the general domain of all statements, sometimes as an individualizable group of statements, and sometimes as a regulated practice that accounts for a certain number of statements". When I speak of medical discourse in the context of Foucault's writings, I am using the term in the second or third senses of his above definition of discourse. I thus use the term medical discourse to refer to

i. a particular or "an individualizable group of statements" that has a regularity[136] between its elements (Foucault, 1972:41, 90). The group of statements that I refer to is the statements that doctors may legitimately use when talking to or about patients.

ii. The rules responsible for the production, distribution and circulation of doctors' statements (Foucault, 1972: 90; Young, 1981:48).

I thus use the term medical discourse to refer to the rules that doctors (have to) follow when they think and talk about health and disease (in order to be regarded as competent).

[136] Foucault (1972:41) clarifies what he means with "regularity" as follows: "an order, correlations, positions and functionings, transformations".

6.2.1 A note on method

Foucault's definition of discourse indicates that he is not as interested in actual utterances or texts as in the rules and structures or practices that generate meaningful utterances and texts (Mills, 1997:7; Hall, 2001:72). Applying Foucault's ideas on discourse to medical discourse thus allows me to move beyond the actual words of some specific doctors and to describe the general rules of medical discourse (Young, 1981:48). Foucault's work on discourse is therefore very suitable for the aim of the current research project, namely to investigate the influence of medicine's intellectual self-image on communication between doctors and patients. Foucault's ideas on the procedures that control and restrict discourse provides a way of understanding and explaining why everything that can be said about sickness and health is not included in medical discourse. It also draws attention to the restrictions on how and by whom medical discourse may be used. Foucault's thoughts on discourse also enable one to recognise the specific reality of discourse. In Foucault's view medical discourse is not merely the representation of natural and empirical facts by means of language. Medical discourse is a discursive practice that is influenced by power relations and which also brings about effects of power. My work in this dissertation is thus conducted at a meta-theoretical level (attempting to describe how it happens that conversations between doctors and patients are produced the way they are) instead of the analytical level (describing and explaining what happens in actual doctor-patient encounters) (Mills, 2003: 117).

What follows in this chapter is not a discourse analysis. Neither do I follow any other systematic method of analysis that is described in the literature on qualitative research methods. I do not attempt to apply Foucault's (1972) archaeological method, as it is set forth in *The Archaeology of Knowledge*. I also do not follow the genealogical method that is

derived from Foucault's work (Armstrong, 1990: 1225)[137]. I do not wish to give a description of the formation of medical discourse. Instead, I make use of Foucault's invitation to researchers "to make what they can of his work" (Mills, 2003:7). Foucault (1975, as cited in Patton, 1979:115) expressed the following words in an interview with Roger-Pol Droit that was published in the French newspaper *Le Monde* in 1975:

> …a book is made to be used in ways not defined by its writer. The more, new, possible or unexpected uses there are, the happier I shall be. All my books…are, if you like, little tool-boxes. If people want to open them, to use this sentence or that idea as a screwdriver or spanner to short-circuit, discredit or smash systems of power, including eventually those from which my books have emerged… so much the better!

I begin my application of Foucault's work on discourse by describing medical discourse as a discursive formation. I outline the elements of medical discourse, namely its objects, concepts and theory or theme. Thereafter I consider medical discourse as a discursive practice. Finally, I describe (some of) the procedures of limitation and exclusion that have an effect on medical discourse. I base my Foucauldian inspired analysis of medical discourse on the descriptions of this discourse in scholarly books and articles.

Before I commence with the tasks listed above, I want to draw attention to the difficulties contained in the assumption that medical discourse constitutes a unity. Medical discourse certainly can be spoken of as a unity since there is a regularity between its elements. A regularity also exists in terms of who uses medical discourse, whom is addressed in this discourse, where this discourse is used, and the status of those sanctioned to use it. However,

[137] A small number of studies have been published that use Foucault's work in various ways to analyse (aspects of) twentieth-century medical knowledge and practice (Heaton, 1999:760). For example, Heaton (1999:759) examined the discourse of informal care and Chambers and Narayanasamy (2008:155) examined nurses' construction of health. The authors of both studies refer to their work as Foucauldian analysis. Heaton's (1999:760) study is an empirical analysis of mainly health policy documents. She addresses questions such as 'What are the conditions of possibility of the discourse of informal care?'; a discourse that emerged in the 1970s. Chambers and Narayanasamy (2008:157-158) interviewed nurses and analysed the interview transcripts in terms of "the regularity and variability of patterns, use of rhetoric, adoption of subject positions, resistance and acceptance of dominant discourses". I could not find a published study that applied Foucault's work of discourse to medical discourse in a way similar to my practice in this dissertation. Heartfield (1996:100) performed a discourse analsyis of nurses' case notes (nursing documentation) that was guided by "the elements of Foucault's archaeology". My study is different from Heartfield's in at least the following two ways. Firstly, I analyse medical discourse in general, and do not use a particular text(s) as the basis of my analysis. Secondly, I focus on doctor-patient (spoken) communication and not on nursing documentation.

Foucault tells us that the unity of medical discourse should not be accepted uncritically. We must consider what is left out of or disallowed to enter the discourse of medicine[138].

6.2.2 The unity of medical discourse

To speak of medical discourse as a unity, as a particular or "an individualizable group of statements" (Foucault, 1972:90), is problematic. Foucault (1972:23-29) urges us to question those ideas, categories and theories whose validity seem self-evident and that organise our discourses according to the principle of continuity. He suggests that the principle of reversal be applied to the study of discourse. This means that what is traditionally regarded as the sources of discourse, such as the discipline and the will to truth, must rather be recognised as performing a negative function of cutting-up (segmenting) and rarefying discourse (Foucault, 1981a:67; Sheridan, 1980:128). Foucault (1981b:6) wants us to think of discourses as sets of discursive events. He refers to this task as "eventalisation". Eventalisation includes "a breach of self-evidence, of those self-evidences on which our knowledges, acquiescences and practices rest" (Foucault, 1981b:6). Eventalisation wants to show that it wasn't necessary for current practices to develop in the way that they did. For instance, "it wasn't self-evident that the causes of illness were to be sought through the individual examination of bodies" (Foucault, 1981b:6).

What is the source of biomedical discourse? What defines the limits of what can be said and thought by modern medical doctors? This is the biomedical model of disease which exclusively developed from and uses the natural sciences (Dixon, 1983:360; Schwartz & Wiggins, 1985:356). I explained in Chapter 1 that this model views disease solely as a deviation from what is normal with regard to the measurable biological variables of an individual patient. The psychological, social and behavioural aspects of illness are not included in the biomedical view of disease. The biomedical model is reductionistic in the sense that it regards disease as purely physical in nature and as caused by a disturbance in the "smallest isolable component" of the biological system, for instance the biochemical level (Engel, 1977:130-131).

[138] Van Leeuwen and Kimsma (1997:106) point out that disagreement between medical practitioners from different countries about "medical decisions at the end of life", such as the differences on this matter between doctors from the United States and doctors from the Netherlands, illustrate that unity as well as diversity exist in medical discourse.

Modern medicine is experiencing a crisis of care. The positivist worldview of modern medicine does not allow the doctor to pay attention to the patient as a whole. The doctor's focus is on the patient's disease. The important question to ask is whether the biomedical model of disease is "adequate for the scientific tasks and social responsibilities" of medicine (Engel, 1977:129). I consider this question in the next chapter. Here I want to follow Foucault's suggestion to use a principle of reversal in thinking about the source of discourse. Not all possible statements about the patient, disease and treatment exist in medical discourse. The biomedical model of disease makes the formulation of statements and new propositions about the physical nature and the physical treatment of disease possible, but prevents statements about the psychological and social aspects of illness. Doctors may of course utter statements about patients' illness experiences. However, such statements are not scientific and fall outside the limits of medical discourse and when a doctor utters such a statement (s)he is strictly speaking not acting as a modern medical doctor. The biomedical model of disease is thus a source of medical discourse, but it also performs the negative function of dividing and depleting possible statements about illness and disease (Foucault, 1981a:67; Sheridan, 1980:128).

Foucault (1972:23-29) wants us to question the theories that organise our discourses and give them the appearance of unities. The validity of the biomedical model of disease seems self-evident to the Western world. This model has become the Western world's point of view on disease. Due to the model's status as "the dominant folk model of disease" in the Western culture, the limitations of this model are easily overlooked (Engel, 1977:130). Engel (1977:130) describes the status of the biomedical model of disease as dogma. Whereas a scientific model undergoes revision or is abandoned when it fails to adequately explain all facts regarding a particular phenomenon, a dogma requires that contradictory facts "be forced to fit the model or be excluded". Foucault (1981b:6) wants us to break out of the self-evidences on which our knowledge and practices are based. He wants us to realise that the "facts" and "the 'real' world" of the natural sciences are not self-evident and transparent. They require analysis and are the unrecognised effects of prior analyses (Sheridan, 1980:217). We need to consider that it was not necessary for current practices to develop in the way they did. It was not necessary for the biomedical model of disease to become the scientific and folk model of disease in the West. In The Birth of the Clinic Foucault (1973) argues that modern medical discourse arose under particular historical conditions and in relation to other types of discourse. Foucault stresses that discourse has a "contingent, nonrational and

arbitrary character" (Kuipers, 1989:104). Medical knowledge could have developed in another direction. The validity of the biomedical model of disease is thus not self-evident.

6.3 Medical discourse as a discursive formation: The elements of medical discourse

Foucault (1972:40-41) uses the term *discursive formation* to refer to a group of statements which has a regularity ("an order, correlations, positions and functionings, transformations") between its elements. The elements of a discursive formation include its objects, concepts and themes or theories. To study the elements of medical discourse is to look "inside the head" of modern medicine. It may be thought of as a study of modern medicine's rationality. Medical discourse informs doctors' thoughts and statements, including their conversations with patients.

The elements of medical discourse are fundamentally influenced by the nature of clinical biomedicine as "a technology that consists of the practical application of the natural sciences to human illness and health" (Schwartz & Wiggins, 1985:333). Medicine views itself as a science and specifically a natural science. Scientific practice can be defined as the systematic acquisition and transfer of knowledge. Modern science is driven by a particular aim. "It is the aim of the human intellect to arrive in a disciplined manner at a totality of coherent, rationally justifiable, and universally valid insights about the various aspects of reality" (Rossouw, 1993:95, my translation). The aim of rational justification means that fellow-subjects must be motivated by **evidence** to accept scientific insights. Evidence serves as the rational justification for scientific views and findings (Rossouw, 1993:96). Therefore, science only studies those subjects that can by some means directly present particular aspects of themselves to researchers (Schwartz and Wiggins, 1985:345). The different facets of the aim of science require that the process of knowledge acquisition be conducted in a disciplined manner. This discipline is evident in the strict demarcation of the problem domains that are scientifically investigated (Rossouw, 1993:96). The strict delimitation of the domains of scientific study means that the concepts of science are **abstract**. The concepts of any particular science focus on only a few features of its subject matter and exclude other features of the same subject matter. In biomedicine the reality of the patient is reduced to the abstract concepts of the natural sciences, "such as biochemistry, microbiology and physiology"

(Schwartz & Wiggins, 1985:336-337). The abstract, natural scientific concepts of biomedicine may hinder the practice of humanistic medicine. Yet Van Niekerk (1999:237) reminds us that the strategy of isolating problem domains for experimental investigation is central to the impressive success of medical and other modern sciences (Van Niekerk, 1999:237).

Medicine understands itself, and is understood by society, as a natural science (Simon, 2010: 337). Medicine thus shares the ontological and epistemological assumptions of the natural sciences paradigm or positivist world-view, as they were described in Chapter 1. These assumptions directly influence the elements of medical discourse; and thus what biomedicine can say about its subject matter, namely human health and disease (Schwartz &Wiggins, 1985: 354). I shall now describe the objects, concepts and theory of medical discourse.

6.3.1 The objects of medical discourse

The objects of a discursive formation are "that of which one can speak in a discursive practice" (Foucault, 1972:201). How are the objects of medical discourse delimited? Biomedicine's positivist world-view only allows discursive objects that belong to the material world and that can therefore be studied empirically and objectively. Two authors eloquently and succinctly state what the objects of medical discourse are. Foucault (1973: xi) writes in *The Birth of the Clinic* that "…the singularity of the patient, …that region of 'subjective symptoms' that –for the doctor – defines …the world of objects to be known." The linguist, Suzanne Fleischman (2001:475), writes in her overview of the scholarly literature on language and medicine that "medical language…is an abstract discourse about disease and organs; it is not about patients and their experience of illness."[139] The objects of medical discourse are thus **disease and** the **bodies** of patients.

Medical discourse can only speak about **physical disease**, in other words disease of the body. Only observable signs of disease and physical treatments can be spoken of in the diagnostic and therapeutic tasks of biomedicine. In its task of diagnosing disease, medicine wants to

[139] The physician William Donnelly (1986:88) makes a similar observation about grand rounds and clinicopathologic exercises. He writes that "…almost everything said about the patient in a typical clinicopathologic exercise in the *New England Journal of Medicine* could be said as well for a lesser primate with remarkably good health insurance. The message is clear: disease counts; the human experience of illness does not."

"communicate directly with disease" (Rich *et al*., 2008:221). In this doctor-disease communication the person who suffers from the disease plays a passive role and is silenced. (S)he is the substance or medium in which the disease exists (Fleischman, 2001:476; Rich *et al.*, 2008:224). As Rich *et al*. (2008:223) put it: "the patient is simultaneously important, as the medium in which disease is recognised, and irrelevant, as clinical ephemera." Due to biomedicine's commitment to empiricism patients' diagnoses and treatment results are expressed in terms of **measurable information**, preferably in the numerical language of laboratories. Human information about disease, such as doctors' observations or clinical judgements or patients' emotional reactions is limited in medical discourse. Feinstein (1987:223-224) describes what is excluded from empirical or "hard" clinical data:

> Among the soft information excluded by this [empirical] model are data about a patient's spectrum of symptoms, severity of illness, co-morbidity, disability, and all the distinctly human reactions – love, hate, joy, sorrow, distress, gratification – that differentiate people from animals or molecules. The exclusions have also diverted attention from the clinician's traditional obligation to offer relief and comfort, not just cure. Consequently, the results of treatment today are often reported with hard data about death, survival, disease and adverse reactions, but suitable information is not assembled to show many important human benefits of modern therapy.

The body is an object of medical discourse and in medical discourse **the body is an object**. In the natural science paradigm "the body is regarded as nothing but a self-contained material object, reductively conceptualised in terms of a physics of mechanisms, and studied, as if it were just an object, in isolation from its inhabited world" (Levin & Solomon, 1990:517). Since biomedicine is interested only in material reality and that which can be objectively measured, the patient is reduced to his/her body and has "the status of object" (Foucault, 1973:xv). Medical discourse is not about patients but about their bodies and the diseases that affect those bodies (Fleischman, 2001:475). The human body is the primary object of biomedical interventions and treatment outcomes "are measured with objectively quantifiable instruments" (Tilburt & Geller, 2007:820).

6.3.2 The concepts of medical discourse

Medicine is a practical science. A distinction exists between the practical sciences and the pure sciences. The pure sciences want to discover the **truth** concerning their subject matters. Practical uses or goals are irrelevant to the pure sciences since they merely want to generate **knowledge** regarding the nature of reality. Physics and biology are examples of pure sciences. On the contrary, practical sciences can be described in terms of their **practical goals**. The concepts of a practical science are all relevant to the particular goal(s) of the science. Medicine is a practical science. Its goals are the promotion of health and the treatment of disease in human beings. Medicine does not merely want to gain knowledge about human health and disease. Medicine includes those concepts of the pure sciences that are relevant to human health promotion and the treatment of disease in human life (Schwartz & Wiggins, 1985:346-347).

Medicine thus makes use of the pure sciences that provide knowledge relevant to its goals and pursuits. Examples of the pure sciences used by biomedicine are anatomy, physiology, microbiology and biochemistry. Nevertheless, medicine also moves beyond the relevant pure sciences to develop concepts that belong to medicine alone (Schwartz & Wiggins, 1985:353). Schwartz & Wiggins (1985:353) provide the following example of a concept peculiar to medicine:

> The notion of hepatitis, for example, is peculiar to medical science. Medicine could never have developed such a notion, however, if it had not utilized and extended some of the well-established principles of physiology and biochemistry - not to mention anatomy, pathology, and microbiology. Hepatitis is not an item in these pure sciences because its conceptualization need arise only if science is aiming at promoting health and treating illness.

Medicine's natural scientific intellectual self-image impacts its understanding of its central concepts. The concepts of medical discourse are abstract. The positivist epistemological assumptions of objectivity and empiricism mean that medicine views its concepts as observer-neutral and corresponding to a completely independent, objective reality that can be physically measured (Levin & Solomon, 1990:534; Tilburt & Geller, 2007:820). Kriel (2000:23-24) lists the following as among the central concepts of medicine: patient, disease

and therapy. The patient as well as disease processes and causality are regarded as merely biological or physical in nature. Similarly, biomedical treatments are physical in nature and are understood as functioning objectively and mechanistically (Kriel, 2000:23-24). I shall now elaborate on each of these three concepts of medical discourse.

The natural science paradigm's ontological assumptions of dualism and materialism fundamentally influence medicine's concept of **the patient**. A mind-body dualism still exists in medicine. The mind and body are viewed as distinct from one another (Levin & Solomon, 1990:528). The material aspects of reality are the subject of the natural sciences. The natural sciences are only interested in human beings as physical systems, equivalent to all other organic or inorganic physical systems. The patient is thus reduced to his/her body. Human experience is not part of the subject matter of the natural sciences and is therefore ignored by medicine (Schwartz & Wiggins, 1985:355). Schwartz & Wiggins (1985:336) elaborate on medicine's materialistic view of the patient:

> [The biomedical] model substitutes for the concrete reality of the patient a construct derived exclusively from the natural sciences such as biochemistry, microbiology, and physiology. In this manner, the reality of the patient is subsumed entirely under the abstract concepts of these sciences. The patient's life is reduced to whatever these abstractions can express.

Since medicine's interest is in the patient's body, the next question to answer is: "what is medicine's conception of **the human body**?" In line with the positivist ontology modern medicine conceptualises the body concretely, empirically and mechanistically. The body is seen as a totality of separately functioning parts (Levin & Solomon, 1990:552; Burger, 2001:81). The structure and the functioning of the body are regarded as a product of the interaction of its smallest constituent parts. Helman (1991:1080) draws our attention to the possibility of patients adopting a mechanistic conception of the body from their doctors and/or the media.

> Patients may believe…, that their bodies are repairable machines that can be diagnosed, measured, monitored, and even kept alive by other machines. This new body image is reflected in language: "nervous breakdown", "blow off steam", "recharge batteries", or "reprogramme myself". Some patients, as a result, regard their doctors as mechanics, plumbers, electricians, or carpenters, rather than as healers.

The concept of **disease** is the most important subject of medical practice and science (Van Leeuwen & Kimsma, 1997:105; Hofmann, 2001:211). Corresponding to its natural scientific intellectual self-image, medicine has a realist[140] conception of disease. According to this view disease is conceived of "as a thing" (Hofmann, 2001: 221). Realists are of the opinion that diseases form part "of the underlying structure of the natural world"[141]. A specific instance of a disease is consequently a certain sort of "identifiable physical entity"[142], which in conjunction with other particular examples of the same disease, constitute a natural kind. As a result, the course of the disease in any particular patient is predictable as it is "guided by natural law and the underlying structure of the world" (Simon, 2010: 335). Diseases then are not invented, but must be discovered (Hofmann, 2001:221) in specific patients and "as general types" (Simon, 2010:335). Despite the view that diseases are empirically identifiable (Rich *et al.*, 2008:222), disease conditions are not considered as independent material objects by realists. In other words, realists do not identify diseases with their causes (Simon, 2010:343). Conditions are understood as having material constituents, for instance the Mycobacterium tuberculosis in the disease condition referred to as tuberculosis. Yet tuberculosis is not equated to its biological pathogen. As Dixon (1983:359) puts it: "disease as a concept… represents an organization of thought…"[143]

Modern medicine's concept of disease represents a break with the humoral theory of illness of Hippocratic medicine. I described the transformation of medicine from Hippocratic to biomedicine in Chapter 1. I will briefly recapitulate this description for the reader's benefit. Hippocrates and his followers saw disease as a single, uniform entity (Van Niekerk, 2002:227-228). In Sigerist's (1933:181, as cited in Jonsen, 1990:84) words, "Hippocrates recognized only disease, not diseases." The biomedical concept of disease differs starkly from this pre-modern notion. Modern medicine recognises various separate types of disease. Each type of disease has a characteristic set of signs and symptoms and an identifiable and

[140] The realist position on disease may also be referred to as ' "ontological", "Platonic", "Cnidian", …, "rationalist", "pro-ontological" and "naturalistic" ' (Hofmann, 2001:221). The realist position is denied by anti-realist theorists who propose that diseases are not real but socially constructed entities (Simon, 2010:335).

[141] With "underlying structure of the physical world" is meant "the structure of the natural world that, according to realists…, lies behind the physical features of the world we are directly aware of and explains the presence of natural kinds, laws of nature, and/or other regularities found in the natural world" (Simon, 2010:335).

[142] "Entity" here must be broadly interpreted as referring to the states or processes of organisms (Simon, 2010:33).

[143] Stempsey (2000: 324) makes the interesting point that, strictly speaking, doctors do not need a concept of disease. The distinction between health and disease has no effect on practical medical decisions. The decision to provide medical treatment does not depend on the presence of disease. Persons receive medical treatment for a variety of conditions that are not diseases, for instance plastic surgery. Then again, certain conditions that are generally considered as diseases may not be medically treated, such as asymptomatic benign tumors.

distinct pathophysiological cause (Jonsen, 1990:85). The modern disease concept has allowed modern medicine to answer some of the basic problems that puzzled humankind and caused great suffering and death for millennia, such as infection and contagion (Lewinsohn, 1998:1263). Yet, modern medicine has not reached a full understanding of disease. Every question that science answers, leads to countless new questions.

The modern concept of disease has changed from identification with the clinical manifestation of disease until the early eighteen hundreds, to a representation of the "essential" cause of each specific disease (the theory of cause [Hyde *et al.*, 2005:73]), in the nineteenth and twentieth centuries (Copeland, 1977:529). Feinstein (1987:218) explains this change and illustrates it with some examples.

> Until the scientific revolution that began with the routine use of necropsy in the early nineteenth century, disease was perceived and named as a clinical manifestation: a *dis-ease*. *Fever, cyanosis, asthma*, and the *falling sickness* (epilepsy) were diseases. After the underlying morphologic, chemical, and microbial causes of many clinical diseases were revealed during the nineteenth and twentieth centuries, the concepts and names of human ailments were changed, whenever appropriate to indicate the "essential" etiologic cause of each disease[144]. *Consumption* became *tuberculosis* or *metastatic cancer*; *dropsy* was replaced by such entities as *congestive heart failure*. The clinical diseases of *angina pectoris* and *familial haemolytic jaundice* were converted into the morphologic diseases of *coronary arteriosclerosis* and *spherocytosis*. With further scientific progress, the etiological concepts and names were expanded to include external invasions (such as microbial agents), internal dysfunction (such as chemical imbalances), and genetic displacements (in chromosomes).

Disease today is understood as pathology on the molecular level (Helman, 2007:123). Biomedical scientists attempt to define disease "in the language of microscopic or radiographic morphology, biochemistry and molecular biology" (Hofmann, 2001:220). As a result medical discourse about disease and biomedical technology is "rigorously up-to-date, highly nuanced, and often precisely quantified" (Donnelly, 1986:81). A unified concept of disease does not (yet) exist in biomedicine. Particular disease concepts may be based upon gross anatomical defects (a fracture, for example), microscopic changes in anatomy (for

[144] Feinstein (1987:218) cites the following source here in his paper: Faber, K. 1923. *Nosography in modern internal medicine*. New York: Hoeber.

example arterial-septal cardiac defect), specific causative agents (for example infection with a known micro-organism), specific deficiencies (for example vitamin deficiencies), genetic abnormalities (for example sickle cell anaemia), physiological or biochemical irregularities (for example arterial fibrillation), groups of clinical signs and symptoms (for example aplastic anaemia), or simply a description of abnormalities (for example peptic ulcer) (Engle & Davis, 1963:517-518; Copeland, 1977:530). Modern medicine views diseases as objects. Disease is seen as an independent entity and not as part of the patient (Cassell, 1976:143). The biomedical disease concept does not include any psychological, social or cultural factors.

Biomedicine's reductionist disease concept is frequently criticised by scholars as well as patients and their caregivers since it doesn't accommodate metaphysical terms such as personhood, partnership, care and healing (Van Leeuwen & Kimsma, 1997:105). For instance, Donnelly (1986:86) points out that medical discourse seems to favour words that pathologize human situations to everyday language to talk about the human experience of illness. "Words like apathy, anxiety, denial, depression, and manipulative come easily to the clinician's tongue. We seldom hear determined, discouraged, hopeful, optimistic, pessimistic, courageous, brave, valiant, sad, happy, and the like." Another example is Barry *et al.*'s (2001:494-495) finding, which I elaborated upon in Chapter 4, that doctors tend to block or ignore patients with chronic physical conditions' utterances about difficult life experiences related to their symptoms. The outcomes of such doctor-patient interviews are typically poor. Furthermore, biomedicine understands symptoms - that is patients' complaints of suffering or behavioural deviations - simply as reflections or manifestations of disordered bodily processes. However, research from a variety of social science traditions indicate that an individual's experience and the clinical manifestation of a specific biomedical condition are strongly influenced by psychological, social and cultural factors. Sociological and anthropological research suggest that systematic variation in the clinical behaviour of different cultural groups includes variation in the specificity of medical complaints, the style of medical complaining in diverse clinical settings, the nature of anxiety about the meaning of symptoms, the focus on particular organ systems, and the response to therapeutic strategies (Good and Good, 1980: 170, 172).

Modern medicine's disease concept also leads to problems in the practice of medicine itself. Firstly, the modern disease concept expresses disease "as a single-state entity, [and] not as a dynamic clinical course." A diagnostic label such as diabetes mellitus or coronary artery disease does not provide a prediction of the various ways in which the disease may develop in

a particular patient. Yet, these different patterns of development are critical distinctions when a doctor assesses prognosis and therapy (Feinstein, 1987: 218). Feinstein (1987:218) illustrates how the same disease may evolve differently in different patients:

> Some patients never know they have diabetes mellitus until it is accidentally discovered late in life; others lose limbs, go blind, and die during adolescence. Some patients with coronary artery disease lead active, relatively unrestricted, long lives; others are incapacitated or dead before the age of 50.

A patient's prognosis is estimated based on his/her "spectrum of symptoms, severity of illness, rapidity of disease progression, or concomitant major co-morbidity" (Feinstein, 1974, as cited in Feinstein, 1987:218). Yet these features are not reflected in disease labels and concepts. Since modern technology has started to make diagnostic evidence available to clinicians in the second half of the twentieth century, for instance via laboratory tests and imaging, the task of diagnosis is no longer the physician's main intellectual challenge. The biggest scientific challenge of today's doctor is prognosis and not diagnosis. Today's doctor must choose effectively between numerous treatment options. To achieve this task the doctor must be able to predict the outcomes for patients in different groups of each disease and to assess the effect of treatment "in each prognostic group". Nonetheless, prognosis does not receive much scientific attention (Feinstein, 1987:219).

Secondly, the current system of disease classification is inadequate for the reason that "disease is cited according to what it *is* but not what it *does*" (Feinstein, 1987:219-220). Disease names represent the essence of a specific disorder but do not indicate what has taken place in the spectrum of symptoms and the functional severity of disease for individual patients (Feinstein, 1974, as cited in Feinstein, 1987:220). For instance, a patient diagnosed with diabetes mellitus "may or may not have acidosis and vascular complications". Similarly, a patient with cancer of the colon "may or may not have bleeding, intestinal obstruction, ascites or cachexia"[145]. Nevertheless, most patients receive treatment or are hospitalised due to the functional effects of the severity of disorders, and not because of the pathological essence of disease. For example, a patient with chronic pulmonary disease may receive treatment for respiratory failure or a superimposed infection instead of the disease itself. For

[145] For the benefit of the reader without a medical background I define the following inaccessible biomedical terms. Acidosis indicates the presence of excessive acid in the body fluids (Acidosis, [s.a.]). Ascites refers to "excess fluid in the space between the tissues lining the abdomen and abdominal organs" (Ascites, [s.a.]). Cachexia refers to a loss of appetite and body fat (Hypothalamic tumor, [s.a.]).

this reason a scientific classification of functional severity is needed for prognosis, treatment and for satisfactory evaluation of the cost of care (Feinstein, 1987:220).

The final concept of medical discourse that I will describe is **treatment**. In keeping with the positivist world-view and the corresponding realist conception of disease, biomedical treatment is conceived of as physical in nature and as functioning objectively and mechanistically (Jaspers, 1989:256; Kriel, 2000:24). Examples of biomedical treatments are pharmacological products or other technological remedies and surgery (Kriel, 2000:24; Hyde *et al.*, 2005:73). Physical treatment may even be deemed appropriate for the treatment of psychosocial problems with purely social causes (Hyde *et al*., 2005:73)[146]. This propensity is referred to as "a pill for every ill" (Hyde *et al.*, 2005:70). Since biomedical treatment is physical in nature, treatment results are commonly reported with physically measured information (Feinstein, 1987:223). In Donnelly's (1986:86) opinion medicine does not have an adequate language to talk about caring for terminally ill patients in acute-care hospital wards. He explains as follows:

> "Symptomatic and supportive"? "Palliative care"? The latter term seems especially limp, inconsequential, passive, and hardly up to the important and challenging task of caring for the very sick. And although the phrase "happy death" may still have meaning for individuals brought up in the Christian tradition, "happy" or "good" death is not part of medicine's vernacular, and such a goal, individualized for a particular patient, cannot be given formal recognition in management discussions among [medical personnel].

6.3.3 The theory of medical discourse

Physicians have used theoretical models to think about and to understand the nature of disease and how to treat it in every era of the history of medicine. It appears that these respective theoretical models were acceptable in their eras of reign. Yet, most models are later found to be faulty (Feinstein, 1987:215). Modern medicine's theoretical model of disease is known as the **biomedical model**. I earlier stated that the biomedical model is based on the natural sciences, namely physics, chemistry and biology (Schwartz & Wiggins, 1985:333).

[146] For instance, Irving (2002:408) observed that elderly, hospitalised patients in Australia were treated with antipsychotic medication for agitation, which might have been caused by unmet daily needs, such as relief of physical discomfort.

Therefore, it views the body and disease as purely physical in nature (Engel, 1977:131). Medical practice or clinical medicine is perceived as the application of the natural sciences to the treatment of disease and the promotion of health in human beings (Schwartz & Wiggins, 1985:333)[147]. The biomedical model does not accommodate the psychological, behavioural and social dimensions of illness (Engel, 1977:130). Yet, I have stressed throughout this dissertation that the non-material aspects of illness are of real consequence for the diagnosis and treatment of disease. Scientific medicine demands physical evidence as support for all statements about illness and disease. Medicine must take into account that its object of inquiry is a suffering human being. Evidence of disease should not only include observation, but also the testimony of the sufferer (Engel, 1985:362).

6.4 Medical discourse as a discursive practice

Foucault (1972:54) refers to discourses as "**practices** that systematically form the objects of which they speak". He urges us through his analytic principles of reversal and specificity to view discourse as more than the linguistic signs used in speech and writing. Foucault (1981a:67; Hook, 2001:532) wants us to treat discourses as practices, in other words as actions. For Foucault discourses do not merely describe reality, discourses constitute reality. When analysts consider discourses as practices, they are able to appreciate the material effects of discourse (Foucault, 1981a:66; Hook, 201:537). Foucault (1977:199) defines discursive practices as follows:

> Discursive practices are characterised by the delimitation of a field of objects, the definition of a legitimate perspective for the agent of knowledge, and the fixing of norms for the elaboration of concepts and theories. Thus, each discursive practice implies a play of prescriptions that designate its exclusions and choices.

On the one hand discourse appears as a productive phenomenon which brings forth utterances, concepts and effects (Mills, 1997:17). On the other hand Foucault's (1981a:67) principle of reversal focuses our attention on the negative, limiting function that a discipline, such as biomedicine, performs on discourse. Doctors and patients can only produce

[147] The principles of the natural sciences, in particular basic biomedical science, are used to explain the mechanisms of disease. Yet, the principles that are followed in decisions concerning patient management are derived from the following non-clinical sciences: biostatistics, epidemiology, economics and sociology (Feinstein, 1987:217).

utterances of a certain kind (Van Leeuwen & Kimsma, 1997:102-103). The **objects** of medical discourse are limited to the material world. The objects of medical discourse are mainly the bodies and organs of patients and (physical) disease. The only **legitimate perspective** for agents of biomedical knowledge is the positivist world-view. Consequently, efforts to elaborate on the concepts and theory of biomedicine must be made in accordance with the natural-science paradigm. The lifeworld of the patient and of the doctor have a very limited place in medical discourse. In Van Leeuwen & Kimsma's (1997:103) words, medical discourse "allows one particular type of experience and simultaneously suppresses or devalues certain other more personal and intimate or subconscious experiences." During the medical interview the patient's story of his/her illness is transformed into medical discourse.

6.5 The order of medical discourse

According to Foucault (1981a:61) there are three different procedures at work in modern, Western societies to select certain statements for and exclude others from discourse. These three procedures are:

i. social or external procedures of exclusion;

ii. internal procedures of control;

iii. a rarefaction of the speaking subjects.

I shall now describe (some of) the procedures of limitation and exclusion that have an effect on medical discourse. I describe the procedures that I identified through reading scholarly literature on medical discourse and by my own reflections on the subject. It is certainly possible that more procedures of limitation and exclusion operate in medical discourse than the ones I next describe.

6.5.1 Social procedures of exclusion at work in medical discourse

Social procedures of exclusion operate from the outside of discourse. They are concerned "with the part of discourse which puts power and desire at stake". These procedures are responsible for averting the powers and dangers of discourse (Foucault, 1981a:56). One particular social procedure of exclusion clearly operates in medical discourse, namely "**the opposition between true and false**".

The modern, western world has a scientific worldview. The ontological and epistemological assumptions of this worldview as well as the findings and the meanings achieved through scientific endeavours form **the true discourse** of the modern period. The true discourse of the society at large is echoed in the medical discourse of its time. What does the division between true and false look like in modern medicine?

In medical discourse facts or true statements concern the material reality that can be studied objectively and empirically. A statement is true if it precisely signals "the 'natural' order of human biology" (Good & Good, 1981:179). The soundest sources of knowledge are facts about molecular and cellular physiology as well as the findings of randomised controlled clinical trials. In contrast, the findings of the humanities and the social sciences are regarded as less reliable sources of knowledge, due to the more subjective nature of these fields of enquiry. For this reason the human and social sciences are mostly excluded from medical education and human and social research are unlikely to receive financial support from biomedical institutions (Burger, 2001:81; Tilburt & Geller, 2007:820).

I earlier stated that modern medicine has a realist conception of disease. According to this understanding diseases are empirically identifiable entities. Furthermore, diseases are believed to exist independently of the patient whose body merely acts as a host for or the site of disease. Modern medicine's conception of disease creates a division between the scientifically knowable **signs** of disease in or on a patient's body and the **symptoms** of disease that patients experience and report. In biomedicine a distinction is thus made between the objective signs and the subjective symptoms of disease (Rich *et al.*, 2008:222). Anspach (1988:371) identified a "clear epistemological hierarchy" in medicine. The most respected, or the truest, form of knowledge is gained with the use of technology, such as in a laboratory. Slightly lower on medicine's epistemological hierarchy are observations made by physicians. At the bottom of the hierarchy are patients' reports about their illness experiences, in other words information about disease symptoms. Symptoms that cannot be explained by one of

the higher forms of medical knowledge, such as the findings of the physical examination of the patient or laboratory data, are often not regarded as valid by doctors. In Donnelly's (1986:86) long-standing experience as a doctor based at a teaching hospital in North America patients with unexplained symptoms may be suspected of imagining their symptoms or even of being alcoholics.

6.5.2 Internal procedures of control at work in medical discourse

Internal procedures of control operate from the inside of discourse. These are the procedures whereby discourses control themselves. The internal procedures of control function as principles of classification, ordering and distribution. Their role is to master discourse as irruption, or chance event (Sheridan, 1980:124; Foucault, 1981a:56). The principle of **the discipline** is actively and evidently at work in medical discourse.

The principle of the discipline allows the generation of new propositions but also forbids certain propositions to enter the borders of medical discourse. According to Foucault's (1981a:67; Sheridan, 1980:128) principle of reversal the discipline acts as a source as well as an inhibitor of discourse. It is a creative as well as a restrictive mechanism. To be allowed into a discipline a proposition must form part of the true discourse of the discipline. This means that a proposition must fulfil the following three conditions.

i. It has to refer to a determinate range of objects;

ii. it has to use conceptual tools of a specific type;

iii. it has to refer to a specific body of theory.

The objects, concepts and theory of medical discourse are deeply influenced by the ontological and epistemological assumptions of natural science. I explained above that the objects of medical discourse are strictly material, its concepts are abstract, and that the only valid theory of disease is the biomedical model. The discipline of modern medicine disallows propositions containing discursive elements of a different nature to form part of its discourse.

6.5.3 A rarefaction of the speaking subjects of medical discourse

The third group of procedures that exercise control over discourses perform "a rarefaction of the speaking subjects". These are procedures whereby discourse controls speaking subjects (Foucault, 1981:61). Foucault (1981:61-64) identifies three such procedures, namely:

i. the ritual;

ii. societies of discourse;

iii. the social appropriation of discourses.

These procedures determine the conditions in which discourses are applied and the rules for those that use a particular discourse, and are therefore rules that limit access to discourses.

Ritual determines the qualifications needed by the speaker; the gestures, behaviour, circumstances and the entire set of signs which have to accompany the discourse; and also the effectiveness of the words spoken, that is their effect on those to whom they are directed, and the limits of their ability to constrain (Foucault, 1981:62). It seems that much of doctors' interactions with or about patients are guided by ritual. The medical anthropologist Cecil G. Helman (1991:1081) describes the hospital as "a tiny self-contained city, with its own history, hierarchies, uniforms, rituals, and slang". Doctors' consultation rooms and health care clinics also fit this description. Medical discourse includes the rituals of the consultation, or the clinical method, and the case presentation. These rituals contain purely physical actions as well as speaking and writing (for instance of medical reports, referral letters, medical certificates and on prescriptions).

Who is qualified to use medical discourse? The answer is simply, those who are formally educated and recognised as medical professionals. That is mainly those who obtained degrees in medicine and surgery at universities[148] and who work as doctors. **What circumstances accompany medical discourse?** Medical discourse (as defined for the purposes of this dissertation) occurs in interactions between doctors and patients and their families or caregivers. Such interactions take place in the social institutions of medicine, namely hospitals, clinics and consultation rooms (Van Leeuwen and Kimsma, 1997:102). The circumstances of medical discourse are thus that a person who is socially recognised as an authority on matters of health and disease, is consulted by a person with a corresponding need in an official setting. **How do the two main actors, the doctor and the patient, behave during a consultation?** The actions of both participants are predetermined by the format of the clinical method. Doctors are taught in medical school to structure their interactions with patients according to the clinical method, and patients learn to anticipate and to cooperate with this method from their earliest interactions with doctors.

The clinical method contains a number of actions that the doctor systematically performs. The doctor first interrogates the patient about his/her symptoms and possibly related factors. This is known as history taking. Thereafter (s)he examines the patient and may perform or order some special diagnostic investigations. Next (s)he identifies the disease label that best fits the results of the preceding diagnostic tasks and then prescribes treatment appropriate for the identified disease (Kriel, 2000:22-23). The patient's role during the consultation is to cooperate with the doctor. The patient is expected to answer the doctor's questions during history taking as thoroughly and truthfully as possible and to adequately perform the actions required of him/her during the physical examination. The verbal behaviour of doctors and patients during consultations also has a specific structure. In Chapter 4 I related Mishler's (1984:67-68) discovery of a "basic structural unit of discourse" in what the author terms unremarkable interviews between doctors and patients. This unit occurs regularly and routinely in unremarkable medical interviews. The unit consists of three consecutive utterances, namely

[148] Universities usually do not allow just anyone who wishes to study medicine to do so. At most medical faculties only a predetermined number of students are selected to follow medical degree programmes. This is mainly due to the large number of prospective students interested in medicine as an occupation (partly or perhaps mostly due to the prestige of the profession) and the limited resources available to provide this training. The selection is largely based on the candidate's most recent academic achievement.

i. a request or question from the doctor;

ii. a response by the patient; and

iii. an assessment or acknowledgement of the patient's response by the doctor.

The doctor then adds a new request or question to this third utterance, and so the next cycle of discourse begins. Medical interviews that are recognised and accepted as standard and appropriate tend to be made up of a connected series of these structural units and are therefore termed "unremarkable". Mishler (1984:77) and Barry *et al.*'s (2001:494-496) research has shown that doctors generally block or ignore statements by patients that diverge from the structure of typical or unremarkable medical interviews. This is especially true in consultations about chronic physical conditions, such as angina, arthritis and asthma. Patients may attempt such diversion by asking questions or introducing conversational topics, especially if these concern psychosocial matters. The doctor largely determines the nature of the doctor-patient interaction.

The next question to answer regarding the ritual in medical discourse is, **what signs accompany medical discourse?** Medical discourse is based on what Harrison (1972:3) refers to as the "empiricist theory of language". The empiricist theory of language shares many of the ontological and epistemological assumptions of biomedicine (Good & Good, 1981:179). According to the empiricist theory of language the utterances of a language can be divided into two categories, namely basic and non-basic utterances. Basic utterances have "contact with the world". They are attached to "bits of 'the world'" in the mind of the language user. Examples of basic words are 'red', 'cold' and 'dry'. Basic utterances refer to direct sensory experiences. Non-basic utterances receive meaning from an association with basic utterances. Examples of non-basic utterances are syncategorematic and abstract words such as 'not', 'unless', 'however' or 'heretical' and 'subsume'. It is thus through basic utterances "that meaning enters a language". Meaning attaches to a basic utterance by means of a conventional stipulation that stipulates "simply that a given language element shall henceforth be associated with a given world element" (Harrison, 1972:9-13, 33).

Within biomedicine the elements of medical discourse are viewed as references to the material world, in particular to biological realities. The meaning of the words and phrases of

medical discourse are constituted in relationship to these realities. The meaning of biomedical terms is thus seen as free of social context and of the perspective of the speaker. In biomedical practice, research and education statements are true and valid if they accurately reflect the material world. Patients' statements are also interpreted in relationship to the material world. The material world that medical discourse refers to is universal and is not connected with or influenced by cultural and social contexts (Good, 1977:51-52; Good & Good, 1981:181). According to the empiricist approach to language, different languages are simply different sets of words that represent universal realties. This theory has a very practical and uncomplicated understanding of translation. The task of translation is simply seen as the selection of the appropriate words or labels for entities that exist throughout the world (Swartz, 1998:27-28).

Earlier I paid attention to the content of medical discourse by describing its objects, concepts and theory. Here, I want to focus on **how language is used** by the authorised speakers of medical discourse. In Helman's (1991:337) words "…medical professionals form a privileged subculture, **with their own language**, rituals of healing, and the use of powerful symbols, such as the white coat". Dixon (1983:362), a family physician and scholar makes a similar statement: "The medical community is identified by, and identifies its members with, a particular language." Bourhis *et al.* (1989:339) refer to this language as medical language. In sociolinguistic terms medical language forms an occupational register (Fleischman, 2001:473). Fleischman (2001:473) translates and quotes the following illustrative description of medical language by the French scholar Jammal[149]:

> …medical language, the occupational register of a tribe of white-coated speakers that gets passed from one generation of physicians to the next through the highly ritualised institutions of medical education. It is widely recognised as what sociolinguists would call an "in-group dialect," i.e. largely opaque outside the medical "confraternity."

What are the characteristics of medical language? The most prominent feature of medical language is probably its large specialised **vocabulary**. This vocabulary is also known as the jargon of medical practitioners and scientists. Donnelly (1986:83) gives the following description of the vocabulary of medical language.

[149] Jammal, A. 1988. Les vocabulaires des spécialités médicales : pourquoi et comment les fabrique-t-on ? (The vocabularies of medical specialties : why and how are they created ?) *Meta*, 33(4): 535-41.

> This language is dominated by an elaborate vocabulary for laboratory findings and disease entities…It is good and proper language for both the well and not-so-well parts of human beings. It includes the extraordinary precise language of biochemistry and immunology and the finely nuanced language of pathology.

Medical terms slip into everyday or ordinary language. For instance, some psychological terms form part of English to the extent that they are listed in everyday English language dictionaries. The words depression, eating disorder and psychopath appear in the Oxford Dictionary. However, the meanings of medical terms in everyday language often differ from the meanings of these terms in medical language[150]. These differences in meaning for doctors and patients have the potential to cause misunderstandings during clinical communication. What further complicates doctor-patient interactions is that both parties may be unaware of such misunderstandings when they occur. Misunderstandings during consultations may result in patient dissatisfaction and non-compliance with treatment advice (Hadlow & Pitts, 1991:193, 195).

Another striking feature of the way that doctors use language is the large amount of **abbreviations** they use during interactions with each other or other medical professionals. This behaviour particularly occurs in hospital settings where more than one doctor or medical professional attends to a patient. Perri Klass (1984:C2) gives the following description of her introduction to the esoteric language of doctors as a junior medical student at Harvard Medical School.

> "MRS TOLSTOY is your basic L.O.L. in N.A.D., admitted for a soft rule-out M.I.," the intern announces. I scribble that on my patient list. In other words Mrs Tolstoy is a Little Old Lady in No Apparent Distress who is in the hospital to make sure that she hasn't had a heart attach (rule out a myocardial infarction). And we think it's unlikely that she has had a heart attack (a soft rule-out).
>
> If I learned nothing else during my first three months of working in the hospital as a medical student, I learned endless jargon and abbreviations. I started out in a state of primeval innocence, in which I didn't even know that "s C.P., S.O.B., N/V" meant "without chest pain, shortness of breath, or nausea and vomiting." By the end I took the

[150] It is also possible that lay persons have different understandings of medical terms among themselves. Hadlow & Pitts (1991:194) found that 46% of a sample of British patients understood the term "eating disorder" to mean "indigestion or stomach ache".

> abbreviations so for granted that I would complain to my mother the English Professor, "And can you believe I had to put down three NG tubes last night?" "You'll have to tell me what an NG tube is if you want me to sympathize properly," my mother said. NG, nasogastric – isn't it obvious?

The jargon and abbreviations that doctors use are neither purely scientific in nature nor what one would expect from professionals who work benevolently and non-malevolently and with the utmost respect for those whom are sick or injured. Donnelly (1986:82) refers to this language as slang. Slang, or informal medical language, is not taught in the classrooms of medical schools and does not appear in medical textbooks (Coombs *et al.*, 1993:987). Again Klass (1984:C2) provides some examples.

> And then there is the jargon that you don't ever want to hear yourself using. You know that your training is changing you, but there are certain changes that you think would be going a little too far. The resident was describing a man with devastating pancreatic cancer. "Basically he's C.T.D.," the resident concluded. I reminded myself that I had resolved not to be shy about asking when I didn't understand things. "C.T.D.?" I asked timidly. The resident smirked at me. "Circling The Drain." The images are vivid and terrible. "What happened to Mrs Melville?" "Oh, she boxed last night." To box is to die, of course.

It is mostly doctors in some stage of training who are familiar with and use slang (Coombs *et al.*, 1993:992). These include the undergraduate students, interns and residents that Klass (1984:C2) refers to[151]. Rude forms of slang are seldom used by or in front of senior medical staff, unless they have somehow indicated their approval thereof (Donnelly, 1986:82)[152]. It is also not used in front of patients. Medical slang is what the sociologist Erving Goffman

[151] The [English] terminology that refers to the positions of medical workers in hospitals is confusing since it is not transparent to the layperson, and differs between Britain and the United States of America. The term medical student refers to an undergraduate student who studies at a university towards a degree in medicine and surgery. An **intern** (USA) or a **house officer** (Britain) is a person who has nearly completed or who has completed his/her medical degree "…and who is working at a hospital to get further practical experience" (Oxford Advanced Learner's Dictionary, 2005:727, 780). A **resident** (USA) or a **registrar** (Britain) is a doctor who works in a hospital and who is training as a specialist in a specific area of medicine (Oxford Advanced Learner's Dictionary, 2005:1243, 1226).

[152] Donnelly (1986:82) emphasises that not all slang used by (trainee) doctors in hospitals is impolite. Coombs *et al.* (1993:995, 997) describe one of the functions of informal medical language as a means of exercising creativity, humour and wit in an authoritarian environment. Donnely (1986:82) provides the following examples of lively and playful metaphors used by young doctors: "Some residents talk of giving patients "tune-ups" when correcting abnormal blood biochemical abnormalities. Tune-ups may then lead to "good numbers" for, say, blood electrolyte, urea, createnine, and glucose values. House staff may chart these numbers in a quickly sketched diagram of squares and triangles. If the numbers are good, one may hear that the patient is "euboxic.""

(1959:128) refers to as 'a backstage language'. Doctors (and possibly other health care professionals) use this language when they can say: "it's just us". Other individuals are not meant to understand the medical backstage language (Watson, 2011:2).

The question of the purpose of doctors' occupational register is provoked by the preceding description of medical language and how it is used. What do doctors achieve by using their occupational register? I found three answers to this question in the literature on medical language. Firstly, as with all occupational registers, medical language is **an efficient communication system** for the transfer of messages between specialists. "Within knowledge communities, …[occupational registers] provide a practical and convenient shorthand for talking about complex matters specific to a field" (Fleischman, 2001:475). Secondly, medical jargon (including slang) helps to **cultivate feelings of closeness and loyalty** among persons who are working under immense pressure as well as to **soften tragedy and relieve strong emotions** (Klass, 1984:C2; Coombs *et al*., 1993:995; Watson, 2011:39). Medical students, interns and residents probably use slang as a strategy to survive and expedite their stressful and exhausting work in hospitals. Their stress is related to working long hours and getting little sleep while they are still acquiring the knowledge and skills associated with their tasks and to constantly being assessed by their seniors in a strict and sometimes harsh manner[153] (Donnelly, 1986:82; Coombs *et al*., 1993:992; Watson, 2011:42). Clinical work may also lead young doctors (and/or student doctors) who work in teaching or public hospitals to experience strong emotions, for example anxiety, uncertainty, frustration and anger. Such emotions are caused by the ever-present threat of death in hospitals, the worry of unintentionally contributing to a patient's death, and patients who do not follow treatment advice and/or show little concern for their health. Using slang may enable practitioners to release feelings that are incompatible with compassion, the appropriate emotion for doctors, and to communicate them to a group of understanding insiders (Coombs *et al*., 1993:995-997). Medical students are usually very pleased with learning and mastering medical language since this means that they are becoming part of a very selective and prestigious in-group. Medical students (partly) use informal medical language to help them feel that they are making the transition from being mere students to becoming real doctors (Klass, 1984: C2; Coombs *et al.*, 1993:993). Thirdly, slang provides doctors with a **private means of**

[153] Watson (2011:42), an ethicist, recounts a conversation with a senior physician who told her that residents often face anger from their patients and their caregivers as well as the residents' superiors. The use of slang and even gallows humour may thus be a form of emotional nourishment for overworked, sleep deprived and emotionally undernourished residents.

communication. Some informal medical language develops out of doctors' practical need to discuss sensitive topics in front of patients and their families. In such situations doctors fear that patients and their significant others or caregivers may be harmed if they understood what was said or speculated about the patient and his/her condition (Coombs *et al*., 1993:995). Klass (1984: C2) provides an example of medical language that creates some privacy for doctors in their clinical work:

> This linguistic separation between doctors and patients allows conversations to go on at the bedside that are unintelligible to the patient. "Naturally, we're worried about adeno-C.A.," the intern can say to the medical student, and lung cancer need never be mentioned.

The final question to address regarding the ritual in medical discourse concerns the effectiveness of the words spoken. In other words, **what is the effect of medical discourse on those to whom it is directed, and what is the limit of its ability to constrain** (Foucault, 1981:62)? Medical discourse contains power and its power extends beyond the consultation room and hospital ward. When the effects of medical discourse are considered its character as a practice becomes more clear. Medical discourse diagnoses and prognosticates. It declares ill persons as sick or not[154]. Medical discourse may be used to express a patient's life expectancy and is used to classify patients' diseases as acute or chronic, benign or malignant, curable or not. Diagnostic and prognostic statements may have profound effects on how patients and their caregivers perceive and respond to illness and/or disease. Medical discourse is also used to dispense treatment advice. It may be used to advise or order a patient to keep to his/her bed, to be admitted to hospital, to undergo risky diagnostic procedures or treatments such as radiation, or even to be placed in quarantine in the case of highly infectious and dangerous diseases. The diagnoses, prognoses and treatment regiments that are pronounced in medical discourse can thus validate or invalidate the ill person's adoption of the sick role. Should the patient be pronounced "sick" (s)he may deserve certain societal rights and benefits, such as permission to stay home from work or to receive a grant from the state. The effects of medical discourse are also felt outside of biomedical institutions. Due to its status and power medical discourse influences other societal

[154] Here, I again use the distinction between the terms illness and disease that occurs in medical anthropology. I explained in a footnote in Chapter 1 that illness in this sense refers to the patient's and his/her caregivers' experience and understanding of being unwell, whereas the term disease describes the modern doctor's understanding of this process.

discourses and practices. For example, within legal and penal discourses medical discourse may be used to declare a person as responsible or not for his/her illegal actions, or eligible for parole based on medical grounds.

Like all forms of authority and power, medical discourse may be challenged or ignored. The ability of medical discourse to constrain is limited by the patient's right to make autonomous decisions about his/her health care. First of all the patient can decide whether nor not (s)he wants to consult a biomedical doctor, and often which individual or type of doctor (s)he wants to consult. Of course ill persons who choose to seek healing outside of modern medicine or through self-help will probably not benefit from the powers of modern medicine to cure disease or to relieve suffering. Secondly, patients with the capacity to make autonomous decisions can choose to follow or to reject treatment advice. Yet, despite the established bioethical principle of respect for patient autonomy in the Western world, doctors often do not fulfil this obligation and may paternalistically make decisions on behalf of the patient. The doctor's power is especially strong in situations where the encounter with a patient is not voluntary. These are cases where the doctor acts as an administrator on behalf for the state. Starr (1982:11) explains and provides examples of doctors' (and other professionals') authority in involuntary encounters.

> In the modern state, professionals often stand between people and benefits they desire or penalties they fear. Social workers, teachers, and doctors certify those who come before them as eligible or ineligible to receive welfare payments, graduate from school, or gain exemption from military service. As gatekeepers into and out of various institutions, professionals acquire means of ensuring compliance quite independent of any belief in the moral basis of their authority.

Medical language, especially as described above by Jammal, also makes one think of Foucault's other two processes of rarefaction of speaking subjects, namely **societies of discourse** and the **social appropriation of discourses**. Medical language is possessed by a few and cannot be owned by just anyone. Medical language belongs to the medical professionals. It belongs mainly to those who are admitted to medical schools to train as doctors. Medical professionals are schooled in medical language through their formal education in the classrooms of universities, but also through their interactions with teachers, senior colleagues and peers and at the bedsides of patients. Medical language is thus passed on to new generations through medical education and the distribution of medical education is

highly regulated. Usually medical schools select only a few of many applicants to study medicine. At most universities this selection is largely based on the respective candidates' most recent academic achievements and medical degree programmes are usually filled with the applicants with the highest academic marks. Unsuccessful candidates, like all health care consumers, do not gain formal access to medical language. Some unsuccessful applicants to medical schools may have had experiences of denied access in other social arenas, such as access to decent schools. The distribution of medical education and medical language is likely to mirror the distribution of other benefits, privileges or even human rights in a particular society. As in all societies of discourse, the roles of speaker and listener are not interchangeable in medical discourse (Foucault, 1981a:63). However, within the past two decades the Internet has made medical knowledge more accessible to those outside the medical profession than ever before. Yet, medical professionals remain the ones with the authority to use medical language and the experts on its use and meaning. They are also the ones who protect medical discourse through a highly regulated system of education.

Foucault's ideas on the procedures that control and restrict discourse provides a way of understanding and explaining why everything that can be said about sickness and health is not included in medical discourse. It also draws attention to the restrictions on how and by whom medical discourse may be used.

6.6 Medical discourse and power

In the final section of this chapter I shall describe the nature of power in doctor-patient relationships and interactions. I base my analysis on Foucault's understanding of power and on the published empirical research reports on doctor-patient communication.

Modern medical discourse is a scientific discourse. It speaks the truth of modern times about health and illness. It is therefore a discourse with power (Foucault, 1978:106-107). The modern medical doctor is the authorised speaker of this discourse. The power of medical discourse and medical practice, which together I term medical power, has certain effects on medical professionals, patients and on their interactions. A consultation between a medical professional and a patient, the latter without validated knowledge and skills related to the diagnosis and treatment of disease, is not a meeting of equals. The balance of power in the doctor-patient encounter is skewed in the clinician's favour. Patient populations are

significantly and perhaps unacceptably influenced, or even controlled, by medical professionals and health care institutions (Ells, 2003:217). The other side of the matter is that patients mostly voluntarily consult physicians in order to gain specific health-related benefits. Before I examine the nature of power in the doctor-patient relationship, I shall briefly present Paul Starr's (1982) interpretation of the basis of the doctor's authority.

6.6.1 The basis of the doctor's power

"Authority, in its classical sense, signifies the possession of some status, quality, or claim that compels trust or obedience" (Starr, 1982:9). Authority includes two sources of control, namely legitimacy and dependence. Legitimacy depends on the subordinate's acceptance of the (superior's) demand for obedience. Dependence rests on the subordinate's judgement of the unpleasant consequences of disobedience (Starr, 1982: 9-10). Professionals claim two types of authority, namely social and cultural authority. **Social authority** entails control over others' actions by giving commands. Doctors practice social authority over patients when they (aim to) control their actions by giving them instructions or advice. However, the doctor's social authority over patients rests on the other type of authority, doctors' cultural authority. For the doctor to dispense treatment advice, they have to name and evaluate the patient's condition. In other words, they need to interpret the symptoms and signs the patient presents with. Patients consult doctors to find out if they (really) are sick, and what the meaning of their symptoms is. They want to know, for instance, if their condition is treatable and what implications it has for some other aspects of their lives. Doctors have the authority to "evaluate the nature of reality and experience, including the 'needs' of those who consult them….Authority, then, also refers to the probability that particular definitions of reality and judgements of meaning and value will prevail as valid and true" (Starr, 1982:13). Starr (1982:13) refers to this type of authority as **cultural authority.** The doctor's cultural authority is antecedent to their social authority (Starr, 1982: 13-14).

> The authority to interpret signs and symptoms, to diagnose health or illness, to name diseases, and to offer prognoses is the foundation of any social authority the physician can assume. By shaping the patients' understanding of their own experience, physicians create the conditions under which their advice seems appropriate (Starr, 1982:14).

Let us return to dependence and legitimacy as the conditions for authority. The most important basis of patients' **dependence** on doctors is the latter's superior competence (Starr, 1082:11). Doctors' specialised and extensive knowledge and skills enable them to cure and treat many forms of disease. This is what patients need from doctors (Beisecker, 1990:106). Doctors also often obtain power from patients' psychological dependency upon their healers. This is especially true in the context of longstanding doctor-patient relationships and anxiety provoking conditions. A patient's emotional dependence on his/her health care provider may inhibit him/her from changing providers if (s)he is unsatisfied with some aspect of their regular provider's service. The **legitimation** of doctors' professional authority entails three claims. Firstly, they do not claim authority as individuals but as members of a community. This community objectively validates the knowledge and competence of its members based on shared standards. Secondly, the standards of the professional community are based on rational inquiry and empirical evidence. Thirdly, the professional's advice and judgement are directed towards the substantive value of health. To the degree that a medical professional violates the values and standards of practice of their professional community, his/her exercise of authority is illegitimate, and in the extreme case (s)he will be guilty of malpractice (Starr, 1982:12-13, 15).

6.6.2 The nature of power in the doctor-patient relationship

Foucault (1984:61) conceptualises power as a **productive force**. His theory of power suggests that power produces the subjects, discourse(s), knowledge, and practices or "rituals of truth" related to the doctor-patient interaction. Power also produces resistances to these social constructions (Irving 2002:406). Seen in this way, medical power does not simply restrict the ways in which doctors and patients may behave. It also opens up a range of possible behaviour and attitudes in the realm of clinical medicine, and produces social benefits and costs. Furthermore, Foucault (1976:98) conceptualises power as something that **circulates**. He denies that power can belong only to a particular person or group of people "who then exercises that power over others". Instead, he proposes that individuals are always in the position of concurrently undergoing and exercising power (Foucault, 1976:98). According to Foucault's (1976:98) conception of power the doctor and patient cannot be contrasted as the powerful and the powerless in the doctor-patient relationship (Bates, 2005:425). Each of them is "subject *to* power and subjects *of* power" (Ells, 2003:215). Yet,

the patient's ability to exercise power is limited compared to that of the doctor (Sheridan, 1980:218).

For Foucault (1982:221) the exercise of power is to **structure the potential field of action** of other individuals. In the doctor-patient relationship power struggles are to a great extent played out in the communicative interaction between the actors. In this context the exercise of power seems to be "about shaping the possibilities for talk" (May *et al.*, 1996:197). The struggle is not only about who talks and how, but also, perhaps mainly, about what is discussed (and about what remains undisclosed). This view of power in the doctor-patient relationship may explain the description of clinical encounters in empirical research reports as tacit negotiations (Stivers, 2002:1127, Heritage, 2005:96) and contests.

6.6.3 The subjects of doctor-patient interactions

Foucault's theory of power suggests that power produces the subjects of the doctor-patient interaction. What is the nature of the patient-subject that medical power creates for the doctor-patient interaction? The ideal patient is passive and obedient to the bearer of medical knowledge, namely the doctor. (S)he presents her/himself as an object for the medical gaze. The medical gaze is subordinating, silencing and non-reciprocal (Rendell, 2004:36). To become a patient an individual needs to be questioned, examined and pronounced as sick by a doctor. The process of diagnosis produces the individual as a medical subject (Frank & Jones, 2003:180). The individual is thus subjected to the knowledge that the medical professional(s) develops about him/her (Heartfield, 1995:101). The patient's body and the disease it carries are the objects of medical knowledge.

The physician is also produced as a particular type of subject by medical power. (S)he is a member of the medical profession and performs her/his work in or in collaboration with medical institutions. The doctor must speak the socially accepted truth about health and disease. (S)he needs to think, speak and act in ways that correspond with the biomedical model, the theory of medical discourse, as well as the standards of medical practice and the rules of medical institutions. The doctor must embody medical knowledge, skills and practices. (S)he is thus also subject to medical power (Måseide, 1991:552).

6.6.4 The productive nature of medical power

Foucault (1984:61) conceives of power as a productive force. (Partly) based on a Foucauldian conception of power, Måseide (1991:557) argues that power is an essential precondition "for competent and adequate clinical practice". Legal and professional standards stipulate such competence and patients often demand it. For this reason Måseide (1991:552) argues that power in medical interactions is "always necessary" and "often benign". The doctor needs control over the medical encounter in order to structure it according to the rationality of the biomedical model. The doctor's relative dominance in the medical interview may allow him/her to identify the patient's **medically relevant problem(s)**. It is the doctor's duty to collect medically significant and sufficient information from each individual patient.

> Even patient-centred practitioners are liable to decide when they have enough information and when to interrupt the patient's talk in order to change the consultative process in a medically rational way. This is not only the doctor's right, but his or her professional duty. The doctor must decide when it is time to make enquiries about what, or when it is time for the patient to prepare for the physical examination (Måseide, 1991:554).

Medical power thus produces knowledge about the patient. The doctor can also use his/her power in the medical interaction to (attempt to) convert the patient "into an **adequate object for medical intervention**" (Måseide, 1991:555-556). Technology often plays a large part in medical assessment and intervention. For the effective and efficient use of technology in clinical settings, patients need to accept it and cooperate with medical personnel in its use. Doctors may use controlling interactional techniques, such as instructing and directing, to prepare patients for and accomplish their cooperation with the use of technology in clinical practice. The doctor may thus transform the patient into an adequate medical object through "relationally regulating endeavours" (Måseide, 1991:556). Another accomplishment that doctors may attain through their dominance in the doctor-patient relationship is the management of time in consultations. Doctors may restrict patients' talk with subtle forms of interactional control (Måseide, 1991:556).

Doctors' power can thus be viewed as a productive force and as necessary for competent and adequate medical practice. Patients also have access to power in the doctor-patient relationship and may employ their power in productive ways. Relationships of power may thus produce benefits to the individuals involved. However, this productive power is a "two-

edged phenomenon". On the other side of the benefits produced by power, there is "what people give up in order to become the subjects of systems that benefit them" (Frank & Jones, 2003:182). For instance, in the description of the identities of doctors and patients above it was clear that the subjective experiences of each are disallowed in the clinical encounter. To my mind this is a direct consequence of the modern ideal of clinical medicine as a replication of the method of natural science. I shall critique this view of clinical medicine in the next chapter.

6.6.5 The circulation of power in the doctor-patient relationship

Corresponding to Foucault's contention that power doesn't only belong to one social group, is the popular view among medical sociologists that the medical profession is one of a number of important **countervailing powers** in society. These countervailing powers include, but depending on the national context and its sociological character, are not limited to; the state and third-party payers of health care, health care consumer groups, the medical-industrial complex that produces products and services for profit, and non-biomedical health care or wellness traditions (Light, 1995 as cited in Light, 2000:203). Differences between the interests, cultures and goals of these parties may cause difficulties, yet noteworthy alignments are possible. Each of these countervailing powers seeks, to varying degrees and in different ways, to fulfil its interests. A dominant force in a network of countervailing powers will over time produce imbalances, excesses and neglects that upset or threaten its opposite forces and estrange the larger public (Light, 2000:203-204). These opposite forces will then work, separately or jointly, towards creating a balance of power that better promotes their interests.

In the meeting between a doctor and patient contests about the content and the outcome of the interaction may arise. Hunter (1992:122) refers to the "silent tug-of-war" that doctors and patients have over ownership of the story of illness. Mishler (1984:121) describes the "conflict and struggle between two different domains of meaning" in the medical interview. Although power in the clinical consultation does not belong to the doctor alone, it is easier for him/her to exercise power in this context compared to the patient. Yet the doctor's power is limited by certain other forms of power. Doctors are subject to legal and professional standards and norms (Måseide, 1991:556-557), including their professional codes of ethics. Doctors will violate those standards and codes if they attempt to force patients to comply with their suggestions, or harm patients with their specialised knowledge and skills (Starr,

1982:11). Doctors do not have the power to coerce patients into compliance. On the contrary, patients need to authorize the doctor's power through adequate participation in the latter's clinical tasks (Bates, 2005:426).

Similarly, the doctor does not need to give the patient an opportunity to describe his/her psychosocial experience of the illness. Yet, the limits of the interaction are not determined by the doctor alone. The patient may attempt to obstruct or to interrupt the doctor's conversational course, for example by remaining silent (May *et al.*, 1996:199) or by volunteering additional information in response to the doctor's biomedically orientated questions (Beisecker, 1990:111). From a Foucauldian perspective of power, multiple possibilities of interacting with the powerful medical discourse are open to patients (Bates, 2005:425-426). Patients may also attempt to influence doctors' treatment recommendations. Stivers[155] (2002:1127) found that some parents of paediatric patients overtly advocate for antibiotic treatment of their children's acute disorders. Although this behaviour occurred rarely in the researcher's sample, the parents succeeded at times to pressure doctors to prescribe antibiotics against the doctors' diagnostic convictions (Stivers, 2002:1123). The current configuration of the power network that crosses through the health care context calls for patient and/or caregiver participation in treatment decision making. This places doctors before the delicate task of encouraging and maintaining patient participation, while resisting pressure from patients to act in ways that compromise their professional integrity (Strivers, 2002:1127).

Empirical evidence indicates that patients differ in their communication behaviour towards doctors. Research findings suggest that most patients desire some power in the consultation, such as access to information and input in clinical decisions, yet few behaviourally demand it during their interactions with doctors. Certain factors antecedent to doctor-patient communication seem to affect patients' communication behaviour during clinical encounters. These include sociodemographic and situational factors. Research results show that patients with a high **social status** are more likely to ask doctors questions and to receive information from them, compared to patients from other social classes. Some characteristics of high status patients are; a high income, a high level of education and membership of the same

[155] Stivers (2002:1112) studied interactions between paediatricians and parents in private health care settings in Southern California. The children of the participating parents were between 2 and 10 years of age and complained of "ear pain, throat pain, cough, or congestion". These interactions can thus be classified as acute care, private, paediatric consultations.

cultural and gender group as the doctor. However, **situational factors** seem to be the best predictors of assertive communication behaviour by patients (Beisecker, 1990:107-109; 116-117).

Beisecker (1990:108-109) reviewed the empirical research literature on patient power, and identified the following situational factors as powerful predictors of assertive communication behaviour by patients during the clinical encounter: the patient's type of illness, the reason for the consultation, the length of the interaction, the presence of a companion, and whether the consultation is the patient's first or a repeat visit to the doctor. Beisecker (1990:116-117) suggests that when patients seek information from doctors or attempt to participate in treatment decisions, they may be attempting to obtain control over their medical condition as oppose to control over the physician. In her opinion patients' desire to gain control over their illness and its treatment, may explain why situational factors are such strong predictors of assertive communication behaviour by patients during clinical consultations.

The relatively recent increase in the **availability of medical knowledge** in the public sphere has been making the boundaries of the society of medical discourse much more permeable. In the twenty first-century patients have easier access to medical knowledge than ever before in the history of modern medicine. Those with access to the Internet (and who are literate) have a wealth of medical knowledge at their fingertips. Matters related to health, disease and health care are also frequently discussed and reported on in the media. Various television and radio shows devoted to health and health care exist. Some of these are even presented by doctors who may become world-wide celebrities[156]. In some countries, such as the United States of America and New-Zealand, the manufacturers of prescription medications may advertise directly to consumers through media such as television, radio, magazines, newspapers and the Internet (Donohue *et al.*, 2007:674 ,680). The presence of medical information in the public arena allows patients to become the subjects of medical knowledge. Knowledgeable patients have greater access to power in the doctor-patient relationship (Bates, 2005:427, 431).

[156] Examples are the American television shows '*Dr Oz*' and '*The Doctors*' that are also aired on South African television. The shows are hosted by medical specialists who so became celebrities.

6.6.6 The relationship between medical discourse and power

Foucault wants us to think of discourse as more than the form and signs of language (Hook, 2001:532). For him the concept of discourse includes the rules that determine what can be said and by whom it can be said. He understands discourses as regulated practices (Foucault, 1972:90). Discourse is closely related to power. Power produces discourse, knowledge and truth, which in their turn strengthens the systems of power they were born from (Foucault, 1976:93; 1980:52; 1984:74). Struggles for power, are therefore also struggles for discourse and truth and the effects of truth. Seen from Foucault's perspective on power, much of the conflict and contest in the doctor-patient encounter are struggles for the possession and meaning of medical discourse. They are struggles about what counts as true with regards to health and disease and who has the right to speak this truth.

6.7 Conclusion

In this chapter I applied Michel Foucault's thoughts on the nature of discourse to medical discourse. Based on Foucault's atlas of the anatomy of discourse, I dissected medical discourse to identify its objects, concepts and theory. Modern medicine's intellectual self-image is that of a natural science. Its elements are based on the ontology and epistemology of natural science. The statements of medical discourse are about material **objects**, in other words, that which can be studied empirically and objectively. The objects of medical discourse are disease and the bodies of patients. Medical discourse has abstract **concepts**. The patient as well as disease processes and causality are conceptualized as merely biological or physical in nature. Similarly, biomedical treatments are physical in nature and are understood as functioning objectively and mechanistically (Kriel, 2000:23-24). In Foucault's terminology the biomedical model of disease can be referred to as the **theory** of medical discourse. The biomedical model is based on the natural sciences. The medical fraternity perceives medical practice as the application of the natural sciences to the treatment of disease and the promotion of health in human beings (Schwartz & Wiggins, 1985:333).

Foucault (1981a:61) puts forward the proposition that in modern, Western societies certain procedures internal and external to discourse work to control discourse. These procedures select certain statements for and exclude others from discourse. I described how 'the opposition between true and false', 'the discipline', as well as 'the ritual', 'societies of

discourse' and the 'social appropriation of discourse' control medical discourse. Only statements commensurate with the ontological and epistemological assumptions of natural science function as **true** in medical discourse. The principle of **the discipline** allows novel but true statements to enter medical discourse, and rejects statements with objects, concepts or theories outside the truth of biomedicine. Medical professionals are the **authorised speakers** of medical discourse. They are also the ones who protect medical discourse through a highly regulated system of education.

In the final section of this chapter I described the nature of **power** in doctor-patient relationships and interactions based on Foucault's conception of power. Foucault views discourse and power as closely related. Power struggles do not only take place by means of discourse, they are also struggles for the possession of discourse (Foucault, 1981a:52-53). Seen from Foucault's perspective on power, much of the conflict and contest in the doctor-patient encounter are struggles for the possession and meaning of medical discourse. They are struggles about what counts as true with regards to health and disease and who has the right to speak this truth.

The task of applying Foucault's thoughts on discourse and power to medical discourse, as it is described in the empirical research literature on this topic, was challenging. I attribute this difficulty to two characteristics of Foucault's work. First, the detail and the abstract nature with which Foucault describes discourse. Yet, Foucault's abstractness was what made his work attractive and useful for my purpose. Second, the fact that Foucault's work on discourse and power does not form a coherent body of knowledge (Sheridan, 1980:225). As Sheridan (1980:225), who translated most of Foucault's writings into English, explains in his book about the philosopher's work:

> There is no 'Foucault system'. One cannot be a 'Foucaldian' in the way one can be a Marxist or a Freudian: Marx and Freud left coherent bodies of doctrine (or 'knowledge') and organizations which, whether one likes it or not…, enjoy uninterrupted apostolic succession from their founders. If Foucault is to have an 'influence' it will no doubt be as a slayer of dragons, a breaker of systems. Such a task should not be seen as negative; indeed it is the system-building that is the real negation.

I followed Foucault's invitation to researchers, "to make what they can of his work" (Mills, 2003:7). Foucault's description of discursive formations gave me a framework for the

analysis of the internal structure of medical discourse. His understanding of discourse as a regulated practice allowed me to examine the influence of the positivist paradigm on the discourse of the medical profession. Viewing medical discourse as a discursive practice draws attention to the restrictive function of medical discourse. While new statements or facts that stem from biomedical research are unproblematically assimilated into medical discourse, statements outside of the natural scientific truth are denied entry into the discourse. No analysis of medical discourse should ignore the power struggles that accompany doctor-patient encounters. Foucault's conception of power as productive and as "circulatory" is extremely valuable in accounting for the behaviour of doctors and patients towards claiming power in the consultation. Foucault's understanding of power as something that circulates counters the common and unconvincing belief that doctors are all powerful and patients completely powerless in consultations. The Foucauldian conception of power draws attention to the powers acting on physicians and on the possibilities of resistance that are open to the subjects of doctor-patient interactions.

Chapter 7

A critique of the appropriateness of modern medicine's scientific self-image, conclusions and recommendations

The reductionism of biomedical science and clinical practice, grounded in an empiricist semantics and epistemology, has produced both the dramatic progress in understanding and treating disease and the loss of holism and humanism in clinical practice that has made the past few decades both the best of times and the worst of times in medical history.

Good & Good (1981:179)

7.1. Introduction

In this chapter I critique the appropriateness of modern medicine's scientific self-image for the task of providing medical care to individual patients. My critique involves the following three issues. Firstly, whether the practice of medicine, that is clinical biomedicine, is correctly thought of as a natural science. Secondly, the impact of modern medicine's intellectual self-image on doctor-patient communication; and thirdly an appropriate conception of truth for the context of clinical medicine. I shall also critique the appropriateness of the norms for doctor-patient interactions in Western and westernized societies. At the end of the chapter I make some concluding remarks and recommendations based on the dissertation as a whole.

Before I start my critique a brief overview of the argument advanced thus far in this dissertation is called for. I commence with such an overview in the section below.

7.2 The influence of modern medicine's intellectual self-image on doctor-patient communication

The practical problem that inspired this dissertation is the crisis of care in modern medicine. I am referring to the common phenomenon of patients and their caregivers feeling uncared for in their dealings with medical professionals (Schwartz & Wiggins, 1985:331; Fehrsen, 2000: xvii). Patients' feelings of neglect stem from the medical profession's tendency to focus almost solely on the patient's disease, without considering other aspects of patients' lives and

experiences that are related to their illness (Schwartz & Wiggins, 1988 in Kriel, 2000:40). Doctors acquire this reductionist form of clinical practice through their medical education and the structure of their work environments. Reductionist medicine may also leave doctors feeling frustrated and unfulfilled. Especially those individuals who want to care holistically for patients. I should add that it particularly seems to be persons with chronic physical conditions who have a need to feel known and understood by their doctors. These patients often want to communicate with their doctors about the problems they experience in their lives which are related to or resulting from their symptoms (Mishler, 1984:77). Yet, such communication attempts are often blocked or ignored by doctors (Barry *et al*., 2001: 494-496; 501). In contrast, the needs of many individuals with single acute physical conditions, such as throat or ear infections, appear to be restricted to the diagnosis and treatment of their biological problems. Such patients may not need or even want to talk to their doctors about matters related to their psychological and social lives (Barry *et al*., 2001: 493-494). In cases like these, especially in emergency room consultations, the biomedical model of health care may be entirely adequate and even appropriate. Nonetheless, the findings of empirical research indicate that effective doctor-patient communication is necessary in all circumstances for optimum medical care.

I am particularly interested in the communication between doctors and patients during consultations. Doctor-patient communication is central to the practice of medicine (Gatens-Robinson, 1986: 175-176; Malterud, 1995:184; Montgomery, 2006:34). Interaction between doctors and patients accomplish many of the tasks of the consultation, for instance arriving at a diagnosis, establishing the doctor-patient relationship, information exchange and shared decision-making (Charon *et al.*, 1994:955; Ong *et al.*, 1995:903-905). Yet, this instance of communication is known (by patients and researchers) to be problematic. The greatest problems seem to be that doctors usually do not communicate sufficiently with patients and do not regard communication with patients as important for their clinical work. Doctors tend to dominate the medical interview. On average they talk more than patients during the interview, and they ask more questions than they answer (Roter *et al.*, 1988:101-102, 108). Doctors pose mostly biomedically orientated questions to patients. They also habitually interrupt patients' speech and thereby hinder patients from stating their main reason for the medical visit or some of their major concerns about their illnesses. Doctors also usually do not provide enough information to patients or involve them sufficiently in decisions and discussions about treatment plans (Kurtz *et al*., 2005:14-16). I once approached a doctor to

take part in an empirical research study on doctor-patient communication. She was uncertain about participating in the research, which involved videotaping and analysing interviews between doctors and patients. She told me: "I do not talk to patients much. I work with my hands." This lady was known by her colleagues as a committed and a caring doctor. She worked in a public hospital in South Africa in a clinic for adult patients with HIV/Aids. Doctors' notorious communication skills do not mean that they do not care for their patients.

I put forward the claim that the difficulties of doctor-patient communication can to a great extent be attributed to modern medicine's intellectual self-image. Medicine understands itself as a natural science. Medical research, medical education and medical practice are all rooted in the natural sciences. Furthermore, medicine's conception of science corresponds with the standard image of science that developed from the logical positivist school of thought. In order to philosophically investigate the influence of modern medicine's intellectual self-image on communication between doctors and patients, I turned to (some of) the work of Jürgen Habermas on communication and to Michel Foucault's work on discourse and power. I applied these two philosophers' thoughts on communication and discourse to the current academic knowledge about the nature of doctor-patient communication and medical discourse (the latter is summarised in Chapter 4 of this dissertation).

My analyses delivered the following insights. Doctors and patients communicate from different perspectives during clinical consultations. The doctor's biomedical perspective is focussed on the external world, whereas the patient's perspective is turned towards his/her experience of illness. Medical discourse, that is the discourse that doctors have available to speak and to think as doctors, is based on the ontology and epistemology of the natural sciences. From the biomedical perspective, only statements in accord with positivism are regarded as true. The different perspectives of the doctor and patient often means, especially in consultations about physical chronic conditions, that the two participants do not accept each other's statements and therefore fail to reach agreement and understanding in their interaction. The doctor's biomedical perspective places him/her at risk of overlooking the patient's rationality during the medical interview and may lead to a failure on the doctor's behalf to attempt to rationally motivate the patient with his/her utterances so that agreement and understanding can be achieved. The difficulties in clinical encounters that are caused by differences in perspective are exacerbated by the unequal distribution of power between the doctor and patient in these situations. The doctor usually has the greatest share of power in the doctor-patient relationship. The different perspectives of the doctor and patient often lead

to conflict and contest in medical interviews. However, due to the power imbalance between the two participants, patients usually express their opinions and wants in an indirect and mitigated manner. One of the best descriptions of the conflict between doctors and patients is by Hunter (1992:122), who calls it "a silent tug-of-war over the possession of the story of illness". Much of the conflict and contest in the doctor-patient encounter are struggles about what counts as true with regards to health and disease and who has the right to speak this truth. In Hunter's (1992:122) words it is "a struggle for the interpretation of life (and death) events."

It can thus be said that medicine's natural scientific self-image creates difficulties in doctor-patient communication. To my mind medicine's positivist orientation explains many of the problems in doctor-patient communication, such as the ones mentioned earlier in this section and in detail in Chapter 4. This basic observation is seldom, if ever offered in the scholarly literature on clinical communication. It has the potential to inspire reforms in medical education and clinical practice that will tangibly improve the quality of doctor-patient interactions for both groups of participants. Something that recent reforms in clinical practice, such as the movement towards patient-centred medicine, are yet to achieve (Pilnick & Dingwall, 2011:1374).

7.3 A critique of the appropriateness of modern medicine's scientific self-image

I now begin my critique of the appropriateness of modern medicine's scientific self-image. Firstly I address the question of whether medicine is correctly thought of as a natural science.

7.3.1 But is it a natural science?

Is clinical biomedicine a natural science, "in the realist Newtonian sense we learned in high school"? (Montgomery[157], 2006:16). This is certainly the perception of medicine held by many, if not most, doctors and members of society (Montgomery, 2006:30). I want to emphasise that my focus here is on clinical medicine, and that I do not discuss the scientific

[157] Montgomery (2006) is the same author as Hunter (1992). Hunter (1992) changed the name she publishes under to Montgomery sometime after her 1992 publication.

nature of medical research or medical education. I use the terms clinical medicine and medical practice interchangeably to refer to the activity of a doctor administering medical care to a patient.

Several medical scholars (such as Dornhorst, 1981; Donnelly, 1986; Malterud, 1995; Kriel, 2000; and Miles, 2007) as well as researchers from the social sciences and the humanities (such as Gatens-Robinson 1986; Montgomery, 2006; and Waymack, 2009) deny the commonly held (crude and unreflective [Montgomery, 2006:30]) view that clinical medicine is a natural science. I agree with these researchers. When one considers the goal of clinical medicine, the nature of its object of knowledge - the individual patient, and the nature of clinical rationality it is clear that clinical medicine is not a natural science. Let us consider these aspects of medical practice one by one.

The **goal** of clinical medicine is to diagnose and treat the diseases suffered by particular individuals. It is aimed at relieving specific patients' symptoms and at curing their diseases. The goal of the biomedical sciences is to create knowledge that enlarges and solidifies our scientific understanding of health and disease in general (Waymack, 2009: 216-217). The practicing physician gathers information about the signs and symptoms of disease in his/her patient as well as (some of) the factors that might impact on the patient's health. Science is aimed at creating generalizable or universal knowledge. The goals of scientific reasoning are precision and predictability whereas the reasoning of the doctor tending to his/her patient is aimed at finding the best possible answer under the particular circumstances (Montgomery, 2006:43). A necessary difference exists between medicine and science. The scientist is expected to act as a disinterested observer during the research process. However, the doctor's moral duties towards the patient forbid him or her to regard the patient as a research subject. The doctor's task is not to test therapies, but to treat the patient's disease (Montgomery, 2006:32) to the best of his/her ability and in accordance with the patient's desires in this regard.

The **object of knowledge** of clinical medicine is the individual patient[158]. This "object" is very different from the relatively stable and simple physical phenomena, for example molecules, studied by certain natural sciences. Almost everything that we might wish to know about such simple phenomena can be explained by referring to the physical and chemical mechanisms to which they owe their continuing existence and characteristics. Scientists' generalizations about the behaviour of simple physical matter are mostly perfectly reliable (Gorovitz & MacIntyre, 1976:56). Knowledge about such matter is thus to a large degree certain knowledge (Montgomery, 2006:43). The certainty of knowledge about simple physical substances stems from the fact that very little diversity exists between such phenomena. Each instance of a molecule of a particular kind, say a water (H_2O) or a sodium chloride (NaCl) molecule, is much like any other instance of the same type of molecule (Gorovitz & MacIntyre, 1976:58). In contrast to the relative uniformity of matter such as molecules and much to the frustration of doctors, individual human patients are subjectively and biologically unique (Waymack, 2009:221). The following three examples illustrate this fact and the element of uncertainty in the practice of medicine that stems from it.

Firstly, a drug or vaccine that is effective and safe to use in most people may be ineffective and even dangerous or at the worst fatal in others. For instance, it is estimated that one or two individuals in every one million that receive the small pox vaccine, may die as a result. Fortunately many of the risk factors for serious side effects from the smallpox vaccine have been identified and health care workers can take care not to administer the vaccine to such individuals (Gorovitz & MacIntyre, 1976:58-59; Centers for Disease Control and Prevention, 2003:2)[159]. Secondly, when a young woman diagnosed with early stage breast cancer is told that she has a 82% chance of being disease-free and alive in five years' time (after immediately undergoing surgery to remove the cancerous growth, followed by chemotherapy), she and her physician(s) have no way of knowing whether she will be one of the 82% with no signs of the disease after five years, or one of the 18% who did not recover (Montgomery, 2006:15). "What about *me?*", she will want to know. But unfortunately, in

[158] Clinical medicine can also be directed at populations as in the case of health promotion activities. An example of a health promotion activity aimed at a group of people is a doctor (or another health care professional) that gives a talk to a group of people on preventing a particular disease(s). Such talks often concern chronic diseases of lifestyle, for example heart disease and diabetes, and are aimed at populations at risk of developing these disorders.

[159] Admittedly, recent advances in scientific knowledge and technology help to explain some of the biological variability among individuals and thereby increase the power of clinical medicine. For instance, genetic factors may determine whether a drug will be useful to, or worthless or dangerous for a particular patient (Waymack, 2009:221). Doctors with knowledge of the genetic determinants of drug efficacy and the technology to utilize such knowledge will be able to practice a much more certain form of medicine.

Montgomery's (2006:194) words: "Statistics don't say. Survivors survive entirely; those who die are completely dead. No one survives 82%..." Finally, the symptoms of patients with the same diagnoses can differ dramatically (Feinstein, 1987:218; Montgomery, 2006:3). For instance, patients with appendicitis are typically between 10 and 30 years of age and arrive at a doctor's office or a hospital emergency room with complaints of abdominal pain. The patient typically has a fever, reports recent constipation and experiences acute pain when pressure is applied to and then withdrawn from a particular place on the abdomen. Yet, the elderly can also suffer appendicitis and their symptoms are usually less severe. Furthermore, not all patients with appendicitis complain of constipation (Waymack, 2009:224).

The question that nags is whether complete knowledge of human biology and pathology, supported by relevant technology will not solve the problems that the uniqueness of individuals causes for clinical medicine? An affirmative answer to this question seems to be a fantasy. Clinical medicine will never be a science in the positivist sense. Even after the last biological puzzle has been solved, human beings will remain biographically, psychologically, socio-economically, politically, spiritually and culturally unique (Montgomery, 2006:34-36; Waymack, 2009:221). Unlike simple physical phenomena, human beings (similar to other complex phenomena like animals, hurricanes and salt marshes) are affected by variables that cannot be controlled (Gorovitz & MacIntyre, 1976:56; Montgomery, 2006:32). Eric Cassell (2004:201) explains why patients cannot be fully known through science.

> Sick persons, unlike livers or enzymes, do not meet the criteria as objects of science. They cannot be completely known or known apart from the knower, and they cannot be measured solely in the objective terms of science. They never exist isolated in space. Their behaviour is influenced by where they are. They are ultimately individual and therefore inevitably different one from another. They are never and cannot ever be isolated in time – all persons sick and well are influenced by the times in which they live and all have a history and a future, both of which are essential to understanding them. Persons can never be analysed or understood as though there were no others acting on them.

Clinical medicine in itself is not a science. At least not in the realist positivist sense that medicine is commonly thought of. Clinical medicine is the **practice** of caring for those who are sick and treating their diseases, and of preventing (further) disease and disability in the sick and those at risk of becoming sick. It is a practice that requires knowledge of scientific

information and clinical research as well as specialised skills and experience (Montgomery, 2006: 3, 16, 32-33). To say that clinical medicine is not a science does not mean that it is not scientific. Indeed, medical practice depends on scientific knowledge and technology. After years of observing doctors and medical students work, teach and learn in academic hospitals, Montgomery (2006:33) describes the character of clinical medicine as follows:

> [Medicine] is far more than a body of scientific knowledge and a collection of well-practiced skills, although both are essential. It is the conjunction of the two: the rational, clinically experienced, and scientifically informed care of sick people. Its essential virtue is clinical judgement, the practical reasoning or phronesis that enables physicians to fit their knowledge and experience to the circumstances of each patient. Details of human biology and countless bits of technological information are called from memory, along with their own experiences and those reported by others, and the whole is focussed by (and on) the details of a particular patient's illness.

Doctors do not reason the way that scientists do. The latter reason deductively, from the general to the specific, or top-down (Montgomery, 2006:46; Miles, 2007: 549). However, the doctor's task and moral obligation is to focus on the specific patient and to determine the nature of that patient's health problem(s). It is not possible for the doctor to directly apply his/her generalizable scientific knowledge of biological facts and laws, such as pathophysiology, to diagnose and treat disease in individual patients. The difficulty in connecting scientific knowledge with the subjective experiences of particular patients lies in the imprecise and abstract nature of biological laws as well as the unrelenting uniqueness of the individual (Montgomery, 2006:32, 38; Waymack, 2009:220-221). Doctors reason "from the particular to the general and then (for confirmation) back again" (Montgomery, 2006:32). Montgomery (2006:32) illustrates the clinical reasoning process:

> [Doctors] start with the details of the present illness – is the pain sharp or dull? what makes it better? – all the while fitting the answers into a complex and general taxonomy of paradigm cases of disease. Because understanding an individual instance of illness requires an inquiry into its circumstances, diagnosis is an interpretive negotiation of the particular signs and symptoms and their development over time. The goal is their narrative coherence in a diagnosis that accounts for all the evidence.

The tasks of clinical medicine, namely diagnosis, prognosis and treatment of disease, are complex and potentially uncertain in nature and require the use of **clinical judgement** – that is the ability to establish the best possible course of action in particular circumstances (Montgomery, 2006:37-38, 43). Most traditional models of rationality does not allow for the concept and practice of judgement (Van Niekerk, 1990:179). Traditional models of rationality state that a rational decision, action or belief has to be based on an assessment of the relevant evidence through the use of appropriate rules (Brown, 1988:vii in Van Niekerk, 1990:179). Yet, some philosophers of science regard judgement as a key element of rationality. Brown (1988:137, in Van Niekerk, 1990:180) defines judgement as "the ability to evaluate a situation, assess evidence and come to a reasonable decision *without following rules*". Hannah Arendt describes judgement as a mode of thinking that focuses on the particular rather than the universal (Van Niekerk, 1990:181, 187). Following Kant's analysis of 'reflective judgement', Arendt conceptualises judgement as thinking particulars. This way of thinking does not incorporate particulars in general rules. It moves from the specific to the universal instead of the opposite direction. "It involves discriminating and discerning the particular in its particularity" (Van Niekerk, 1990:181).

Harold Brown developed a model of rationality in which judgement is the most important concept (Van Niekerk, 1990:185)[160]. Two of the main features of Brown's judgement model, as summarised by Van Niekerk (1990:185), are the following. Firstly, the idea of a **rational agent** is considered as fundamental and ideas such as 'rational belief' as derivative. A rational belief is understood as a belief that is reached by a rational agent. According to Brown the opposite is maintained in traditional models of rationality. In traditional rationality models the role of the rational agent is not treated as important and emphasis is placed on the logical connections between the evidence and the belief that is developed from that evidence. Secondly, Brown characterises a rational agent by her ability to make judgements in situations where there is a **lack** of adequate rules to determine her decision. A clear difference is again evident between the judgement model of rationality and traditional models of rationality. According to the judgement model it is not the availability of rules that makes rational action possible, as it is maintained in the traditional models. On the contrary, the judgement model states that we rely on our ability to be rational particularly when we have no rules to follow. Judgement is thus seen as a key feature of rationality.

[160] See Brown, H.I. 1988. *Rationality*. London: Routledge & Kegan Paul.

Judgement, as conceptualised by Brown and Arendt, is clearly of great importance and relevance in the rationality of clinical medicine. Doctors work with individual and unique human beings. They work with one patient at a time and every patient is different in one or more ways from the patients the doctor has treated in the past, even if they (appear) to suffer from the same disease. It is especially in situations where the 'rule' does not apply that doctors need to exercise their clinical judgement. Such as when the signs and symptoms of a particular patient's disease do not fit the typical disease profile, or when a treatment plan is not followed by the expected and desired outcomes, or when a procedure does not go according to plan.

The rationality of clinical medicine is thus different from the rationality of the natural sciences. Clinical rationality is, as it must be, suited to its object and its objectives. Clinical medicine is a practice and the nature of its rationality is **interpretive, dialogical and narrative** - not deductive (Gatens-Robinson, 1986:167, 175; Montgomery, 2006:37; Waymack, 2009:221-225). I presented Hunter's (1992) view that clinical medicine is essentially narrative in nature in Chapter 4. Waymack (2009) summarises Hunter's account well in the quotation below:

> …when one observes what physicians do in the clinical setting…we find them telling *stories*. The practice of medicine is built upon and conducted through narratives (Waymack, 2009:218)…It is *how* the patient informs the physician of his or her "complaint." It is *how* the physician gathers more information from the patient and weaves that narrative into a medical story. It is *how* medical students and residents learn clinical decision-making. And when the medical story is somehow returned to patients, it becomes how they may come to understand their suffering and their personal prospects in the medical context of diagnosis, prognosis and treatment (Waymack, 2009:220).

Narrativists[161] like Hunter (1992) or Montgomery (2006) oppose the view that clinical medicine is a positivist science. They argue that doctors bridge the gap between their universalizable, scientific knowledge and the non-universalized individual patient through narrative and interpretive reasoning (Waymack, 2009:220, 225). I shall briefly reconstruct this argument drawing mostly on Waymack (2009:221-225). The doctor's task is to find out what the matter is with the particular patient. The physician can begin this task only by

[161] I borrow this term from Waymack (2009:225).

listening to the patient – listening to the patient's story and to his/her body. The doctor gains knowledge about the particular by facilitating a dialogue of well-positioned questions and their informative answers. To facilitate such a dialogue requires a wide range of knowledge of various sorts (Gatens-Robinson, 1986:175). The physician works with the patient to transform the patient's highly subjective story into a medical story that is more objective in nature. A more generalised version of the particular patient's story is needed so that the doctor can measure it against the variety of medical stories in his/her vast and well-organised database of past cases. The doctor builds up this database throughout his/her education and work career, including by routinely listening to and presenting case histories in a group of medical professionals. The cases in the physician's database are general in nature and are arranged in an accessible taxonomic order. In a sense these cases are narrative in nature. As Waymack (2009:222) explains: "They will not be mere Polaroid snapshots, but instead will be plotted stories with characters, events, and chronological ordering all organised to make these stories meaningful."

The doctor prunes the patient-autobiography by identifying its medically important features and cutting out or bracketing its purely subjective features. The physician preserves and organises the parts of the patient's story that are of medical consequence according to the structure of medical case histories. To create a medical story the doctor thus performs the narrative tasks of editing, translating and even co-authoring. This is an interpretive activity quite different from the method of disinterested observation that is used in the natural sciences. The doctor thus transforms the patient's initial story, a story in the patient-autobiographical genre, to a narrative in the medical genre. The general medical genre contains sub-genres, for instance "infectious, autoimmune, metabolic, vascular, neoplastic, genetic" (Montgomery, 2006:63). Each sub-genre also consists of a number of subspecies. The doctor formulates a hypothesis and eventually a conclusion regarding the individual patient's condition by matching the newly created medical narrative with a specific medical sub-genre and subspecies. The relevant sub-genre and subspecies also provide the doctor with information about the treatment and prognosis of the patient's (possible) disease. Similar to other experts, doctors solve familiar problems through pattern recognition based on a vast supply of memory and experience (Waldrop, 1984:1282).

The rationality of clinical medicine is thus narrative or case-based. In Montgomery's (2006:46) words "case narration is the principle means of thinking and remembering – of *knowing* – in medicine." This rationality is shared by other professionals, such as lawyers, moral philosophers and detectives, whose work is based on the particular case. The doctor follows the rational process of abduction to decide what a specific case is a case *of*. Montgomery (2006:47) explains this process as follows:

> Reasoners start from a particular phenomenon and, using preliminary evidence, hypothesise its possible causes; those hypotheses are tested against details revealed by closer examination. This circular, interpretive procedure moves between generalities in the taxonomy of disease and particular signs and symptoms of the individual case until a workable conclusion is reached.

Clinical medicine is thus not a natural science. It is best described as "a learned, rational, science-using practice" (Montgomery, 2006:36). Science is a tool instead of the soul of clinical medicine. To perform his/her clinical tasks the doctor needs knowledge of the biomedical sciences, adequate clinical experience and skills, as well as knowledge of the vagaries of the human condition (Montgomery, 2006:41).

A further question nags. Why does a significant portion of the medical profession continue to regard clinical medicine as a science of the positivist sort when the nature of their knowledge and their clinical experience should lead them to deny this view of medical practice? At least three interrelated explanations can be offered. The most obvious of these is that medicine's position of **status and power** in modern societies stems to a large extent from the scientific nature of much of its information (Montgomery, 2006:39; Miles, 2007:548). Modern, Western societies regard scientific knowledge and reasoning as epistemologically superior. The second explanation is of a **practical** nature. The doctor acts on behalf of the patient. (S)he has to make important and occasionally vital decisions regarding the medical care of individual patients. To perform these tasks requires certain knowledge. One of the main strategies that physicians use to reduce the unavoidable uncertainty of their practice is to regard, albeit with scepticism, the best obtainable information as real, absolute and reliable. These are the characteristics of natural science (Montgomery, 2006:39; Miles, 2007: 548).

The final explanation is **psychological**. People cannot live their everyday lives as gloomy sceptics, even though some recognise in moments of serious philosophical reflection that the possibility of absolutely reliable and objective knowledge from the practice of empirical science is unlikely. We find it extremely difficult to sustain ambiguity and vagueness in our beliefs. Patients, especially those for whom the prospect of serious illness brings on a life crisis, want complete and certain knowledge for themselves and their doctors. We want our doctors' knowledge to be complete, we want them to be able to apply that knowledge to our particular circumstances with precision, and we want to know with certainty that their suggestions will be helpful to us. Who would want to disappoint such high expectations of one's profession? Who would not want to offer the desperate patient some certainty? And so a *folie a deux* between doctor and patient may be born. The doctor pushes aside the uncertainty of his/her knowledge and practice and offers the patient the certainty of positivist science. This strategy may turn out well in most cases. It also breeds unrealistic expectations of medicine in patients and physicians alike. When bad outcomes occur patients are disappointed and angered and often put the blame on their doctors. Lawsuits against doctors may arise out of anger and perceptions of error and neglect. Doctors who convince themselves that clinical medicine is a positivist science may experience undeserved self-doubt and low levels of self-confidence in the face of poor outcomes, and may unjustly confess to professional malpractice (Montgomery, 2006:39-40; Waymack, 2009:227-228).

7.3.2 The impact of medicine's intellectual self-image on doctor-patient communication

An obvious criticism of modern medicine's self-image, particularly in the context of this dissertation, is that it impacts negatively on doctor-patient communication; when effective clinical communication[162] is essential for health care. The above description of the narrative rationality of clinical medicine illustrates the importance of interaction between the doctor and the patient for the doctor to diagnose and treat the patient's disease and to make prognoses. Yet, empirical research findings indicate that doctors tend to restrict communication with patients, and that doctors generally do not appreciate the importance of

[162] Effective or adequate doctor-patient communication includes a variety of components, such as the disclosure of medical and social information by patients, the development of doctor-patient relationships characterised by mutuality and comfort, shared decision-making, provision of medical information that patients can understand and responsiveness by doctors to patients' requests for information (Teutsch, 2003: 1116).

talking and listening to patients for clinical medicine. Doctors' communication behaviour impacts on their patients. Patients' satisfaction with their health care, their adherence to the treatment prescribed, their ability to understand and to recall the information provided by the doctor, and even their health and psychological well-being may be affected by the doctor's manner of communication. It seems that the aspects of the doctor's communication behaviour that have the biggest impact on the patient are the extent and the manner of information sharing by the doctor, and the doctor's style of communication. Consultations during which doctors take time and trouble to share information with patients, are not overly domineering and display affective communication behaviour [163] have better patient outcomes than consultations without these qualities. Unfortunately these qualities are frequently absent from doctor-patient interactions and patient satisfaction, adherence to treatment, as well as recall and understanding of the information imparted by doctors are typically poor. Adequate information exchange during clinical interactions and a participatory doctor-patient relationship are also needed for shared decision-making about the treatment plan to be followed.

Modern medicine's positivist world-view impacts negatively on clinical communication because of its one-dimensional focus on the external reality. Theoretically clinical biomedicine is exclusively interested in the patient's body and the physical disease or abnormality present in that body. Yet, the patient who suffers disease is not a purely physical being. His/her mind as well as the social and cultural dimensions of his/her life play an important role in how (s)he experiences illness, what (s)he wants from and how (s)he behaves towards the doctor and how (s)he will respond to the doctor's advice and requests. Clinical medicine has the greatest potential to be successful if it considers the psychosocial aspects of the patient's life. The doctor's door to the psychosocial element of patient's life is communicative action, that is action "aimed at reaching understanding" (Habermas, 1979:1). However biomedicine's positivist epistemology means that doctors often do not view communication with patients as important beyond asking the patient about the nature and the development of his/her symptoms and his/her general medical history. The doctor views the information that the patient shares about his/her symptoms as tentative until it can be verified as true by means of (more) objective observation. Doctors typically do not share enough information with patients, nor do they elicit or pay sufficient attention to patients' (attempts to

[163] Affective communication behaviour aims to address the patient's need to feel known and understood and to form and maintain a positive doctor-patient relationship. This type of communication includes statements and non-verbal behaviour with definite socio-emotional content and intent (Ong *et al.*, 1995:906).

express) concerns, requests and beliefs regarding treatment. In Chapter 5 I argued that doctors' frequent apathy towards sharing information and treatment decisions with patients stems from biomedicine's focus on the **physical** treatment of **observable** disease in the patient's **body**. According to the biomedical tradition the patient's mind has no role to play in the treatment of disease. The biomedically trained doctor is therefore unlikely to be interested in the patient's illness experience or his/her thoughts. The doctor is also not likely to engage the patient's mind in the treatment decision, or to be concerned with the patient's understanding of and agreement with the information and decisions imparted. The biomedical model does not sufficiently accommodate communicative action between the doctor and the patient. This is an important reason for unsatisfactory results or even failure in biomedical practice, as for instance in the medical care of persons with chronic disease.

7.3.3 The biomedical conception of truth

My analysis of doctor-patient communication based on Habermas' universal pragmatics (in Chapter 5) indicates that biomedicine's scientific conception of truth may create many of the above mentioned problems in clinical interactions and may result in poor patient outcomes. The 'true' statements of medical discourse are about the material aspects of reality. The biomedical understanding of the concept of truth is concerned with a characteristic of certain statements. Truth refers to the correctness and precision of these statements. These statements are regarded as correct because they refer to facts that were determined through stable and scientifically established procedures and therefore can be verified by anyone with the necessary expertise (Rossouw, 1982:102). The true statements of medical discourse precisely signal "the 'natural' order of human biology" (Good & Good, 1981:179). The question is whether this narrow, scientific understanding of truth is appropriate for the context of clinical medicine? And if not, what would an appropriate conception of truth be for medical practice? In response to the first question and in the light of my argument that medicine's positivist world-view negatively influences clinical communication and consequently the quality of clinical medicine, I answer 'no'. I expand on this answer later in this section (see 7.3.3.2). In response to the second question, Hennie Rossouw (1982) provides a rich, quite poetic and very useful conceptualisation of truth for the context of communication between a doctor and a patient. I shall now reconstruct Rossouw's argument and shall then, as indicated above, continue my critique of modern medicine's understanding

of truth in the light of Rossouw's description of an appropriate concept of truth for clinical medicine.

7.3.3.1 Rossouw's (1982) conceptual analysis of the truth as an ethical duty

Rossouw (1982:102-103) argues that we should distinguish between the meaning of the concept of 'truth' in scientific discussions and investigations, and the meaning of the concept of 'truth' in everyday relations and interactions between individuals, such as interactions between a doctor and patient around a sickbed. Everyday relations and interactions transcend the limits of the scientific discussion by far. The agents of scientific discussions are ultimately interchangeable and anonymous subjects of information, whereas everyday interactions occur between named individuals within a responsible community. Rossouw (1982:102) makes the point that in the scientific context the meaning of the concept of 'truth' "is synonymous with the correctness of factual assertions" (my translation)[164]. However, to speak the truth in everyday relations and interactions is an **ethical duty**, and not simply a matter of correctness of factual assertions. Correctness is the norm and ideal in the scientific conversation. If a statement is not correct it means that a mistake was made. To make a mistake is not an action that can be morally judged, but at the utmost exposes the agent to epistemic criticism. A correction can undo a mistake. Conversely, the opposite of telling the truth as an ethical duty is to tell a lie. Lying is ethically reprehensible. To be undone a lie must be forgiven.

Rossouw (1982:103-104) next addresses the question of what it is that makes a person ethically guilty towards his fellow-man when he tells a lie? Rossouw answers that the telling of a lie is an ethically blameworthy act because it involves a **violation of trust**. Trust is a fellow-man's well-founded expectation that my actions, including my speech acts, will be of help to him in his life orientation in relation to the future ("*toekomsgerigte lewensoriëntering*"). When I lie to my fellow-man I am deliberately letting him down. By telling a lie I am not steering him in a direction that is good and beneficial to him, but I am leading him astray and upsetting his life orientation. Rossouw argues that as a violation of

[164] The direct quotations from Rossouw (1982) are my translations of the original work in Afrikaans.

trust, the lie is "the **breaking or undermining of an agreement**" (my translation). This agreement refers to

> the foundation of the everyday community in which we as name-carrying individuals live and exist together. The agreement is not a contract with written rules, but rather a mutual understanding based on trust, an assurance of trust that joins us in a mutual responsibility for one another. Through this agreement we are accountable to each other and we have claims on each other.

What is this agreement that connects us to one another through trust about? For Rossouw (1982: 103-104) it is about

> the understanding that we will serve each other in the common disclosure of the reality in which we as persons have to find our way, that is in which we have to seek a life orientation and a destination of our existence ("*bestaansbestemming*").

The agreement is primarily a speech-agreement in which the common, life orientating disclosure of the reality takes place in the concrete, inter-subjective conversation. When we communicate we share the way in which we orientate ourselves in the reality with each other. The bond-like character of the concrete conversation gives us the authority to speak, but it also makes us responsible to each other for the quality of our statements. This is the ethical imperative that we signal with the word 'truth' in the everyday vernacular (Rossouw, 1982:104).

Rossouw (1982:104) thus makes the case that in the context of everyday relations and interactions 'to tell the truth' does not merely amount to conveying bare or brute facts, no matter how correct the facts may be. The philosopher now explicates the concept of truth as an ethical duty (Rossouw, 1982: 104-106). The truth in this sense **does not consist of bare facts**. Bare facts are abstractions that are established by methodological restriction of the full extent of reality. The aspects of reality that are not included in naked facts are the most important aspects of reality for the name-carrying individual engaged therein. The truth is never bare. Rossouw (1982:104) illustrates this point colourfully in the following quotation. "To tell the truth, is not a 'strip-tease'. The truth is always dressed – textile, text and context. The truth is a coherence in which the frayed threads of isolated facts are woven into a pattern." The *meaning* of factual information forms part of the truth, in other words the concept of truth includes the importance or the value of the information for the person whom

it affects. Factual information derives its meaning from the context in which it functions for concrete persons. The context determines which facts are, and are not, *germane* to the point in question for the individual in his/her concrete situation. Rossouw (1982:104) concludes that to tell the truth as an ethical duty does not only mean to convey correct, but bare facts. To tell the truth as ethical duty involves a discussion of the context in such a manner that "the meaning of the facts in their pertinence can be understood."

Another aspect of the truth as an ethical duty is that the truth is **productive**. It gives rise to an adequate action and an appropriate attitude. The action of telling the truth is only completed once it is understood, once the person addressed has meaningfully received it and it appropriately affects his/her life orientation. Also included in the concept of truth is the outcome of the conveyed message. When one wants to speak the truth in the moral sense you must take responsibility for the influence of your words on the course of events, for the way the listener reacts, and for the way in which your words are understood and processed. The productive character of the truth places it in a necessary relationship to **time**. There is a "moment of truth" that needs to arrive. Telling the truth becomes effective at a fixed hour. "The truth asks for the right word at the right time." Since telling the truth as an ethical duty is only completed when the truth is understood, speaking the truth requires time. Understanding is a process that involves taking possession of and becoming familiar with the meaning of what was revealed. "Understanding takes time". The only way the conveyed truth can bear its fruit is slowly (Rossouw, 1982:105).

A third aspect of the truth as an ethical duty is that the truth is **never brute**. The truth is not something that one can stand or cannot stand, but rather something one can stand on. "The truth clothes the bare facts into meaningful information that contains guidelines for human behaviour, that opens up new possibilities for life orientation." The truth thus liberates and shapes the future. Since the truth is not brute, the truth cannot be brutally spoken. Brute facts can be fired like missiles while the one who fires the weapon remains out of range. Someone who speaks the truth as an ethical duty cannot stay out of range. The bond of trust makes him fully responsible for the manner in which his statement arrives and takes root. To speak the truth has the well-being of the other as purpose (Rossouw, 1982:105).

Based on his conceptual analysis of the truth as an ethical duty, Rossouw (1982:106) draws some conclusions about telling the truth to patients in clinical medicine. He states that the patient, as a *fellow human being* in suffering, has **a right** to the truth. The patient's right does not relate to the simple facts of a medical diagnosis and prognosis. The patient, especially in the case of serious and chronic disease, has the right to have the reality of his situation communicated to him in a manner that allows him to understand the meaning of what is happening to him. The relevant facts must be woven together in such a way that they can become productive truth for patient's the specific situation.

On the question of 'how' the truth should be shared with a patient, Rossouw (1982:106) does not think that a system of technical rules or instructions can or should be stipulated. Yet he emphasises that the person who conveys the truth to the patient should **have time** for the patient. The truth that must be delivered is not contained in correct and precise information in a readily comprehensible form. The truth that has to be communicated is "the formation of the meaning of the reality" ("*die sinwording van die werklikheid*"). The formation of meaning takes time. To help the patient with this process requires time. "To have time for someone means that you care for him."

7.3.3.2 A critique of the appropriateness of the biomedical conception of truth

The biomedical concept of truth corresponds with the scientific concept of truth. Whereas this is an appropriate notion of truth for biomedical science and research, it is not an appropriate understanding of truth for clinical medicine. As I argued earlier, clinical medicine in itself is not a natural science or the direct application of (natural) science. The doctor-patient encounter is clearly not a case of scientific activity in which the identities of the persons involved are of no consequence. Medical practice is rather a form of what Rossouw (1982:102) refers to as everyday interaction. It is a meeting between two named individuals who stand in a particular relationship with one another. They meet with a shared goal, namely to identify the patient's condition as a specific medical entity and to find an appropriate treatment for the condition. In the context of the clinical consultation to speak the truth cannot simply mean to utter statements that have been or can be established as scientifically correct. To speak the truth in the doctor-patient encounter is an **ethical duty**.

The doctor has a moral obligation to tell the truth, in the broad sense described by Rossouw (1982), to the patient for the following reasons. Firstly, the doctor's moral obligation to **respect the patient's autonomy** compels him to tell the patient the truth about her condition (Beauchamp & Childress, 2009:289). The doctor has a duty to convey to the patient the information that is pertinent to the latter's situation in a way that leads to understanding. The doctor's conversation with the patient should strengthen the patient's autonomy so that her knowledge and understanding of the relevant information can be used in her decision making about the course(s) of action to follow with regards to the management of her disease (Beauchamp & Childress, 2009:103, 289). Secondly, as in all everyday interactions a **bond of trust** exists between the doctor and the patient as conversational partners. When name-carrying individuals communicate with one another they implicitly promise to speak the truth and not to deceive each other. Whereas strangers have an obligation of general beneficence towards each other, doctors have an obligation of specific beneficence towards their patients. When a patient initiates a relationship with a medical professional, for instance by making an appointment to consult the physician, that patient enters into a contract with the professional. This contract entitles the patient to receive the 'whole truth' from the doctor and assigns the obligations of veracity and beneficence to the doctor. Within the doctor-patient relationship the patient has a corresponding duty to be truthful in her disclosures to the doctor (Beauchamp & Childress, 2009:205-206, 289) so that the doctor can successfully perform his professional tasks.

The positivist conception of truth is thus not appropriate for the context of clinical medicine. Merely declaring bare facts to the patient without concern about how she receives the information or the outcome of the message, is not adequate or ethical. The doctor has an obligation of beneficence towards the patient. The goal, rationale and justification of medicine are to promote the well-being of patients (Beauchamp & Childress, 2009:205). The patient in her entirety, body and mind, suffers disease. Especially in the case of serious and/or chronic disease, illness disrupts the patient's life and even her life-orientation. The patient has a need to understand what is happening to her body, what she can do about it, and how the disease and its treatment may affect her life and relationships. The doctor can fully perform his duty of beneficence towards the patient only if he acknowledges that it is the whole person who must be helped. The doctor's duty to promote the patient's welfare is not limited to physical treatment of the disease(s). The doctor's duty includes sharing information about the disease and its management with the patient in a manner that makes the

information meaningful to and productive for her. When the patient has received, understood and processed the information she desired, along with receiving physical treatment for her disease and/or symptoms, the doctor has adequately fulfilled his obligation of beneficence toward her. It is then that the patient's right to the truth about her condition has been upheld. Sharing information with the patient in a way that leads to understanding is also necessary for the health care she receives to be effective. The patient needs to receive and understand information about the treatment of her disease so that she can remember and correctly follow the treatment advice and therefore improve physically and psychologically.

A further implication of the argument that the conceptualisation of truth as 'an ethical duty' is appropriate for the context of clinical medicine, is that **the doctor has to view the utterances of the patient as valid**. The biomedical doctor is trained to treat subjective information and patient's anecdotes of illness with scepticism (Montgomery, 2006:48). In general, doctors do not believe patients' symptom reports unless they can be verified by corresponding signs of disease in the patients' bodies. However, since the doctor-patient encounter is a type of everyday interaction, a bond of trust should exist between the two participants. They each have a responsibility not to mislead the other with his/her speech acts. The doctor ought to trust the patient, meaning that the doctor should believe in and rely on the moral character of the patient. The doctor should have reasonable confidence that the patient will act (and speak) with morally good intentions and according to appropriate moral norms (Beauchamp &Childress, 2009:41).

When a patient tells a doctor about a symptom, such as pain, that the doctor cannot empirically explain; the patient is nevertheless, most probably, reporting an experience that is real. It is important that the doctor acknowledges the patient's experience, even though his biomedical technologies cannot account for it. If the doctor rejects the patient's complaints without hesitation due to a lack of empirical proof to back it up, it will leave the patient with a range of negative emotions for example hurt, anger, frustration and feeling distrusted. It may also do severe and perhaps irreparable damage to the doctor-patient relationship. In such circumstances a more appropriate, therapeutic and 'truthful' response from the doctor would be to acknowledge the patient's experience, to admit that medical science cannot explain everything or solve all problems, and to treat the patient's symptoms as safely as possible. The treatment may simply be to support the patient emotionally, to provide practical advice and even to suggest safe alternatives to medical care. Granted, there will be patients that intentionally try to deceive their doctors, for instance in cases of addiction to prescription

medicine(s) or of feigning illness to receive benefits from the government or an insurance company. However, in most instances malingering patients will make up a small minority of the doctor's case load. The doctor should be aware that patients may malinger and he should be able detect this behaviour and to address it in a professionally adequate and morally correct manner.

Just as doctors should regard patients' symptom reports as valid, they ought to treat patients' utterances in the 'voice of the lifeworld' as valid. I described the voice of the lifeworld in Chapter 4 and reported the findings of empirical research, namely that doctors typically ignore or block patients' utterances about the lifeworld; especially during consultations about chronic physical conditions. Patients use the voice of the lifeworld when they speak about problems that they experience in life which are related to or resulting from their symptoms (Mishler, 1984:91). In medical interviews doctors usually view the content of lifeworld statements as immaterial, since it does not fit into modern medicine's discursive formation and the scientific understanding of truth. However, patients' utterances in the voice of the lifeworld are about the meaning of their symptoms for their everyday lives. Included in Rossouw's (1982:104) definition of the truth as an ethical duty, is the meaning of factual information. Utterances in the voice of the lifeworld should thus be treated as important in medical interviews. The doctor has duties of beneficence and veracity towards the patient. These duties include supporting the patient in the formation of the meaning of living with the particular disorder. To perform this task the doctor needs to listen to and take seriously the patient's utterances about her illness experience. Moreover, as I indicated in Chapter 5 (see 5.3.2.2), in the case of consultations about chronic physical conditions the patient's illness experience contains information that the doctor should consider to formulate an adequate treatment plan and is thus of primary clinical consequence. The doctor does not only have to avoid ignoring or blocking the patient's utterances in the voice of the lifeworld, but he should also elicit and encourage them.

The final implication of the conceptualisation of truth as an ethical duty in the context of doctor-patient interactions that I want to point out concerns the use of **time** in medical care. Rossouw (1982:105-106) makes it clear that speaking the truth as an ethical duty requires time. To tell the truth in medical consultations, especially when it entails serious and/or chronic conditions, takes time. It is necessary that the doctor puts aside sufficient time to communicate the truth to the patient so that she can understand the information and can appropriately integrate it into her life orientation.

7.4 A critique of the appropriateness of the norms for doctor-patient interactions

I described the norms for doctor-patient interactions in Western and westernized societies in Chapters 1, 5 and 6 (in particular under 5.3.1.3 in Chapter 5). For the benefit of the reader I now briefly summarise this description. The meeting between doctor and patient is conventionally not a meeting of equals. The doctor is usually the dominant person in the medical interview. (S)he determines the rules of the clinical interaction and directs the encounter. Customarily only (s)he is afforded the right to perform certain regulative speech acts, such as to suggest treatment plans. Shared decision-making about the treatment of the patient's disease can only happen if the doctor feels so inclined (Charles *et al.*, 1997:687). The doctor also controls the development and content of the interaction. (S)he determines the conversational topics and controls when the patient takes conversational turn(s). The patient is typically not allowed to introduce, pursue or end a conversational topic. The doctor usually restricts the topics of the interaction to what can be accommodated with the biomedical perspective on health and disease.

The question I address here is whether it is proper for the doctor to have such a high measure of control over the medical interview? I agree with Måseide (1991:557) that the doctor needs power in the consultation to competently and adequately perform his/her clinical functions. For example, the doctor must raise specific topics and question the patient about particular aspects of his/her illness experience in order to generate a diagnostic hypothesis and a treatment plan. Such conversational leadership by the physician is appropriate. As Måseide (1991:552) points out, this type of power is "always necessary" and "often benign". The doctor's use of power to accomplish his/her clinical tasks illustrates Foucault's (1984:61) conception of power as a productive force. In so far as the doctor needs to control the interaction to competently and adequately attend to the patient, the patient - as a partner in the process of diagnosing and treating the disease - has a duty to comply with the doctor's direction.

However, the doctor's conversational dominance should not infringe on the patient's conversational and autonomy rights. As in other everyday conversations both participants in the doctor-patient encounter should have the right to introduce, maintain and terminate conversational topics; to take conversational turns; and to speak without being unreasonably interrupted. Patients have a right to receive sufficient information, in a manner that facilitates

understanding and decision-making, about the diagnostic and treatment procedures that their doctors recommend as well as about the diseases they suffer from and the impact it may have on their lives. This right should be respected regardless of whether the patient explicitly asks for the information or not. Patients also have the right to (an opportunity to) express their concerns, requests and beliefs about their illnesses and/or their treatment; and to have such expressions taken seriously by their physicians. Empirical research indicates that although all patients desire information regarding their diseases and the treatment options available (Charles *et al.*, 1997:683; Guadagnoli & Ward, 1998:337), not all patients (and the same patient does not always) prefer to independently decide on the course to follow with regards to treatment. Some (and sometimes) patients want to delegate or share this responsibility to or with the doctor (Charles *et al.*, 1997:683). Irrespective of whether the patient wants to independently make the treatment decision, it remains important that the doctor enquires about and incorporates the patient's concerns, desires, and values into decisions about his/her health care (Guadagnoli &Ward, 1998:329, 337). Research findings suggest that consultations during which patients' conversational and informational rights are honoured, have better patient outcomes compared to consultations where these rights are not respected. Corresponding to patients' conversational, informational and autonomy rights are doctors' duties of beneficence and respect for patient autonomy.

The intellectual self-image of the modern medicine can easily prevent the doctor from tending to the patient's needs and rights which extend beyond physical treatment of his/her disease. More specifically, medicine's positivist world-view is very likely to keep the doctor from sufficiently talking and listening to the patient and from drawing the patient's mind into the practice of medicine. Inadequate attention to the patient's mind can easily result in less than optimum and ethical health care. For it is never only the patient's body that suffers disease and therefore never only the body that should be cared for. Health care that pays insufficient attention to the patients' non-material needs and rights also has the danger of turning the doctor into an (extremely learned and skilled) technician as opposed to a caring healer. A purely natural scientific form of medicine may in most cases mean poor job-satisfaction and a one-dimensional occupational experience for the physician. A humanistic doctor needs the same level of scientific and technical knowledge and skill as a purely biomedical doctor. Yet, the humanistic physician requires additional knowledge and skill, namely to attend to the psychological and social aspects of the patient's illness experience.

7.5 Concluding remarks and recommendations

I conclude that modern medicine's intellectual self-image has a pervasive and negative influence on communication between doctors and patients during clinical consultations. This is because medicine's positivist world-view results in an almost exclusive focus on the physical aspects of disease in clinical medicine. The patient's mind and his/her social world are not of great significance from the natural scientific perspective. Medical professionals may thus easily regard their clinical task solely as the physical treatment of physical disorders. They are very likely to consider many communicative activities as unrelated to their clinical task, such as eliciting the patient's concerns and reason(s) for scheduling an appointment; allowing the patient to talk about his/her illness experience and to respond to such utterances in earnest; providing the patient with sufficient information and ensuring his/her understanding of the information, and facilitating the patient's involvement in treatment decision-making. Inadequate doctor-patient communication can easily affect the quality of medical care and patient outcomes in a negative manner, as well as diminish the quality of the doctor's occupational experience. For this reason I conclude that medicine's natural scientific intellectual self-image is not appropriate for the task of providing medical care to individual patients. Two additional reasons support this conclusion, namely the misidentification of clinical medicine as a natural science and the inappropriateness of a scientific conception of truth for the context of doctor-patient interactions. Effective communication should be recognized as an **integral component** of good clinical medicine. It is not a component that can be added to or removed from the practice of medicine depending on the doctor's orientation with little effect on the quality and the outcome of the health care.

Based on these conclusions a few questions need to be addressed, namely: what do we want from doctors? What are the implications for the medical profession of the conclusion that medicine's intellectual self-image negatively affects doctor-patient communication and is inappropriate for clinical medicine? What about the factors apart from medicine's intellectual self-image that affect the interaction between doctors and patients? I now address these questions in the order they are listed above.

What is it that we want from doctors? Most people, or at least most of those with acute physical conditions, will probably answer that they want competence in diagnosis, treatment and prognosis from their physicians; and that if the doctor is kind whilst performing these functions they will see it as a bonus. Yet, I argue, supported by the findings of empirical

research, that competence in diagnosis, treatment and prognosis as well as ethical medical practice is dependent on effective doctor-patient communication. My plea for sufficient interaction with the patient is not a plea for good bedside-manners. It is a plea for recognition of the non-material aspects that impact on the causation, experience and treatment of disease and the non-scientific components of competent clinical practice. Only recognition of and attention to these aspects can transform clinical medicine and save it from its current crisis of care.

Greenhalgh *et al*. (2006:1184) formulate a more specific question related to the question above, and describe this as a question that has not been debated much; namely: "How much of the lifeworld should be admissible within the primary care consultation?" The authors themselves do not offer a response to their question. I propose that Mishler's (1984:91) original definition of the voice of the lifeworld in clinical medicine, namely the voice that patients use when they speak about problems that they experience in life which are related to or resulting from their symptoms, demarcates the purview of the doctor's responsibility for lifeworld issues adequately. It would be inappropriate to suggest that the doctor be involved in the patient's lifeworld beyond what concerns the patient's experience of illness and disease. The involvement of medicine in patients' lives beyond what can be seen as holistic medical care, intrudes on the roles of other legitimate professions and institutions in society, such as psychology, the family unit, the clergy *etcetera*. However, it is the duty of the medical profession to care for injured and diseased persons. To care for the patient means that the doctor is concerned about the patient as a suffering individual. It is the doctor's duty to attend to the physical and mental needs of the person suffering from disease.

The next question to address is about the **implications for the medical profession** of the proposition that medicine's intellectual self-image negatively affects doctor-patient communication and is inappropriate for clinical medicine. I shall not respond to this question in depth since it falls outside the scope of the current project. I offer the following broad remarks and recommendations on this topic. Firstly, the medical profession will do well to transform its intellectual self-image and world-view to better agree with the nature of clinical practice and to make room for the psychological and social dimensions of the patient's life within health care. Such a world-view will facilitate effective doctor-patient communication and thereby contribute to quality and ethical clinical medicine and good patient outcomes. Secondly, I recommend that the medical profession revise its conception of science. Modern medicine's positivist conception of science may be replaced by an intellectually more robust

and updated theory of science. Such a theory will acknowledge that interpretive reasoning, as is characteristic of the rationality of clinical medicine, and knowledge without guaranteed certainty, are legitimate elements of science (Waymack, 2009:225-227). Yet, if one considers the psychological explanation offered earlier for the continued adherence to a positivist conception of science by most members of the medical profession, it seems unlikely that the current perception of science in medicine will change easily or soon (Waymack, 2009:228)[165].

Foucault (1981a:66-68) makes some very useful suggestions for resisting the procedures that control and restrict discourses in the form of his principles for the analysis of discourse. According to Foucault's recommendations, the first requirement for any group, within or outside of medicine, that wishes to transform medical discourse (so that medical practice and doctor-patient communication can be transformed) is to become aware of the processes that rarefy medical discourse. My recommendation for the medical profession is to cultivate **consciousness** of medical discourse. Firstly it is necessary for the profession to realize the reality of discourse. This realization includes recognising that the language that doctors have available to think, talk and write about health and disease – that is medical discourse - does not simply and innocently represent facts about the material world. It is necessary to realise that medical discourse itself constitutes reality. It is a practice controlled by rules. The profession need to realise that the biomedical model of disease is not only the source of medical discourse, but also a force that restricts. Whilst this model allows endless new positivist statements to be generated and to enter medical discourse, it refuses statements at odds with the discursive elements of medical discourse entry into this discourse. In additional to an awareness of the procedures that control and restrict **what** doctors can utter about health and disease, consciousness of the processes that control **who** may use medical discourse and **how**, is also necessary. Further, it is necessary that physicians become aware of the close connection between discourse and **power** and that discourse is both an effect and an instrument of power.

I advocate for consciousness among the medical profession of medical discourse as a discursive practice, the procedures that control medical discourse and maintain it as the dominant discourse about health and disease, the discourses that are repressed by medical

[165] It also has to be acknowledged that the medical profession with its current natural scientific self-image is not well positioned to respond positively or meaningfully to appeals to transform its world-view and conception of science. This is because the profession has "no mechanism to perform such fundamental, paradigm-changing cognitive acts". However, through critical contributions of the sort this dissertation hopes to make, such transformation may become possible (Kriel, 2013).

discourse, and the types of subjects that medical power casts doctors and patients as. To stimulate such consciousness is the contribution I wish to make with this dissertation. I want to point out the reality of medical discourse and its effects on doctors, patients and on their interaction with one another. It is my hope that a deeper awareness of the reality and the effects of medical discourse will persuade the profession, in the interest of its duties of beneficence and respect for patient autonomy, to work towards creating a world-view that can contain the aspects of reality that cannot be known empirically and purely objectively. However, this will require the profession to relinquish some of its current power over patients and in the health care arena in general. The prospect of giving up some of its power may discourage the profession as a whole to transform its view of reality and the manner in which it operates. Yet, the decision of whether to (attempt to) transform medical discourse does not simply lie in the hands of the medical profession. Power is also available to others who are affected by medical discourse. These countervailing powers include those who are unduly influenced by medical discourse, as well as those whose goals and interests are in conflict with medical discourse. Such groupings, which include doctors who want to practice humanistic medicine, can attempt to destabilize the dominant discourse and to make their voices heard.

The third question that I want to address is about **the factors besides medicine's intellectual self-image that affect the interaction between doctors and patients.** Throughout this dissertation I have emphasized that various factors influence doctor-patient communication, such as the characteristics of the context in which the communication takes place as well as the personal characteristics of the participants in the interaction. I do not suggest that a broadening of medicine's world-view and a transformation of its intellectual self-image will completely prevent difficulties in communication between doctors and patients. Clinical communication will probably always remain one of the most complex forms of interaction (Chaitchik *et al*., as cited in Ong et al., 1995:903) in the modern world and will therefore remain susceptible to difficulties. Examples of factors that will continue to influence doctor-patient communication negatively, regardless of medicine's self-image, include time pressure, linguistic and cultural differences between doctors and patients, and communicative reticence in patients with a low socio-economic status. However, a form of medicine that is responsive to the psychological and social dimensions of disease has the potential to mitigate most of the difficulties that may arise in the interaction between a doctor and a patient.

I conclude with a few remarks on the larger significance of the work undertaken in this dissertation. I consider the value of this research as pointing out a factor that is usually overlooked in scholarly work on clinical communication as well as in the design of interventions to improve this form of interaction. The factor I am referring to is the natural scientific intellectual self-image of modern medicine. I have argued that medicine's positivist view of reality pervasively and negatively influences clinical interaction. As yet I have not encountered another instance of this argument in the literature on doctor-patient communication. It is unlikely that educational approaches and interventions with the goal to improve the interaction between doctors and patients will have much or lasting success while doctors are taught to approach their clinical work in a positivist manner. The current project should be followed up by more detailed proposals of an appropriate world-view and intellectual self-image for clinical medicine. Once such a world-view is formulated and accepted by the medical fraternity, it should lead to changes in what and how medical students are taught. The influence of a broadened world-view on doctor-patient interactions can then be investigated. Based on the insights delivered by the current philosophical investigation, I am confident that a world-view that can accommodate the psychological and social aspects of reality will lead to more effective clinical communication and better patient outcomes.

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