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General Medical and Birthing Experiences of New Mothers in the Capital Health Region: An Empirical and Socio-historical Investigation into the Concept of Personal Agency.

by

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B.A., University of Victoria, 1992
M.A., University of Victoria, 1995

A Dissertation Submitted in Partial Fulfilment of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the Department of Psychology

We accept this dissertation as conforming to the required standard

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Abstract

The concept of personal agency in clinician-patient interactions is problematized by the development of societally legitimated power differentials in medical practices. The abrogation of patient perceptions of agency is also connected to interventions that tend to reproduce the separation of persons from their biological/physiological systems in reductionist, technical medical practices. Such practices continue because of their development within and harmonization to, dualistic western meta-categorizational philosophical principles. Mainstream psychological and social-psychological epistemology and methodology are deeply implicated in the undermining of the creation of a coherent, socially contextualized understanding of agency because of an adherence to Cartesian dualism.

The empirical investigation consisted of the thematic qualitative analysis of 40 semi-structured, in-depth interviews with new mothers in the Capital Health region who gave birth between 1997 and 1999. Information was gathered concerning their experiences with medical personnel and institutions in general as well as focusing on their prenatal, birthing and postnatal care under 4 different clinical settings. Mothers received health services either from male or female physicians paid by traditional fee for service, by salaried physicians of either gender or from registered midwives. The results demonstrated the critical importance of patient agency in clinical relationships with regard to satisfaction and health information-seeking behaviour. The more involved and democratic model of care offered by midwives was reported as being highly satisfactory because the relationship fostered patients' agency and informational needs. New mothers reported their physician to be only marginally supportive or often unsupportive of their needs for health information and agency. The investigation also highlighted many problematic aspects of patient care at Victoria General Hospital, especially in the ante-natal ward. Many mothers experienced insufficient care and attention by hospital staff and physicians. Many staff were reported as being poorly trained in breast feeding techniques leaving many new first-time
mothers feeling confused, anxious and angry. Labouring mothers who chose midwives reported overwhelmingly more satisfaction with their care at the hospital as compared to patients of physicians. Needs for personal agency are fostered when midwives work as intermediaries between patients and hospital routines that were often found to be counterproductive to the care of labouring and new mothers.

Theoretical implications were discussed. The results demonstrated a model of personal agency contextualized by both communicative and societal relationships. A combination of the models of Vygotsky and Holzkamp helped to explain patient experiences interacting with medical personnel and institutions. The findings also discuss at length some implications for health policy in the care of expecting and new mothers. Structural impediments need to be addressed in order to support rather than constrain the patient needs in becoming more fully informed regarding self and infant care.

Examiners

Dr. Holly Tuokko, Co-supervisor (Department of Psychology)

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This investigation received considerable support in the form of a SSHRC Fellowship and a Dr. Julius Schleicher Fellowship for Research in Medicine, for which I am extremely grateful.

I feel fairly confident in saying that, much like anyone who has gone through the extended hazing ritual of writing a dissertation, I feel a mixture of despair and elation in bringing this project to completion. Certainly everyone else I have spoken with on this subject agrees that a rather lengthy hiatus would seem to be in order before looking at the text in regard to a reconfiguration in terms of articles and/or a book. Much like running a marathon (though I must admit I have never actually done such a thing) one must circumnavigate numerous walls of pain. The process is made all the more difficult by the nightmarish feeling that no matter how near one is to the end, one can mysteriously only travel half the required distance. During one critical period encompassing some soul-eroding personal losses (including a serious illness) it seemed that this project would remain uncompleted. So much for the despair.

Speaking from a vantage-point at the other end of the spectrum I can say that I am relieved and very satisfied that I was allowed and encouraged to complete the dissertation I wanted to write. I have grown both personally and professionally through all the experiences encountered during this project. I benefited enormously from my time in graduate school and have learned enough to feel I have something to offer my undergraduate students and just enough to
feel motivated to pursue knowledge regarding the million things I now realize I know nothing about.

There are many people I have to thank for sharing their knowledge, for being generous, for giving feedback and encouragement and by their examples. Firstly I would like to thank Charles Tolman for his mentorship for several years and to thank him for introducing me to the world of activity theory and critical psychology. I learned more in his classes than in any other and I am especially thankful to him for demonstrating the necessity for promoting a theoretically coherent and concrete social-psychological system devoted to emancipation. The ideas we discussed inspired me to attempt to design this social psychological investigation to be emancipatory for the reader as well as the research participants. I wish to thank Dr Holly Tuokko and Dr. Daniel Bub who generously agreed to take this project on as co-supervisors close to its completion. Their support in allowing me to write the dissertation I wanted to, is greatly appreciated. Dr. Helena Kadlec has been a warm and supporting committee member and friend and I am especially grateful for her support in my successful application for some major funding that allowed me to eat during the analysis phase. Dr. Peter Stephenson has been there in the trenches with me through thick and thin. His quiet confidence as a principled social scientist and his outrageous sense of humour gave me a model of mentor and close friend that will have a profound impact. He was there literally every day to make sure I was not falling headlong into despair and to cheer me up when I most needed it. He generously gave both personally and professionally as well as allowing me to work with him on some very interesting projects. His is a continuing friendship I will always relish.
There are many others who generously gave of their time for this project. I would like to thank all the interview participants including the new mothers, nurses, midwives and physicians. A big kiss (and a tickle) and my heartfelt love go to my beautiful baby son, Liam Coughlan whose imminent arrival was the inspiration to contextualize this investigation of agency and medical relationships in terms of pregnancy and birthing experiences. Jennifer Mullett gave me my first real opportunity to stretch myself as a qualitative analyst. Trudy Johnson read the first draft and gave her opinions, probably saving me from severe embarrassment as well as buying me many much needed drinks along the way. Maureen Stephenson was there when I needed a shoulder to cry on and made me more sumptuous meals than I can ever repay. Ellie Stephenson kept me young by playing football with me and letting me tease her. Morag MacNeil helped me to see I needed help when everything went wrong and allowed me to indulge my passion for teaching by giving me sessional teaching contracts. Paul Taylor provided jokes whenever I went to the psychology department office. In the darkest days, my sister Cecelia reminded me that I am the brains of the family and more importantly that I have a family in Worthing, who love me. My friends, Tisha Richbell and Terry Munro in London let me stay at their homes, bought me drinks and kept me laughing when I really needed to run away. Thanks go to William Grant for his contributions to science. And last but not least I am indebted to Karen Jung who came along in the “nick of time”. She read over the second draft and along with her wonderful companionship provided insightful comments that made this lengthy discussion a little more readable. Her love, intelligence and
generosity of spirit helped me to see beyond my wall of grief and to believe in another and as a consequence, to start to believe in myself again.

Namaste.
Dedication

This research dissertation is dedicated to my beautiful son Liam Coughlan, whose imminent arrival had an important effect on the direction of the investigation of patient agency. I love you and miss you, so very, very much.

This is also dedicated to the memory of my father, Edward Patrick Coughlan who would have been very proud (and probably very surprised) to witness the completion of this doctoral project. It was one of his dreams that I might become a scholar, and follow in the footsteps of some of his Irish heroes, although I offered him scant hope of this reality when he was alive. Goodnight Dad.
Chapter 1

Introduction

The present climate in Canadian healthcare is often reported to be beset by increasing levels of stress. Commentators and demographers are predicting that problems managing the system will further increase this stress over the next thirty years owing to the aging of the population and the consequent increased demands for care, as well as the mass retirement of trained personnel (Statistics Canada, 1995; Tarlov, 2000; Townson, 1999). Much publicized differences of opinion regarding the direction of health reform between powerful interest groups (such as physicians' organizations and governments) and less powerful groups (such as patients, nurses and various "alternative" professional clinicians) can be viewed as evidence of society's intent in focusing on and improving healthcare outcomes. However, such discussions are also often rife with conflict born of professional socio-economic interests (Hayes & Dunn, 1998; Rachlis & Kushner, 1994; Townson, 1999). As my research will demonstrate, these conflicts are also grounded in subject/object and mind/body dichotomies that structure and organize modern medical institutions and modern medical practices. The domination of dualism as a meta-categorizational organizing system makes the subject of agency (the ability to formulate and act on personal intentions) problematic at a theoretical level as well as having impoverishing effects experienced in everyday living practices. The experience of personal agency is further constrained by societally legitimated power differentials and is especially prominent and problematic when patients interact with health institutions and personnel. However, asymmetrical power differentials and the resulting impoverished sense of agency experienced
by many patients in modern healthcare systems, is now being increasingly questioned.

Pressures to dilute the domination of healthcare practices by a traditional elite comprised of professional medical personnel come from a host of directions. Increasingly since the inception of universal health coverage, Provincial and Federal governments whose main concerns are concerning fiscal matters have influenced health policy in an attempt to exercise more control over medical practices (Evans, 1984; Evans & Stoddart, 1988; Townson, 1999). In addition, professional clinical and government stakeholders are both experiencing accelerating pressure from interests that are more usually associated with patients. In this regard, increased availability of medical information to lay persons (owing to the revolution in technological communicative media) has increased desire for patient input into their treatment protocols (Clarke & Evans, 1998; Maeside, 1991; Morrow, 1997; Roter & Hall, 1993) and the growing popularity of alternative healing practices (Gordon, 1996; Koenig, 1999; Vickers & Zolman, 2000). Health consumers are increasingly articulating their need to voice their opinions, to research their own health issues as well as demanding a choice in treatments and greater respect for their decisions (DiMatteo, Hays & Prince, 1986; Morrow, 1997; Mullett & Coughlan, 1998; Street, 1989, 2001).

These stresses are heightened in certain locales (such as in the Capital Health Region) where demands for medical services are high owing to the increasing density of aging Canadians, and the wealth and education level of the population in general who can afford access to the Internet and to pay for non-allopathic medicine. Thus, it would seem a prudent time to assess the needs and desires of differing
stakeholders and particularly the experiences and opinions of patient groups in the Capital Health Region.

The purpose of this present study is to elicit the opinions of patients regarding perceived satisfaction with the present health delivery system, and how medical relations and the utilization of differing communicative strategies in consultations, either promote or interfere with perceptions of patient agency. Previous research in British Columbia (for example, Chappell & McClure, 1998; Mullett & Coughlan, 1998) found that senior patients seem to experience problems in communicating their needs to physicians. In addition, these investigations detailed how patients and physicians often hold contradictory views concerning a whole host of issues, including how well the present system works and the desirability of recent government interventions (e.g. Low Cost Alternative and Reference Based Pricing with regard to drug plans). This present study represents a further qualitative investigation of patients' experiences, perceptions and opinions of the functioning of clinical practice in the Capital Health Region (which is comprised of the City of Victoria and surrounding suburbs) in British Columbia. In particular, the investigation will look at two interconnected research questions. The first concerns whether the findings of Mullett and Coughlan (1998) which interviewed seniors regarding their general experiences with medical personnel and institutions, can be generalized to a younger cohort of relatively frequent visitors to health service centres. The second aspect of the investigation will look specifically at experiences for expecting and new mothers in accessing health care related to a recent pregnancy. For both questions the investigation will interview women who have experienced a pregnancy and birth in the Capital Health Region.
In general, apart from infrequent visits to physicians and hospital emergency departments for acute problems and a small percentage of younger people who suffer chronic illness, many younger people are ill equipped to formulate informed opinions concerning ongoing relations with medical institutions. However, one group of younger people do tend to have a more intimate knowledge of interactions with the medical system: patients who are new and/or expecting mothers. The choice of researching the experiences and opinions of new and expecting mothers with regard to their medical care offers some unique opportunities.

Pregnancy and maternity represent occurrences that have been medicalized for most of the 20th century and yet in the strictest sense they are not "illnesses". Unlike many chronic illnesses, the overwhelming majority of pregnancies and births occur with mother and child leaving care in full health. The pregnant "patient" is also unlike the general case of acute care patients as she is not generally experiencing an illness when she avails herself of health services. Unlike real illnesses there are scant reasons to intervene medically and to pronounce the illness as being "cured" or "palliated". Patients who leave care are not thought of as having "recovered". While modern maternity care and public health system involvement has led to some great improvements in mortality rates during birth, the great majority of births are not really medical interventions in the strictest sense (McNiven, Hodnett & O'Brien-Pallas, 1992; Scully, 1980). As a result there has been an increase in criticism from some clinical and patient communities that medical institutions, their ideologies and practices are often unsuitable for the care of pregnant and birthing women owing to an extension of practices geared to the diagnosis and treatment of disease (Ewigman, 1993; Porter & McIntyre, 1989). However, the medicalization of normal,
low-risk pregnancy and birth is jealously guarded by the medical establishment (Ewigman, 1993; Scully, 1980).

The medical model of maternity care has received criticism from many outside the profession because this need to preserve the medical status of birthing has led to a tendency for too much intervention, which in part, has received criticism by some commentators as merely serving as a justification for its medicalization (Calvert, 1980; Gorbauld, 1995; Hodnett, 1995). Unnecessary diagnostic or surgical procedures can be both dehumanizing for the patient and expensive for the system (Gorbauld, 1995; Townson, 1999). This study of patients’ experiences and opinions of their care during pregnancy and birth is important because it is a unique case where medical ideology and practices have colonized primarily non-medical events. Thus, such an investigation may provide important insights into how medical systems function when policing the borders of their discipline. Arguments for the continuing hegemony of medicine over pregnancy and birth may be more pronounced precisely because the case is weak and there have been recent inroads made by midwifery professionals. In addition, the effects of medical structures on patients may also be different because the patients themselves may not consider themselves to be “ill”.

The investigation of new mothers’ experiences with their health practitioners may highlight aspects that are important to other types of patients. Because serious illness has a tendency to further diminish patient perceptions of agency in dealing with medical institutions and personnel, these matters may be under-reported under these situations (Maeside, 1991; Morrow, 1997; Pendleton & Hasler, 1983). Those who have recovered from serious illness are happy to have recovered and although their experiences may have been less than satisfactory, the positive outcome of
treatment may well diminish the importance of their perceptions of not having been
treated as they might have wished. Illness tends to promote dependency and
acquiescence to medical systems because censure by gatekeepers to medical care
may carry with it deleterious health outcomes. To many medical personnel, being a
"good patient" entails being passive and acquiescent to medical intervention.
Patients who maintain their power by questioning medical decisions or seeking more
information are often viewed as "bad patients" and many patients quickly become
socialized to this distinction (Clarke & Evans 1998; Levinson Stiles, Inui & Eagle,
1993; Sharf & Street, 1997; West, 1984). In summary, the investigation of
experiences and opinions of women receiving medical services for pregnancy and
birth is interesting in and of itself because of the recent introduction of midwifery as
an insured service. In addition, because pregnant and birthing women are not
necessarily "ill", their experiences and opinions may more clearly reveal the
effects of formal medical structures and relationships on their perceptions of their
choices and treatment.

In order to report adequately on the views of new mothers in the Capital
Health Region regarding a number of health-related topics, a qualitative interview
protocol was utilized. Forty extended open-ended interviews were carried out with
new mothers that paid special attention to the experiences and opinions regarding
their relationships with their clinicians and the healthcare system in general. Patients
were divided into four sub-groupings based upon their self-report of how they
accessed healthcare services during a recent pregnancy. Patients were divided into
four groups based upon the following four models of how expecting mothers
accessed health care delivery: mothers who were patients of male physicians paid
by “fee for service”, mothers who were patients of female physicians paid by “fee for service”, mothers who were patients of physicians of either gender paid by salary and clients of midwives. Ten recent mothers were interviewed who reported receiving care during a recent pregnancy in each of these aforementioned ways.

Previous research has indicated that many patients (especially female patients) may be more satisfied with physicians who are female as opposed to male and with physicians who spend more time communicating with their patients (Mullett & Coughlan, 1998; West, 1984). Because of the time constraints inherent in consultations funded via fee for service provisions, this may mean that patients would be more satisfied with doctors who are paid by way of salary rather than fee for service (Mullett & Coughlan, 1998; Waitzkin, 1995; West, 1984). Since January 1998, prenatal, birthing and postnatal care as provided by midwives (including home and hospital births) has been included in the services covered by the British Columbia Medical Services Plan. In addition to comparing the experiences of patients with male and female physicians and physicians who are remunerated either by way of salary or fee for service, this study has made a further comparison with the experiences and opinions of expecting mothers who chose midwifery services under the new plan. Thus, this present study also functions as a qualitative evaluation of midwifery services in the mainstream of provincially insured medical services.

The purpose of this study was to investigate how differing models of accessing healthcare services are linked to general levels of satisfaction, experiences of consultational communication and patient perceptions of independence and agency. An overwhelming proportion of research in the health sector tends to be centred on the interests of the clinician (Street, 2001; Morrow, 1997). Investigations of diagnostic consultations are chiefly concerned with finding
ways to increase the power of physicians to gain compliance from patients to medical advice (Ainsworth-Vaughn, 1994; Fisher & Groce, 1990; Tarlov, 1992; Waitzkin, 1995). Thus, the orienting assumptions as well as the tendency to utilize questionnaire research designs tends to ignore, or at best limit, the subject of patient agency. In order to aid in the discovery of aspects linked to the needs and desires of patients, the choice of method in this present study maximizes the control over the interviewing process for volunteer participants, as much as possible. The predominant data-gathering method in this study therefore utilized extended semi-structured open-ended interviews that would be analyzed using a version of inductive thematic analysis. Thus, while certain aspects of healthcare experiences were identified for exploration, there were no hard and fast hypotheses that were being tested. The experiences and opinions of the participants were the central interest of this inquiry. The interviews were qualitatively analyzed in terms of content and the majority of aspects highlighted in the results and discussion were governed by patterns discovered during the analysis of the audio-taped data.

Before we tackle the empirical aspect of this project, there is a need to outline a discussion of the author's theoretical orientation to the subject matter. In this endeavour I will discuss and provide evidence that health communication, health promotion, population health and psycho-immunological approaches, when added together, tend to show that patient agency may be one of the most important underlying variables linked to experiences of health and recovery from illness. In general, patient agency is rarely discussed in detail in mainstream health research but is sometimes viewed as a more peripheral and poorly understood aspect in some more radical, health-related scientific literature.
While the importance of patient agency is not well understood by the mainstream health research community it is an even more problematic concept in mainstream psychology. The theoretical problems emanating from mainstream psychological systems surrounding coherent explanation of the human experience of acting as an agent in one's own interests, are numerous. The inability for mainstream psychological systems to adequately address and account for such motives may be a major contributing factor in the lack of visibility of agency in the mainstream health research literature.

This study is informed and contextualized by the investigator's background in critical social psychology. The viewpoint that this study builds upon is that experiences of agency are interpenetrated by individual, social and societal realms. Individual experiences of the possibilities for volitional action need to be seen in the context of the particular cultural/biological nexus that represents the field of possibilities existing for human organisms. Unlike other species, including higher primates, humans live in a universe of meaning appropriated from predominantly socially mediated and constructed environment (Berger & Luckman, 1966; Parker & Spears, 1996; Shotter, 1993; Tolman, Coughlan & Robinson, 1997; Vygotsky, 1987, 1986, 1960; Wertsch, 1991). Thus, individual experiences and perceptions are deeply intertwined and interconnected with cultural meaning systems, societal institutional organs and communicative processes. However, there appear to be major problems in constructing any coherent and concrete theoretical orientations to the investigation of agency and communication in mainstream psychological and social psychological research (Lethbridge, 1992; Shotter, 1993; Toiman, 1994; Wertsch, 1991). I intend to offer persuasive arguments to demonstrate that mainstream psychological formulations suffer from the debilitating influences of
dualistic and in particular, Cartesian philosophical assumptions. Psychology must first transcend the limitations of dualistic, Cartesian psychological assumptions before any adequate explanation of human agency can be detailed (Lethbridge, 1992; Tolman, 1994; Tolman, Coughlan & Robinson, 1997).

In order to properly understand the context surrounding the acceptance of Cartesian dualism as a central pillar of psychological theoretical systems the evolution from ancient to medieval philosophical systems must first be outlined. Dualistic thought did not begin with the acceptance by psychology of the Cartesianism framework. Descarte's dualism is a relatively recent scientific version of a traditional western dichotomous meta-categorizational principle that can be traced at least as far back as classical Greece. Cartesian dualistic conceptions are merely the latest, scientifically rationalized version of a general dichotomous meta-categorizational trend throughout the evolution of Western culture. To properly situate and discuss the concept of agency and the problems of dualism in stymieing any coherent theoretical understanding of agency, an abridged history of the development of dualistic meta-categorizational systems is provided as a precursor to the influence of dualism on psychology. This discussion of the roots of dualism (presented in Chapter 2, immediately following this introduction) will situate the acceptance of this meta-categorizational principle in relation to the development of material and economic practices of evolving western culture.

In Chapter 3, the tradition of Cartesianism is further discussed by a more detailed analysis of the effects of these assumptions on conceptions of agency by outlining the problems inherent in three different mainstream psychological systems. This chapter will offer arguments that show that an adequate explanation of the experience of personal agency is problematic in mainstream psychology. All the
major theoretical pillars and schools of thought within the discipline are built upon a continuing belief in the divide between sensation and perception. When mainstream formulations accept this basic premise a logical examination of the theoretical implications reveal that if agency is tackled at all it is either impossible to explain or the explanation results in an untenable reductionism. If we look at the three most mainstream schools of thought in psychology we will find that either agency is external to the organism (as in behaviorism), reduced to the level of the individual (and by implication leading to essentialist beliefs) as in many humanistic accounts or is merely an epi-phenomenon and an under-investigated consequence of the intra-psychic interaction of cognitive modules. While all of these schools of thought offer some valuable insights, they are all in some way uni-dimensional, abstract and thus incomplete. The chapter will end with a brief discussion of an alternative conception based upon a melding of Gibsonian perceptual theory with Vygotskyan and German critical psychological theories.

Chapter 4 will continue the discussion of Cartesian dualism by detailing how dualistic categories form the basis of modern psychology and extended into modern social-psychological research. The internalization of the Cartesian version of dichotomous categorization into mainstream psychological thought and the accompanying problems for social psychology will be discussed at length. An explanation of the sub-discipline's evolution will be contextualized by reference to scientific and extra-scientific cultural developments including socio-political and socio-economic conditions in the marketplace of knowledge production.

Chapter 5 will continue the discussion of the effects of dualism with an examination of holistic and dualistic assumptions throughout the evolution of medical practices. These trends in medical assumptions and models of practice will be
discussed in relation to, and contextualized by the development of vertical societal relations and power in modern industrial institutions. In the same way the discussion of the development of meta-categorizational systems was related to actual dominant practices in the development of Western culture, the continuation of dualistic trends in medicine are contextualized by the relation to dominant economic structures and practices.

Chapter 6 will deepen the discussion of medical practices by presenting a current literature review regarding doctor-patient relationships and interactional strategies utilized in health relations. The experiences of illness and health are deeply affected by western industrial societal power differentials and these differences are inter-penetrated and often reinforced by unsatisfactory communicative interactions in diagnostic consultations. This review of the research literature will demonstrate that communication in mainstream diagnostic consultation is often impoverished by clinical ideologies that generally seek to enforce the authority of clinical experts while simultaneously abrogating the agency of patients. The construction of modern medical institutions and medical practices will be shown to be heavily influenced by the assumption of both mind/body and subject/object dichotomies.

The rationale behind the choice of investigative methods in the study of patient experiences of the health system in Victoria will be discussed in Chapter 7. In summary, the use of semi-structured qualitative in-depth interviews with new mothers concerning their experiences with medical institutions offers an opportunity for research participants to exercise their agency. By choosing this investigative protocol the research design enables participants to discuss
experiences important to them and in a narrative form of their choosing. A
detailed account of this qualitative interview protocol is included. In Chapter 8 the
results of this study are presented comprising of the themes and patterns
discovered in the analysis of the interview data. These will be divided up into
broad topic areas that were found to be of importance to the participants. Within
these broad topic areas, the order of the presentation of the findings will be
presented in the order of importance that participants placed on them. Finally,
Chapter 9 will discuss the meaning of the patterns discovered in the analysis of
the patient interviews in relation to previous research. In addition, theoretical and
healthcare policy implications of the results will be discussed.

As outlined in the chapter summaries above, before embarking on the
empirical qualitative investigation of patient experiences with medical institutions a
discussion of some theoretical issues regarding agency and some contextual
information concerning the literature pertinent to medical practices and relationships
will be presented. It will be argued that medical practices and institutions have
tended to preserve and consolidate power imbalances that tend to limit patient
agency in interactions. Modern mainstream North American psychological
conceptions tend to undermine emancipatory considerations which can be
demonstrated by the scant attention paid to the concept of humans as agents acting
in their own interests as well as by the inadequate theoretical foundations for a
psychology of emancipation. In this regard, both mainstream North American
psychological formulations and western medical practices are all undermined by the
basic assumption of Cartesian dualism. Descartes separation of mind and body but
especially subjective and objective aspects has been seminal in modern times but at
a meta-categorizational level this modern dualism is merely a variation of some more ancient conceptions. Before we detail the effects of Cartesian dualism on psychology and medicine, the following chapter will present an abridged history of how pre-Cartesian dualism developed in relation to predominant cultural practices even in their more ancient origins. Such a narrative provides a socio-historical basis for understanding how the meta-categorizational system of dualism developed and was mostly unquestioned in the construction of the subsequent scientific paradigm and medical practices.
Chapter 2
The development of dualistic categorizational systems.

There has not been a universal assumption in philosophy that categories should necessarily be discretely dualistic. In fact, although much rarer nowadays owing to western colonialism, many cultures devised distinctly non-dualistic and non-dichotomous systems of categories. Of the few still existing today, some North American native, Buddhist and Vedic configurations exemplify a more holistic interpretation of embodied existence. From the earliest fore-bearers of the western tradition, dualistic categorizational systems can be seen to have governed the socially constructed political, economic and cultural arrangements. However, it is the realm of material and social practices that shapes philosophical systems and these systems are reinforced because of their continuing relation to the predominating form of material practices (Marx 1846/1963; Volosinov, 1973).

Ancient classical conceptions

In the western tradition stemming from the classical Greek period forward, the predominant cultural project has been the acquisition of land and the subjugation of "other" peoples by means of firstly military and later by ideological domination. Philosophical considerations and the meta-categorizational systems that are utilized in guiding societies are linked to the overall material practices of the culture and are reinforced through the use of the linguistic tools of communicative interaction (Duranti, 1997; Volosinov, 1973). The material,
economic, ideological, and communicative practices appear to be seamless, and while they are interpenetrated, material and economic forces set the foundation (Marx & Engels, 1846/1963). Societies that are predominantly "warrior" will find dichotomization a natural description of their reality and useful in their continuing societal project concerning the annihilation and/or domination of "others" and/or the natural world.

In the various early pre-classical Greek divinities there was a sense of a non-chaotic universe that was holistic. Mythical figures represented an undivided natural-supernatural continuum where the natural world, the world of humans and the world of the Gods were often practically indistinguishable. This mythic/natural holism was gradually eroded by late Homeric conceptions and the classical tragedian tradition in which the human character and human actions were seen to largely determine the fate of humanity (Tarnas, 1991). As Greek society evolved and became more concerned with a project of colonial domination, there was a move to the gradual separation and dichotomization of philosophical categories (Spetnak, 1984).

In certain earlier Greek renditions of this dualistic separation, the ordering principle was mythical or supernatural, while in others the ordering principle was considered to be material and governed by chance or blind necessity (Finley, 1966). Parmenides, theorizing that ordering principles were superior and changeless, concluded that "true" reality is separate from expression in human affairs. This formulation set the conditions for the separation of being/becoming; appearance/essence; rational/irrational and truth/perception that became the
grist for later philosophizing about the nature of embodied natural existence. Anaxagoras also greatly contributed to a fundamental dualism when he postulated the separation of "nous" (or mind) from the rest of the natural order and posited this "quality" as superior and as giving form and motion to the universe (Tamas, 1991). In much the same fashion, what I am referring to as "agency" in human affairs has been contested and categorically reassigned throughout European intellectual history. It has been a concept that has been elusive because it has been expressed through different concepts such as "will", "hubrus" and "grace", for example. However, the general trend has been to dichotomize the universe and important concepts such as those concerned with a self/environment continuum have suffered from this gradual process of abstraction, making concrete contextualized explanation of humans and their activities and intentions, extremely problematic.

The Pythagorean table of opposites created out of a philosophy that was a blend of the mystical and rational-mathematical continued the direction of oppositional explanation and expanded the gulf between the natural and the mythical. The Sophist tradition assumed the explanatory high ground temporarily, positing that as all explanations are divergent and therefore (as Protagorus expounded) "man becomes the measure of all things." In this turn we have an early contemplation of the subjective/objective divide that forms a major pillar of western dualism that has endured, continuing to ensnare scientific and particularly, psychological scholarship to this day (Tolman, 1994).
Opposed to the subjective relativism of sophistry, the critical occupation of humanity according to Socrates is the discovery of knowledge through virtue. Although one must accept that he may well be the unwilling accomplice in Plato's rationalization of his own philosophical system, Socrates is reported to venture that to know virtue one must discover the "essence" that is the determining principle and which animates examples of virtue that we see in everyday experience (Church, 1956). The separation of pure essence from everyday examples was further reinforced by Plato's separation of transcendent "forms" (to which the soul is closely related) from mundane experience in which the soul is embodied (Finley, 1966).

The dualism of Plato was exaggerated by the political as well as intellectual crises of his day that furthered the separation and dichotomized categories of the "philosopher" versus the "common man"; the mind and soul as opposed to matter and ideal "forms" versus the phenomenal world. Although fundamentally considered "rationalist" in character, the foundation of Plato's rationalism, unlike more modern versions, was universal and divine, but it was also similar to modern conceptions in that rationality was discussed in terms that defined it in opposition to "irrationality" or "necessity". The irrational was associated with nature, instinctual desire, the body and matter, whereas the rational was associated with mind, the transcendent and spirituality (Keller, 1985). The dichotomization of the soul/mind from necessity/nature was furthered by the predominantly political idea that freedom is expressed only by the "guardian classes" of society in their bid to overcome the slavery of their
biological embodiment (Arendt, 1958). In addition to the bifurcations discussed above, classical Greek systems internalized the dichotomous categories of male/female, high/low social castes, abstraction/contextualization and an early contemplation of individual/society, all of which have been formative in the evolution of western categorizational mechanisms. Aristotle further contributed to the dichotomous world view as he reassigned Plato's "soft" dualism of gender in his system by widening and hardening the distinction (Eisler, 1987).

**Medieval variations of dualism**

Roman stoicism developed out of Plato's idealistic dualism, and this in turn exerted a strong influence over formative Christian theology (Synnott, 1993). Seneca followed in this dualistic tradition, although his opposition between body and soul was not as emphatic as Epictetus' outright condemnation of the body and worldly nature as inimicable to spirituality. Marcus Aurelius spoke of the divide between the higher and lower aspects of humanity, viewing death as a "release from impressions of sense... and from service to the flesh." The Christian configuration of dualistic categories was (and continues to be) decidedly Platonic but somewhat variable in terms of the relative strength of the opposition with regard to particular dualistic categories. For instance, the Christian view of the body (as opposed to spirit) has been historically somewhat ambivalent, depending on the view of particular theorists (Tamas, 1991). Saint Paul gives a different rendition of the place of the body depending on whether it is considered physical or spiritual (as in the case of the redeemed body in the afterlife). The Pauline view of the physical body, in connection with biology is not
quite as negative as in Plato's characterization. Certain sections of the New Testament describe holy miracles that intercede in human affairs and particularly in aid of physical needs, a tradition that today finds expression in liberation theology. Origen, however was an extreme fundamentalist and considered the body (and especially sensuality) to be an enemy of the soul. He was so convinced of the perception of the danger from sensuality to his spiritual existence that he castrated himself in an effort to save his soul from eternal damnation (Chadwick, 1966). John Chrysostom (circa 400) was also adamant concerning the enmity between the body ("a whited sepulcher") and soul, but later moderated this position saying that the body could be useful but only in relation to a remembrance of "Him who framed it." Augustine, who probably had the greatest effect on Christian doctrine was more in the mellow of Chrysostom's latter view of the body, referring to it as "a revelation of the goodness of God" but still considered it to be a separate and inferior category in relation to the spirit. In general, the mythical aspects of Greek life that fostered pluralistic and indeterminate characteristics of mythical figures became transformed to Christian oppositional archetypes that were fixed and deeply antagonistic to each other.

Later, Thomas Aquinas rejected aspects of both Platonic dualism and Aristotelian materialism and developed a theology of body/soul unity and bodily resurrection. At the same time, however, he magnified the male/female divide and probably greatly institutionalized the misogynous dichotomy of woman, nature and evil as opposed to man, spirituality and reason (Ranke-Heinemann, 1990). Undoubtedly the institutionalization of gender and body/soul oppositions
led in part to, among other cruel and oppressive practices, the horrors experienced throughout the Inquisition.

The dualistic vision of early Christian belief as derived from Plato; Aristotle; Judaism; Pauline theology; Gnostic dualism, Zoroastrianism and Neoplatonism reinforced each other in Christianity after Augustine. Dominant elements of Judaism that found expression in Christianity included the experience that evil pervaded man and nature and that both were deeply alienated from the divine. Particularly Judaic elements finding a renewed expression in Christian theology, included the strict adherence to law, the attempt to separate and preserve the faithful minority from the contamination of "others" and the expectation of apocalyptic punishment (Tarnas, 1991). All of these ordering mechanisms were deeply dualistic and reinforced the Christian dichotomous categorizational constellation.

Modern scientific dualism

Whereas in early Christian formulations reason was very much tied to the mundane phenomenal world, being considered inferior to the realm of the divine, it was eventually to replace God as the superior category and final appeal in the modern world-view. The dawn of the modern era led to changes in some dichotomous hierarchical polar opposites, including a new emphasis on some previously relatively weak oppositions (e.g. individual/society) but many of the old oppositions remained. The changes that emerged were related to the emergence of a new social class in the continuing project of domination and the new social
practices that advanced the power of this pre-industrial mercantile class
Including further attempts at colonial empire-building.

These changes to the hierarchical dichotomous system that emerged in the modern era facilitated the growth of new political and economic forms based on monetary capital that challenged the ancient philosophical systems. One of the fruits of these massive changes from feudalist authoritarianism to the beginnings of industrial capitalism was the radical conception of "the individual" who was now partly freed (should he be a member of elite society) from some of the stifling encumbrances of medieval relations. Later into the industrial age ordinary peasants also needed "freeing" thereby facilitating their mobilization in the new economic reality. The practical requirements of a mobile labour force in early industrialization led to the gradual demise of the centuries-old agrarian collective identity and this change in economic practices led to the modern conception of a more individualized sense of identity.

In connection with a gradual change from a feudal collective sense of identity to more modern individualist conceptions, the advent of Protestantism was important. Protestant Christianity represented a re-evaluation of the relationship between the divine and each individual human soul that disempowered the Roman church and its functionaries as necessary via mediums for human redemption. The Protestant focus on individual relations between man and God gradually led to a belief that it was incumbent upon the individualized believer to demonstrate their God-fearing nature through various forms of application, including work. However, the majority of the fruits of such
work, if consumed in a decadent fashion, could be viewed as spoiled with the possible risk of censure owing to an incursion into sinful activity. Thus, Protestant individuals demonstrated their worthiness by amassing wealth and power and attempted to extend the reach of Christianity in much the same way as their Catholic brethren, by the domination of non-Christian 'others'. As the industrialization of western economies became dominant, both personal and socio-economic relations assumed an individual ontology based on the metaphor of market relations. By the mid-20th century such instrumental relations based on the logic of the marketplace became internalized to an extent that this radical reformulation of individual identity had become almost invisible.

However, once these new "radical" forms are in place, and people are brought up in them, then this individualism is greatly strengthened, because it is rooted in their everyday practice, . . . it comes to seem the only conceivable outlook, which it certainly wasn't for their ancestors who pioneered it.


Industrial capitalism, Protestantism, and the growing superiority of logical methods reinforced each other in forms of discourse and action to transform the old dualistic systems into a slightly amended version that suited the new secular pre-industrial and industrial projects. Science became the legitimating organ in the social actions and social relations of the modern era, including the individualist narrative of social relations constructed to reflect the necessity of the appropriation of individual labour.
an assertion of knowledge always legitimates certain kinds of actions and certain kinds of institutions. If something is known, in the sense of known to be true, then we are supposed to act on the basis of it, and if we do not then we are being foolish, irrational and disruptive. Thus an assertion of knowledge is always an assertion about proper social actions and social relations.

(Wright, 1992, p. 6)

Galileo had earlier declared that the use of mathematical reason would unravel the mysteries of an atomistic nature and lay the foundation for the science of mechanical physics and the essential principles of scientific methods. He entrenched the concept of primary and secondary qualities as a major dualistic divide and argued that judgment concerning nature should be made considering only the quantifiable "objective" qualities (such as size, shape, weight, motion and number) and that secondary qualities (being subjective) should be given far less credence. Descartes contributed to the separation of these qualities, in a form that inverted Galileo's formulation. Through a combination of skepticism and mathematics, he proclaimed the essential hierarchical division of the world to be the primary indivisible rational thinking consciousness (res cogitans) and the material, secondary and divisible object of consciousness (res extensa). Thus, although the main thrust of this separation was considered to be a division of soul (later understood by others as mind) from all material substance including the body, the more lasting and formidable separation (especially for psychology) was between the subject of experience
and the objective world. This would divide sensation from perception and would be consolidated by the philosophers following in the empirical tradition such as Locke, Hume, and Berkeley as practically indisputable.

From here there arose a division of the new "rational" methods. One that followed in the empiricist tradition of Bacon, Hobbes, Locke and Mill that devoted attention and gave predominance to the objective world, and a rationalist tradition stemming from Descartes, that gave primacy to the ordering principle of rational ideas. It is paradoxical that the empiricist tradition that flourished in Britain (and was a reaction to the Cartesian position of the primacy of the internal ordering principles) only solidified the subjective/objective divide by emphasizing the primacy of the opposing pole of this division. Therefore, empiricism rather than countermanding the rationalist position, empiricism actually consolidated Cartesian principals. The combination of both schools reinforced the modern notion that the individual should be considered the site of rational knowing and the foundational unit of future scientific rumination and analysis.

Mind-body dualism certainly was not new, but now linked to a subjectivized philosophy it attained levels of abstruseness not previously encountered. A second important result, obviously linked to the first, was a fundamental individualism which made the individual mind, not the collective mind or universal logos, the foundation of all certainty. A third important result, owing more to the context of the new science in which the philosophy
was developed than to the philosophy itself, was a pervasive mechanicism.

(Tolman, 1994, pp. 5-6)

The fruit of the dualism between rational subject and material world was science, including science's capacity for rendering certain knowledge of that world and for making man master and possessor of nature. In Descartes vision, science, progress, reason, epistemological certainty and human identity were all inextricably connected with each other and with a conception of an objective, mechanistic universe. Upon this synthesis was founded the paradigmatic understanding of the modern mind.

(Saul, 1992, p.84)

The Christian dichotomies of spirit/matter and God/natural world were transformed into mind/matter, subject/object, man/nature, individual/social and the rational-scientific methods versus the irrational, intuitive and emotional. While Cartesian rationalism suggested and affirmed the conception of man as opposed to and dominant vis-a-vis nature, modern empiricism solidified the divide. The development of the modern version of dualism by Descartes was to have a lasting effect on the development of scientific systems and would prove to be extremely problematic for the development of psychology. His system is often discussed in terms of the legacy of mind/body dualism but the most problematic divisions were the separation of subject and object. This is a restatement of the classical Greek dichotomy of essence and appearance encoded as the
separation of sensation and perception in psychology by representationalist theories of perception.

Scientific knowledge has always contained and legitimated hidden and specific cultural values and commitments (Danziger, 1990; Putnam, 1981; Rorty, 1979; Tolman, 1994). These values, meaning-constellations and commitments are rooted in the concrete societal projects and are encoded through social relations in the discourse of cultural systems (Volosinov, 1973). Meanings are locally contested within discursive fields, with the power to control a particular field residing in claims to a specific reading of rational scientific knowledge, embodied in the social relations and writings of disciplinary and professional institutions (Dant, 1991; Scott, 1990; Shapiro, 1988). The regularities of hegemonic discourse are rooted in social practice and because versions of knowledge cannot operate reflectively on the context within which they emerge, it is unlikely that they can remain unaffected by the power relations that permeate the political and historical processes of the social project of which it claims to analyze (Dant, 1991; Foucault, 1984; Weedon, 1987).

It attempted simply to break the captive logic of arbitrary power and superstition with reason and scepticism. Now, that same self-justifying has asserted itself within the new system. It took us four and a half centuries to break the power of divine revelation only to replace it with the divine revelations of reason . . . yet to argue against reason means arguing as an idiot. The structures of argument have been co-opted so completely by those who work
the system that when an individual reaches for the words and phrases . . . he finds they are in active use in the service of power.

(Saul 1992, p. 36)

The evolution of western culture up to and including the establishment of the modern scientific world view provided the essential features of the dichotomous constellations that have molded experience and expressed themselves in conceptions of diverse aspects of embodied existence. The addition of the individual/social and the reordering of the rational/irrational bifurcated categories interacted with the older, but continuously utilized bifurcations of mind/body; male/female; essence/appearance; culture/nature and class divisions to constitute a constellation of assumptions and research strategies in scientific investigation.

Although it may well be true to look at the rising predominance of science as a revolution in epistemology, culture and eventually economic systems, at the meta-theoretical level it was merely a further evolution and continuance of a system of dualistic categorization linked to the dominant social project of dominating other cultures and/or nature. The predominant cultural project of the domination of nature and "otherized" cultural systems remained the same but the future continuance of this project would now hinge on the utilization of scientific methods as the means to achieve these goals. At the meta-categorizational level, little would change except of course the foundation of this epistemological rationalization (Coughlan, 1995).
Mainstream psychology and the sub-discipline of social-psychology, being integral to the modern industrial project, inherited the assumptions of the natural science paradigm and conflated this particular model of scientific investigation with science "per se". As a result, mainstream social-psychological research has assumed the meta-categorizational system of dualism in its more modern Cartesian version, as well as a specific form of this organizational principle by abstracting the individual from the naturally occurring concrete relations of culture and social interaction. These assumptions have hampered the creation of a meaningful system of social-psychological scholarship that is adequate to explain the realities of everyday experience. Further, mainstream social-psychological formulations were (and continue to be) contextualized by extra-scientific, economic necessities of procuring funding and garnering status for practitioners. The usual funders/purchasers of scientific research are more interested in practical applications in social engineering. Thus a great deal of social-psychological research was far more interested in the prediction and control of both outcomes and individuals. Consequently, the production of psychological knowledge actually tends to hamper the emancipation of ordinary people from modern systems that are often perceived as antithetical to personal needs, goals and desires. Most modern social-psychological research has tended to follow in the footsteps of the parent discipline by assuming theoretical orientations that are ill equipped to explain personal agency and instead often become complicit in the development of technologies that actively seek to limit experiences of personal agency. The problems of the internalization of these
principles into mainstream North American social psychological research will be discussed in greater detail in the following chapter.
Chapter 3

The inadequacy of mainstream Cartesian renditions of agency in psychology

This chapter will continue the discussion of dualism as a meta-categorizational system in western thought and deepen the understanding of this influence on the development of modern social-scientific systems by focusing on a critique of a major foundation of modern psychology: mainstream theories of perception. Dualism as expressed in mainstream perceptual theories has far reaching effects on scientific notions of self and agency in psychology and by extension, social-psychology.

Dichotomization is a major meta-categorizational foundation of many scientific and extra-scientific cultural products in western industrialized nations. The breadth of general acceptance is due in part to mainstream perceptual theory which is built upon dualistic pre-cursors to modern scientific systems. Modern scientifically supported versions of dualism stemming from Descartes and as expressed in mainstream representationalist perceptual theory are major determinants of the vacuum of coherent theoretical explanation in the areas of "self" and "agency". The overall meta-categorizational system of western dualism, along with the modern expression of this in the foundations of psychology cannot be seen as disconnected from inadequacies in the development of modern socio-cultural systems and the consequences that appear as problems in the expression of personal agency in industrial economies.
The modern context

The beginning of a new millennium has brought a similar sense of pessimism and powerless similar to that felt at the turn of the last century. In industrial western nations as well as the third world many people have grave doubts concerning the ability to enact changes to personal circumstances. External social, political and cultural occurrences seem to constrain rather than galvanize a sense of competence. In the global village, power is wielded from ever more remote distances and consequently is increasingly perceived as debilitating to many people's sense of personal agency. While the majority are unable to identify the source of an increasing physical/spiritual/moral anomie, many critical social and political commentators (for example, Saul, 1995; 1999; Townsend, 1999; Foucault, 1984, Harvey, 1990) trace this feeling of uncertainty and experience of dwindling horizons for personal action to the simultaneous demise of the democratic nation state and the dawn of a "corporatist new world order". This substantial evolution of late capitalist culture is a development John Ralston Saul has referred to as the dawning of an era of the "New Medievalists" (Saul, 1995). His point here is that we are entering a period where personal agency is being steadily eroded by the privatization and commodification of public services. This undermines the general public interest in many cases and is linked to an increasing sense that the public sphere is no longer able to address the interests of the ordinary person. This is supported at a philosophical level by various "postmodern" viewpoints that tend to be little more than a rationalization
for a restatement of autocratic governance common to pre-democratic medieval culture.

In Saul's view, global "corporatism" represents a substantial threat to personal agency worldwide. Residents of the industrialized world are forced to increasingly scramble to reorganize their lives to rapidly changing economic and political conditions and are further hampered by the dissolution of the mediating influences of social welfare policies to support a generalized entitlement and security (Saul, 1995; Harvey, 1990). People are finding that they are working longer hours than was current 20 years ago with fewer or no benefits. More energy is expended on basic survival chores leaving little time for community, national or global problems. Desperately poor communities especially in the third world are further rent asunder by internecine warfare. Even in the relatively stable industrial world, communities have fractured and devolved into collections of fearful and instrumentally related, competitive individuals (Harvey, 1990). A culture of fear is reinforced by the corporate media, and being suspicious of others, many have been convinced to seek both shelter and an impoverished sense of agency in passive, consumerist-inspired recreation (Beaudrillard, 1994; Palmer, 1990). In late industrial culture we have been taught to be fearful of social and personal intimacy. The inability to act co-operatively has led to a general malaise of disaffection with society leading to a retreat into subjectivized nihilism and the faux intimacy of mediated or virtual communion (Beaudrillard, 1994).
Considering the near impossibility of trying to change things for ourselves, or to form communities that can conceive of working co-operatively towards some shared vision of change, most are coerced to retreat to one of the few legitimate positions left for expression: recreation linked to passive consuming, as individuals (Baudrillard, 1994; Saul, 1995; Palmer, 1990). At the legal level we are free to dissent in industrial democracies, but increasingly the field of discourse is accepted as one of the only legitimate avenues for the expression of agency (Foucault, 1984; Horrocks & Jevtic, 1996; Baudrillard, 1994). Postmodern philosophies of various shades and stripes have both described this trend and reinforced its acceptance (Harvey, 1990; Norris, 1990). Real avenues of political activism or even academic and scientific non-conformity are being removed from the menu of available courses of action as states increasingly abandon the funding of formerly public institutions to the corporate sector. The enlightenment ideal of the progression of freedom and justice has thus become truly idealistic in that, at best, discourse concerning these matters has replaced and become mistaken for broad-based consensual activity towards a realization of actual solutions to practical societal inadequacies (Norris, 1990; Harvey, 1990). Most have already left the running of all important aspects of their lives to bureaucratic and corporate organizations. For the few who remain in the fray; their acceptability as "respectable" social commentators rests on their self control in not allowing individualized, radical discourse to lead to organized social action (Reicher, 1996; Michael, 1996). The message many academics have generally internalized is that, for us, discussion is sophisticated but concerted collective
action may be regarded as suspicious on both scientific and political grounds (Reicher, 1996).

Much of “postmodern” philosophy and some discursive variants of social constructionism are attempts to overturn elements of inequality in the “modernist” project and to explore the cultural embeddedness of some of our more repressive institutions (Berger & Luckman, 1966; Shotter, 1993). However correct their criticisms concerning modern industrial scientific and economic systems might be, in general their programmes have reinforced the notion that resistance is primarily found in altering individualized discursive forms. Amendment at this idealistic discursive level is promoted along with the vain hope that such alternative discourse will be reflected in actual personal, social and societal events, at a later date. This postmodern discursive resistance to inequality is a variant of trickle-down economic theory used as a metaphor for a theory of social development. This co-option of critical philosophy to neoliberalist ideology by the use of such metaphors and the resultant impotence of resistance to “corporatist” domination cannot be over-emphasized. In actual fact, the focus on purely individual discursive events (as opposed to social action) results in a focus way from serious modernist societal goals such as equity and justice. The postmodern move to valorize discourse has led to a change of focus to play (as opposed to purpose), chance (as opposed to design), surface appearance (as opposed to depth) and indeterminacy (as opposed to determinacy). The substitution of action-oriented modernist programmes with
postmodern subjectivized relativist accounts merely reflects the experience of anomie inherent in late industrial society (Harvey, 1990).

At a deeper level the advent of postmodern and subjectively oriented discursive social science is consistent with the move from a predominantly production oriented to a consumerist society. The replacement of objective modernist with subjective postmodern narratives provide a rationale for such changes within the capitalist paradigm and does not represent a true break with the traditional aims of industrial capitalism (Tolman, Coughlan & Robinson, 1996). The emancipatory value of the broad group of postmodern accounts is extremely limited because of their unacknowledged reinforcement of discursive events as a reality unto themselves and their reliance on metaphors of consuming recreation as the predominant template. Desire and fantasy were always a part of cultural life but late capitalism has exploited the standardization and commodification of fantasy as the predominant engine to increased value production in the global economy.

The production that now counted was the production of new needs, wants and desires in order to fuel consumption. It was in this context that play replaced purpose, with corresponding emphasis on anarchy, chance, exhaustion, performance, indeterminacy and non-interpretation. Attention was directed to desire and fantasy.

(Tolman, Coughlan & Robinson, 1996, p 129-30)
The results of postmodern attempts at broad-based emancipation via fantasy were never really viable. Such programmes were flawed from their very outset because of their acceptance of the radical separation of individual consumers of texts from concerted co-operative practical action. The move from modernist to post-modernist individualized narrative "accounts" serve as a consolidating force for the late industrial period and actually work to inoculate oppressive systems from egalitarian efforts as they function to side-track social emancipatory activity into subjectivized, disconnected and ultimately vain individual discursive re-interpretation as an alternative to organized acts of resistance.

Such ideas could not succeed without broad social acceptance of certain ideas concerning "human nature." Our problems in mounting a defense against such a postmodern construction may well be in large measure owing to a pre-disposition to accept that humanity is naturally comprised of independent competitive and consuming individuals. Such individuals who exist in a society that operates mechanically, instrumentally, and selfishly and who are convinced by socialization in such societies to be passive, will tend to accept this model of human nature and social relations as true and immutable. In the current state of affairs, where a majority of the denizens of modern industrial cultures feel themselves to be socially disempowered and have therefore retreated to express their desires and personal agency in the malls, sports arenas and T.V. rooms, there is a willingness to accept the truth of individual passive subjectivity as natural. This lived reality of individuals as passive reactors to stimuli from the
environment is parallel to and informed by the striking resemblance of classical traditional theories of human nature, the relation of consciousness to the world and by implication, mainstream "representationalist" theories of human perception.

These models and narratives of the relation of humans to their environment and the explanation of human experiences of perception seem reasonable because modern western cultural forms have continually reinforced this belief. These models developed because of their connection to and applications within historical contexts. They matured and became practically irresistible because they were in harmony with the overall predominant societal project of industrial capitalism. The tragic separation of human consciousness from action in the world, from other members of the human community and even from aspects of our own selves owes a great debt to the history of dualistic systems of categorization and in particular to the Cartesian dichotomous version. Traditional representationalist theories of perception are fundamental expressions of Cartesian dualism and this is linked to the acceptance of humans as passive being seen as a natural fact.

Representationalism and cognitive psychology

The three moment scheme (Input-Central Processing Mechanism-output) which characterizes representationalist theories of perception is a direct descendent of the Cartesian dualist concepts as described in article XVI of The Passions of the Soul. The entire system is characterized as constituting a one-way mechanical causative chain. The information necessary to the system is
input in the form of sensations and the Central Processing Mechanism (CPM), related to the actions of the soul, is constrained by its own nature but most importantly by sensory data. The soul becomes part of the mechanical network leaving it vulnerable to be replaced as the brain as the site of central processing in later renditions common in cognitive science (Tolman & Robinson, 1997). This three moment mechanically organized scheme of representation radically separates the realms of sensation and perception leading to subject/object dualism which forms one of the fundamental assumptions of all modern mainstream psychological and social-psychological investigative practice.

According to this model, subjective experience concerning the separate outside world is only in terms of the play of nervous energy. Not only are the realms of subjective experience and objective world split apart but the experience of radically isolated individuals becomes the primary focus of psychological and by extension, social-psychological practices. Inter-subjectivity is relegated to a secondary, problematic concern. The current experience of modern individualism then becomes a natural, rather than a culturally embedded, fact of existence. In mainstream social-psychology, as mentioned previously, the additional complication of social life is tackled with a qualitatively similar toolbox of methods that are generalized from psychological theories assuming representationalism. Thus, internalizing Descartes' scheme, all mainstream theories and methods have reinforced a conception of relations that is congruent with the modern industrial and consumerist project. Cartesian formulations in social-psychology have seriously undermined any coherent explanation of the
reality of experienced volitional activity, inter-subjective meaning creation and the evolution of culturally saturated institutional systems.

The combination of subject/object dualism and mechanical causation has led to a general assumption in most schools of mainstream psychology, that the world is forced upon us, constraining our actions to be merely reactive to the environment while at the same time we are separated from this “objective” world. The combination of the three-moment scheme and the one-way mechanical causation severely restricts any coherent explanation of agency for people endeavouring to order their life in terms of their own needs and desires. The Cartesian derived, three moment perceptual scheme has led to insubstantial and problematic descriptions of the relation of individuals to their cultural life as well as some unparsimonious mechanical theories of communication which similarly fail to adequately reflect actual interactive discursive behaviour.

A subject-object dualism only makes sense to the ordinary mind when it is supported by mechanical causation and representationalism . . . which does indeed correspond to our actual abstraction and isolation as individuals in bourgeois society. Causality and representation help this appear natural.

(Tolman & Robinson, 1997)

The problem remained that while it seemed so natural to assume this Cartesian explanation of perception that tragically isolated the individual subjective experience from the world, later scientific rumination laid bare some troubling contradictions. Future explanations of the connection of human
consciousness with a now separated world would either have to be extremely convoluted and unparsimonious or they would have to attempt to artificially conflate the objective sphere into the subjective or the reverse via some form of reduction.

Acceptance of representationalism means that we can only have an indirect experience of the physical and social environment. This leads to some logical quandaries in terms of the application of this paradigm, in psychological practices. If we are to accept the indirect realist account, then what credence can be given to psychological observations? The mainstream psychological gaze is at logical odds with the representationalist theoretical framework within which it operates. The inconsistency appears when the assumption of indirect realism is applied to the subject in a psychological investigation but to make conclusions acceptable as rigorous science, it must be abandoned in terms of the investigators' perceptions (Katz & Wilcox, 1984).

Behaviorism

Behaviorism is a grand example of attempts to artificially overcome this duality by conflating the subjective realm into objective behaviour, but with little success. Cognitive aspects of an organism were translated to be seen only in terms of bodily movements. For example, thinking was studied in terms of supposed laryngeal movements and personality as a general tendency to react to stimuli (Heidbreder, 1933). The rejection by behaviorism of the existence of consciousness for all practical purposes is however, not always clear. Some behaviorists denied its existence altogether while others asserted that regardless
of whether it existed or not, it was not amenable to scientific psychological investigation. Either way, mental processes were considered not to be the concern of psychological investigation whereas external behaviour was (Talyzina, 1981). The second view can be recognized as a reintroduction of Cartesianism into the behavioristic system. The active participation of the organism in choosing to construct its future through "consciousness" was viewed as threatening scientific objectivity and excluded from investigations as it disrupted the aim of scientific psychological research which was objective prediction of behaviour (Lethbridge, 1992).

In Skinner's version of the behaviorist project, the mind was viewed as "a fiction" (Skinner, 1971). The set of assumptions he worked with which postulated that behaviour is shaped by its consequences states that behaviour before the process of operand conditioning, is a randomly emitted phenomenon (Skinner, 1953). A "self" is a repertoire of behavior appropriate to a given set of contingencies which cannot choose to act on the world: instead the world causes actions in the organism (Skinner, 1971). Thus, this position is one that cannot conceive of a coherent theory of self let alone an explanation of agency (Lethbridge, 1992). Human behaviour is reactive rather than active: it always merely responds to and is determined by externalities. According to this view, the fact that we experience consciousness and something approaching agency does not mean that material stimulus events do not cause our behaviour. Such things, as are experienced are "diversions": collateral by-products of the play of stimuli on our biology and history of S - R chains and are "epi-phenomena". Yet, there is
no explanation of why, how or when this epi-phenomenon emerges or what its function might be!

The organism (meaning any organism) was considered passive. Behaviour would be emitted in response to various forms of stimulation and it was assumed that it would be an objectively predictable response. Thus, this reductionistic variant of Cartesian psychology was not only antithetical to the study of consciousness and agency but completely abandoned these topics in its framework. Theirs was an unsuccessful strategy of overcoming dualism that conflated subjectivity into behaviour in a mechanical externally oriented arrangement that preserves individualism (Talyzina, 1981, Lethbridge, 1992).

In its favour, at least behaviorism did not always replicate the representationalist aspect of Cartesianism. Many in the field held to a direct realist, unmediated account of perception. However, even in this attempt the project was to be unsuccessful as later investigators were forced to reintroduce the CPM in the form of various layers of "intervening variables". While attempting to explain consciousness in terms of stimulus-response chains and operand conditioning, many behaviorists couldn't dispose of or explain the differing constitution of particular organisms in particular environments. It was generally agreed that there were no marked differences between one organism and another. The view that the same psychological laws apply equally to all species meant that they failed to understand the evolutionary aspects of qualitative change and ignored the marked differences that human cultural life engenders (Razran, 1971). The return of this middle term, or a set of intervening
variables of course looked very similar to the CPM and returned us again to a Cartesian dualism.

From behaviorism to cognitivism

As a revolt against the spartan, reductionistic and mechanical dualism of behaviorism, both cognitive and humanistic psychology reconfigured a different model of the appropriate object of psychological investigation (Lethbridge, 1992). However both models would assume Cartesian representationalism and would both fail in offering any coherent account of agency or inter-subjective engagement. While behaviorism attempted to artificially dispose of the gulf between subjective experience and objective world via a reduction, it would seem that such a separation was something that appeared to be somewhat revolutionary and actually embraced by cognitivism. The only possible explanation for such a claim can be that psychology suffers from an extremely serious memory malfunction. Fodor’s, classical use of computational models tries to hide the Cartesian scheme by the use of slightly different terminology but he explicitly points to the radical separation of the physical world and individual subjective experience. He reaffirms the divide by claiming two descriptive levels that arise by the artificial separation of the world and sensation (at the sense receptors) which mechanically convert sensations into arbitrary neural codes. These are later decoded into representations using certain “processing qualities” of the neurological C.P.M., to produce perception. The assumption is that the senses are provided with an impoverished description of the world and that the inadequate data can only form an image or representation of the original input
data by the intervention of various cognitive "modules". Sensations merely record this impoverished data by registering energy as intensity, frequency, wavelength etc. There is a great reliance on memory to make sense out of static energy to add depth perception, locomotion, movement and meanings from static images or representations of the world. It is assumed that memory is used to fill in the discrete momentary snapshot of the stimulation of sense organs which is devoid of information concerning time (hence movement) and the dimensional arrangement.

In the case of organisms as in the case of real computers, if we get the right way of assigning formulae to the (psychological) states, it will be feasible to interpret the sequence of events that causes the output as a computational derivation of the input.

(Fodor, 1975, p. 74)

The reductionism of cognitivism is opposite to that of behaviorism in that the mental realm is assumed but activities are separated and said to be accomplished by means of the use of appropriate "modules". The self is not really addressed but we can consider that cognitive psychology also treats it as an epi-phenomenon of the interaction of these various cognitive compartments, if not in theory, at least in practice. Metaphorically, the person is transformed into an interaction of computer machine parts which has a tendency to reify processes by their connection to structures assumed to be in the brain. Again, without a reasonable rendition of the self there is little chance that a coherent
model of human agency will be revealed. The self is portrayed as a passive structure or schema that integrates all the self related information, perhaps an "executive module". Cognitive psychology has much to say about abstracted and separated self-concepts but has very little to offer concerning "self", itself. In other words while cognitive psychology discusses how we form impressions or ideas about the self it comments little or nothing on how, why, where, when or what the self is. As with behaviorism, the cognitive model is reductionistic, mostly mechanical and radically separates the individual from the inter-subjective reality of active life for a cultural species.

Qualities of active agency, will, consciousness and so on are merely contingently present if they are present at all.

(Lethbridge, 1992, p.25)

We have no direct access to the world only access to our neurological representations. In this view, meaning is not something that can be approached directly but only apprehended in subjective experience, something in the back of our individual brains. This unparsimonious explanation of human consciousness not only reproduces the same minefield of contradictions as earlier forms of dualism, it does not explain the lived experience of humans as existing as agents in the world. There is no explanation of how we experience choice in relation to physical, biological and cultural constraints. The utility of this version of self, supported by the metaphors of computational industrial machinery actually produces an impoverished "image" of both individuals and societies that is consistent with the aims and practices of late capitalist industrial society.
Self-efficacy and locus of control

There were a few mainstream psychological attempts to explain human agency but at most they labeled constructs and only succeeded in describing limited aspects. These attempts side-stepped theoretical problems because the subject of agency is problematic for both behaviorism and cognitive science. They are standpoints that are ostensibly outside the general thrust of these mainstream systems but were accepted as important contributions because while they didn’t affirm any theoretical system they neither denied nor constructed a new paradigm. Bandura’s concept of self-efficacy occurred at a transitional phase between behaviorism and cognitivism. Bandura (1977) defines the concept of ‘self-efficacy” as an appraisal of whether one perceives an ability to successfully cope with a particular situation or not. Self-efficacy appraisals are considered to have emotional and cognitive aspects and these reactions were posited as having an impact on the initiation of “coping behaviours”. Bandura (1986), Litt (1988) and Haney & Long (1995) all agree that estimations of “self-efficacy” are different to “control appraisal”. In their view, self-efficacy appraisals mediate the appraisal of perceptions of the ability to exercise control over a situation and any consequent coping behaviour. The literature includes the investigation of hypothesized links between perceptions of self-efficacy and abilities in performing physical performance tasks.(Feltz, 1988; McAuley, 1985) career tasks (Stumpf, Brief & Hartman, 1987) as well as health behaviours (Ewart, Taylor, Reeses & Debusk, 1984). In all studies it was found that those who were measured to have higher self-efficacy performed better. Experience
with particular situations was associated with greater self-efficacy, perceptions of control and success in the performance of laboratory tasks. Higher levels of perceived control and self-efficacy are inversely linked with somatic anxiety and positively related to perceptions of task satisfaction (Haney & Long, 1995). This research confirmed other investigations in this area demonstrating that perceptions of low self-efficacy and control tends to be associated with a “disengagement” coping strategy whereas perceptions of high self-efficacy and control tends to be associated with an “engagement” coping strategy. By disengagement it is meant that participants tended to cope with certain tasks by the use of various avoidance strategies and that engagement requires behaviours that are consistent with concentrating on the assigned task. However, such research regarding self-efficacy assumed rather than demonstrated construct validity and defined its usefulness by correlating it with other assumed constructs and measuring the effects on external correlates. There was no attempt to explain the genesis or by what means such appraisals take place nor how this phenomenon is connected to existing theoretical systems. Instead, discussions of this version of perceived agency were limited to the creation and labeling of the construct and an empirical appraisal of predictive viability in situations where agency was defined as the individualized ability to react to experimenter-defined situations in laboratories.

The kinds of beliefs that people hold about their own sense of personal control and the ability to act in their own interests have profound effects on their adaption to major life changes. (Langer, 1983; Lefcourt, 1983; ) One of the only
ways this has been investigated in general cognitive terms is under the rubric of "locus of control" (Rotter, 1966; 1975; Parks, 1985). This concept is defined in relative terms as an orientation regarding environmental and personal circumstances as either under personal control or dependent on external circumstances. Rotter & Mulry (1965) discussed how expectancies for control influence a person’s choice of performance situation. Using this construct they found that those who were measured to identify with an internal locus of control preferred skill testing situations whereas those with an external locus of control were more at home with chance tasks. This was supported by Strickland (1978) and again later by Sandler, Reese Spencer & Harpin (1983) who both agreed that people are more motivated by situations that are congruent with their personal beliefs about the degree of control they generally perceive. Those who perceive little agency in their life in general are comfortable with situations that also restrict such control. In addition, Rothbaum, Weisz & Snyder (1982) argue that a general orientation to give up power to others or the situation (external locus of control) tends to be reinforced over time and leads to generalized defensive and reactive behaviour strategies. This construct has often been used in an attempt to account for health behaviours. Patients’ perceptions of illness and disability have been related to coping styles (Johnson & Sarason, 1978; Kobasa, Maddi & Kahn, 1982; Lefcourt, 1983; Strickland, 1978; Sullivan & Reardon, 1985), the effects of social support on a sense of control when ill (Albrecht & Adelman, 1987; Lefcourt Martin & Saleh, 1984; Sandler & Lakey, 1982), the success of recovery through rehabilitative medical intervention (Abella
& Heslin, 1984; Schlenk & Hart, 1984) and the communicative strategies that increase or mitigate against perceived control over health behaviour (Brenders 1989).

As was the case with Bandura's concept of self-efficacy, the concept of locus of control was an attempt to address the reality of choice but without any coherent connection to any existing systems. For the most part the conceptualization of the subject of cognitive psychology meant that agency was a phenomenon viewed as at best, peripheral to the purview of investigation. Such a definition of the field of cognitive science avoided the problematic theoretical issue of building a coherent explanation of agency upon the foundation of a representationalist perceptual theory, which because of its construction of organisms as primarily passive, all but precludes the possibility.

**Humanistic psychology, self and agency**

Humanistic psychology evolved as a reaction to the bleak mechanicism of behaviorism and although it could be viewed as an opposite pole in most aspects, there was a similarity in that both schools emerged in an effort to reconfigure psychology on a less inadequate basis than their predecessors (Murphy and Kovach, 1972). Behaviorism was a reaction to the introspectionism of nineteenth century structuralism whereas humanistic psychology was a reaction to the extreme objectivism of behaviorism. In turn, the Humanist project attempted to re-establish a subjectivist point of view, albeit at a higher level. The Humanistic movement in psychology was a protest against banishment of the particularly human experience of meaning-creation, values and intentions from
psychological inquiry (Murphy & Kovach, 1972). Rather than the structuralist project of examining the separated contents of consciousness, the humanistic paradigm was interested in the experiences of people conceived holistically (Lethbridge, 1992). The problem with this reaction was that it was merely the "flip-side" of behaviorism and was itself an equally one-sided reconfiguration of the object of psychological investigation, now conceptualized as separated subjective experience. While criticizing behaviorism for its biological reductionism, the Humanist movement posited that humans are "hard-wired" towards the exercise of certain constructs such as "self-actualization". Commentators have seen such humanist constructs as essentialist (and Platonic) characteristics and at a fundamental level cannot be conceived as anything but another version of a psychology that at base rests upon biological reductionism (Lethbridge, 1992). This being so, we can clearly see that this project was equally unable to derive a coherent explanation of agency (other than being driven by an unexplained innate drive towards self-actualization) or of inter-subjectivity.

Problems in humanistic conceptualizations were noted by followers and others relatively quickly. Schisms ensued and in general this movement was accused of being unscientific. In the 1980's it became complicit in a cross-pollination with New Age philosophizing regarding the supernatural. In its later stages it fulfilled much of its detractors' prophecies as it deteriorated into a philosophical rationalization of a mix of upper-middle class bourgeois values, integrated with quasi-religious navel-gazing as an apologia for competitive
material acquisitiveness and instrumental social relations. Self and self-actualization were conceived of as harmonious to the aims of industrial culture and thus reinforced the tenets of individualist subjectivism. In fact these later "new-age variants" not only accept individualized and narcissistic identities and social relations as a natural fact, they provide a rationale for why they should be actively sought, as goals in and of themselves.

All three of the aforementioned positions (behaviorism, cognitivism and humanistic psychology) are one-sided in their approach to psychological investigation (Lethbridge, 1992; Parker & Spears, 1996). None of these systems can sufficiently address the individual in terms that preserve the natural contexts of consciousness, inter-subjectivity, cultural and biological constraints. All have used some form of reductionism in their systems, all assume and reinforce dualistic configurations that stem from Cartesian dichotomous philosophy and the representationalist explanation of perception (Parker & Spears, 1996). Therefore, all have reinforced an understanding of the abstract individual. Both behaviorism and cognitive science have also conceived of the individual as reducible to separated, operationally defined variables which has led to the mainstream North American impoverishment of social-psychological investigation. Instead of empowering the "individual" according to the rationale of the rhetoric, the individual living person has suffered a conversion into a data-point: an abstract, disembodied and meaningless existence that is perfectly compatible to the scientifically rationalized bureaucratic project of intervention and manipulation (Danziger, 1990). The reductionist and dualistic assumptions
carried over from the parent discipline and the application of methods tied to these Cartesian models has meant that there is no adequate understanding of the self, personal agency or inter-subjective and cultural relations.

If the mind is to be understood as a domain of skills and techniques that renders the world meaningful to the individual then our conception of the mind as a Cartesian entity sealed into its own individual and self-contained subjectivity must be revised (Harre and Gillett, 1944 p. 22).

An alternative conception in the Western tradition

There are several ways to reconceptualize the relation between the individual and the physical and social/cultural environment but I will touch briefly on one possible western escape from dualism that can be constructed by a combination of a scientifically amenable theory of perception and a dialectical social theory. A more logically tenable perceptual foundation for explaining our concrete experience in the physical and socio-cultural world is offered by James J. Gibson. Gibson (1986) offers a non-dualist realist perspective that explains how meanings are appropriated from the relationship of the organism and environment and assumes rather than denies the agency of the organism. This ground-breaking work is a great step away from Cartesian representationalist perceptual theory and has opened up a possibility for superseding dichotomous Aristotelian laws of identity, non-contradiction and excluded middle by providing the foundation for an extension into social relations if melded with a dialectical
social ontology. The mixture possesses real possibilities for overcoming the problems of dualism, individualism, mechanicism and reductionism.

In *The Ecological Approach to Visual Perception* (Gibson, 1986) the focus is primarily, but not exclusively on vision. He firstly attempts to explain that in order to talk about perception one should approach the subject using the appropriate level of analysis applicable to the lived experience of particular organisms. From the point of view of scientific logic based upon the methodology of reductionism, this would seem truly radical. The world to a particular organism is related to that organism and rather than talk about how the senses can be analyzed into separate components and thereby respond by neurologically encoding abstract sensations he prefers to talk about perceptual organs as his unit of analysis. These organs "pick-up" information that exists in the light (and other mediums) that are transmitted from objects in the environment to the matrix of perceptual organs. Gibson realizes that although one can analyze reactions to stimuli at the level of separated physical energies, it is not helpful for understanding how each perceptual organ actually works as a unit to use the information (Ben-Zeev, 1981). Rather, it is more helpful to conceive each perceptual organ (the eye, hearing etc.) as actively working together to gather the information through both exploratory and performatory activity.

Information is about complex structures in the world and specifies an environment to an animal. For traditional, including cognitivist theorists, the sensations are impoverished and need active processing by the mind to arrive,
indirectly, at a derivative image of the world. In contrast, Gibson approaches the problem at a more appropriate **psychological** level stating that we appropriate information about our environment directly, or to put it another way, "stimulation specifies the environment and no elaboration is necessary" (Michaels & Carello, 1982). An evolutionary perspective is utilized accepting that although the world existed before the evolution of organisms, the perceptual organs evolved along with both the organism and the world. Perceptual organs developed to utilize information that exists in the environment (or the aspects of the world that is appropriated and relevant to the particular species of animal). As animals are active and are chiefly interested in events, perceptual organs co-evolved to track events in both space and time and also to utilize information about movement of the organisms and movement of structures.

Whereas Gibson’s ecological theory of perception overcomes the radical separation of the individual from their environment and the duality of sensation and perception, the separation of the individual perceiver from the social/cultural sphere can be accomplished if we meld Gibsonian perceptual theory with two levels of dialectical social theory. The combination of a non-dualist theory of perception and non-dualist social theory have far reaching consequences in helping explain personal agency in coherent scientific terms.

The human species is unlike others because although other organisms may occasionally avail themselves of the use of tools, such usage is rarely if ever generalized to the point that tool use becomes a **dominant** activity. For humans, our environment although based on the pre-existing “natural” world, is now
continually changing at the hands of tool-using humans in a vast number of ways. Thus, our use of these tools has long been a dominant form of existence. Natural substances are converted to artificial materials for a vast variety of uses, many of which have enriched and simplified human existence. However, human technological advancement has also created some problematic side-effects that make human existence more difficult and insecure. It is not that there are two separated environments of the "natural" existing unchanged and the artificial, changed by the human dominant form of tool use. Again, Gibson avoids the normal traditional separation of untouched natural world from the artificial constructed and amended environment of humans. We are nature, in that it is "natural" for humans to change the environment that we inhabit, and create a hybrid non-separable meaning system that is the relation between individual humans and the socially mediated, physical-cultural environment. It is a natural phenomenon of humans to form societies, create languages and design institutions and therefore this cultural environment is also "natural."

This social extension of Gibson can be accomplished by utilizing aspects of Activity theory (especially the work of Leont’ev and Vygotsky) and a further extension to explain power and constraints on personal agency as discussed by German Critical Psychology and in particular, Klaus Holzkamp. Both Activity Theory and German Critical Psychology are constructed using non-dualist dialectical logic and share a further common foundation in Marxist social theory. They both follow naturally from Gibson’s rudimentary exploration of socially contextualized individual perceptions.
According to Gibson (a view that is shared by Marxist social theorists) we are born as humans into a world that has undergone several thousand years of transformation by an evolving system of cultural traditions and socially embedded symbolic systems that are accompanied by all the artifacts of this development. Human culture, including systems of symbolic interaction, values, ethics, morality and productive relations have created changing meanings in relation to shifts in the choice of particular social, economic and ideological tools. This development both constrains and opens-up the development of our changing cultural intentions and their expression in activity. Our action, which is mediated socially, adds a new dimension and both increasing levels of complexity as well as constraints to the possibility of the appropriation of "affordances".

Human infants do not just passively accept information about the environment nor do they become little Robinson Crusoes and actively explore as individuals. This aspect is extremely important in Mead's (Concrete Social Behaviorism) and Vygotsky's explanations of how individual consciousness evolves as a consequence of action that is mediated by inter-subjectivity (Mead, 1977, Vygotsky, 1978). Children are introduced to the present crystallization of cultural meanings about the human-environment relationship carried in language and social relations. Although there exists a certain latitude in generating relations to the physical/cultural environment, values act as constraints on what will be perceived as sanctioned, legitimized or what may become a dominant relation. Not only is our environment transformed in the way of artifacts (Heft,
1989) but our horizons of the possible or legitimated modes of activity are also transformed and constrained because we are introduced to them through socially mediated, culturally embedded activity (Mead, 1977; Vygotsky, 1978).

Marxist psychological formulations share a common ontological position of explaining the development of social relations, belief, and values with reference to and springing from activity. In a sense, Marxist social ontology needs the basis of Gibsonian direct perception as much as Gibson’s non-dualist perception cries out for coherent extension, expansion and perhaps completion, at the levels of both social meaning creation and institutionalized societal relationships. They share enough in common to help complete one another.

Lev Vygotsky has been associated with a school of Marxist psychology developed in the Soviet Union which has now blossomed throughout much of Northern Europe and particularly throughout Scandinavia. Activity theory could be thought of as a descendent from the writings of Vygotsky and Leont’ev (1979; 1981)forming a loose affiliation of approaches to social psychological functioning. (Tolman, Coughlan & Robinson (1996). Vygotsky’s outline of the concept of the culturally embedded relation of active learning and socialization, the zone of proximal development, contributes greatly to the continuation of a non-dualist perspective (Vygotsky, 1960, 1978, 1986). Much like Wittgenstein, Vygotsky believed that the meaning of linguistic forms can be objectively approached when we look at their use. While Wittgenstein leaves his accounts open to being used in some very relativist narratives (as he implies elsewhere regarding a separation of the world of symbols and material) Vygotsky grounds his system
most definitely in the realist perspective. Active appropriation of material needs leads, in his view, to the development of linguistic abilities and this changes human capabilities to relate to each other and to relate to their environment through the explanatory medium of symbolic interaction as a form of tool. Much like the Gibsonian insight of tool use in overturning the sharp distinction between the animal and its environment, linguistic systems are seen as tools that develop out of concrete social action. Such a view can also bolster the Gibsonian contradiction of the notion that consciousness (and by extension, perception) is a wholly private and individual experience. Information concerning affordances (the relations between organisms and their environment) are available to all who share the same biology and in the case of humans, the same or similar cultural socialization. The meaning exists in the relation of (in this case) the human organism and its cultural-natural niche. Language develops from practical activity in the world and the appropriation of what the world affords. Thus, language developed from human social action is used to help develop individual consciousness of self, affordances and personal agency. Language is a crystallized carrier of legitimate social activities, intentions and therefore values. The younger members of society enter into this culturally mediated world of action by mastering the linguistic codes in a Zone of Proximal Development (Vygotsky, 1978). The linguistic code organizes action in what is perceived by the culture as legitimate forms and the use in social interaction is the first phase of organizing the younger member's appropriation of available cultural affordances. There is no private code in which representations or images of the reality are
shaped in the mind. The so-called "inner language of representation" does not exist. The symbolic appropriation of the meaning of individuals' relation to the physical/cultural environment is firstly a social phenomenon, rooted in activity. Through social institutions, a zone of proximal development is created in the interaction of neophytes with more skilled members of a culture. Through this zone and the appropriation of cultural affordances, the social is internalized and thus becomes the individual's mode of symbolic appropriation that is experienced as private or subjective consciousness.

There is no dualism between inner representation and a social linguistic system and no dualism of social linguistic system and the activity of appropriating affordances. Here, what is considered to be the private language of "thought" is not strictly speaking, inner or private, in the sense it is closed off or an individualized subjective experience. What is now (for want of a better word) "inner" owes its existence to and is non-different to what is "outer" in the social space and what is in the social space is a linguistic crystallization of affordances appropriated through activity.

Vygotsky's zone of proximal development and the appropriation of social and cultural norms and values from the linguistic mediation of activity explains how younger members of cultural groups take ownership of cultural knowledge and develop an individual experience of conscious awareness. This argument is saved from becoming merely a reduction of personal subjectivity to socialization by the understanding that individual and social levels are again in constant dialectical relation. The point is that this dialectical relationship is also
unsymmetrical} in that while crystallized cultural meaning leads and may well constrain individual subjectivity in the process of socialization, it does not determine. Meaning creation is a constant process of dialectical negotiation between individuals and between themselves and their culture.

While there is an implied notion of cultural values as constraining the appropriation of affordances, in the Vygotskian perspective, a fuller account is given by the German critical psychologist Klaus Holtzkamp (Tolman, 1994). Ideological values and societal relations, as mentioned before are crystallized in language because language is a social tool that aids in the activity of the appropriation of affordances. In class societies that are comprised of hierarchically arranged strata, whereby certain members have a wider horizon of opportunity for action than others, there is somehow a differential in the perception and utilization of affordances. In Europe, where there has been a considerable history of continually reproducing class sub-cultures, social meanings, vertically layered legitimate forms of action and even the use of linguistic codes can be seen to be quite different from one class or geographical region to another. Is it that those who find themselves at the top of the hierarchical class structure are somehow superior because they are able to maintain their superior ability to appropriate a greater variety of affordances or is there something which is effectively blocking the same appropriation to those who are less powerful? In bourgeois industrial culture, those who own the means of production seem to have a greater ability to avail themselves to choices of action and thus to reproduce their power and enriched living
conditions ever more. As Marx (1932/1977) commented, those who own the 
means of production also control the means for the production of ideas that suit 
their own ends. In other words “the ruling ideas are always the ideas of the 
ruling class”.

Over time certain ideas are encoded in language and in the constellation 
of legitimate social institutions that govern the generation of meanings in a 
culture. Those who wish to be admitted to be seen as legitimate in the eyes of 
institutions developed by the elite of a certain culture, must accept the social 
meanings, linguistic codes and legitimacy of these institutions. This includes, (in 
the case of western medieval and industrial cultures) a certain tolerance for 
unequal distribution. By the reproduction of these class relations through the 
socialization process of one generation by the previous one, certain members of 
society will always be subject to a limited field of action befitting their place in the 
lower regions of the hierarchy of social relations. Thus, they will be precluded 
from the ability to legitimately choose from a variety of courses of action that are 
open for others.

They will experience or endure, in Holzkamp's words, “restricted action 
potence.” In order to be part of the activities of society and by sharing in a 
linguistic code that is amended to both reflect and constrain their particular place 
in the economic activity of a society, they must submit to some restriction on their 
choices of action. In Gibsonian terms they will fail to perceive or fail to feel 
competent to act on certain affordances that others take for granted. By 
agreeing to certain limitations on their freedom to avail themselves of certain
action possibilities they agree not to see themselves as legitimate appropriators of particular types of affordances, and this sacrifice gives them a limited entrance to the broad system of legitimated cultural activities. The price of entering into society through linguistically mediated social institutions is a culturally socialized failure to perceive or act on certain affordances or action possibilities. In other words, affordance horizons can be either enlarged or curtailed by means of the internalization of social meaning systems learned through linguistically mediated interactions and activity. These are related to socially and ideologically mediated class based systems of activities.

Holzkamp has extended the discussion of linguistic and ideological tools as the means that evolving societies utilize to construct and enforce unequal relations. Agency can be constrained by physical, biological and by ideological means but these means are always in relation to, and are set in motion by, the dominant cultural and economic systems operating within a society. Agency is necessary to the appropriation of the cultural-natural world by an individual but this agency (also seen as affordances and action possibilities) can be restricted depending on ones relation to the predominant forms of production and reproduction. Ones' subjective experience or consciousness can become fully harmonized with an unequal culture so that the situation ceases being experienced as in opposition to ones interests, needs and desires. In such a situation the acceptance of this “false consciousness” (Marx, 1932/1977) precludes many forms of resistance to win back the extinguished action possibilities.
In reality, even those who have become acculturated to relinquish many of their own interests and to identify with institutions that are oppressive, have at least a minimal experience of discomfort and as a consequence often seek to rectify the situation with minimal forms of resistance. However, in sophisticated industrial society even the forms of resistance have slowly been co-opted. This is where (as mentioned previously) postmodern discursive philosophy has unconsciously conjoined and reinforced consumerist interests to remove people from the world of co-operative action to extend their possibilities, to a separated world of individualized, subjective, discursive narrative. Play, superficiality, indeterminacy, individuality, difference, relativism are all to be celebrated and preferably in a form that sustains the consumerist market economy. Thus, the paths of resistance left legitimately open to most, only further compounds actual alienation. This disrupts the perception of and actions in relation to certain physical/cultural affordances and constrains many from achieving potential action potence and the potentiality of personal agency. Agency is the perception of the actual relations between the individual and their physical/cultural niche and is therefore rooted in intersubjectivity and promoted by unimpeded co-operative relations.

The model of the individual as constructed by the technology of mainstream psychological formulations, by constant use over a considerable period can function ideologically to inform, through socialization, all succeeding generations of people that such a reality it is a natural “fact” rather than a culturally constructed norm. The "individual", so reconstructed as abstracted from
social and cultural contexts, is also abstracted from the real potential of individual agency and latent power that is rooted in the concreteness of intersubjectivity and communicative interaction. (Harre & Gillett, 1994). The real potential power as individuals can in actuality be accomplished by understanding that an individual exists primarily in relation to a community of shared values, social commitments and interdependent goals. However, by the deployment of the rhetoric of particular versions of science in which social-psychology is deeply implicated, we now tend to surrender real potentiality for enfranchisement in exchange for passivity. The construction of a disoriented, anomic and neutralized human identity composed primarily of qualities that can be made to respond to bureaucratic intervention and an existence of marginalized compliance is a model that psychology and social-psychology have largely reinforced and legitimated through the scientific enterprise.

The personal resistance that can be deployed in this impoverished atmosphere tends to be inversions of predominant modes of conduct (seen as anti-social schisms or sub-cultures) self-destructive reactions (as in various means of escape through substance abuse). Other legitimated forms of resistance include harmlessly escapist behaviour (as in an addiction to sporting events or other trivia), a purely rhetorical discursive resistance (as in the re-narration of subjugation or abusive life events in terms more complementary to self-esteem) and/or in forms harmonious to the predominant economic interests through the purchasing and consumption of products or services. There exists a tendency to believe that we can emancipate ourselves if we make a few
adjustments and make the commitment to redouble our efforts to harmonize ourselves with the forces that are in actuality, often opposed to our interests in expressing unrestricted agency. The kinds of problems that many people suffer as a result of restrictions on their ability to be agents are construed by western institutions (supported by mainstream renditions of psychiatry and psychology) as resulting from deviant individual maladjustment and crises of personal belief rather than as evidence for the inadequacy of the current social paradigm. Mental suffering is conveniently defined as a possibly treatable individual, biological or behavioural malfunction rather than as an often understandable, if not reasonable, reaction to perceptions that the available menu of legitimate culturally-mediated affordances are at odds with the individual's reasonable needs and desires (Parker & Spears, 1996).

This extension of the Gibsonian direct perceptual perspective by elements of Vygotsky's and Holtzkamp's Marxist-based explanations of social psychological function is, as yet, quite cursory. Further and more careful explorations of the utility of conjoining these aspects to fully socialize Gibson's concepts needs to be accomplished in later ruminations. However, the utility of Gibson's relational system in overcoming the snares of logically incoherent and unparsimonious explanations that stem from Cartesian and traditional cognitivist accounts of perception cannot be overstated. The further elaboration of non-dualist systems will perhaps contribute to improved theoretical explanatory schemes but more importantly, lead to an extension of agency and emancipatory action (Hayes, 1996). Agency is not a private internal experience but a social
phenomenon. As such it can be supported or hidden and distorted by cultural systems and harmonious conceptions of psychological functioning.

This chapter has outlined how mainstream representationalist theories of perception have drawn on the meta-categorizational system of dualism, particularly the scientifically legitimated version stemming from the writing of Descartes. The acceptance of mainstream perceptual theories has problematized the understanding of agency as well as seriously undermining the explanatory potential of social psychological formulations in general. The following chapter will trace the development of social psychology following from the assumptions of the parent discipline that is based upon the acceptance of a dualistic theory of perception. The discussion of this development will be contextualized by the predominant socio-economic goals of western industrial culture in which social psychology has been heavily implicated.
Chapter 4

Development of problems in social psychology

Man is a credulous animal and must believe in something. In the absence of good grounds for belief, he will be satisfied with bad ones.

(Bertrand Russell)

Previous chapters have outlined how dualism has been a foundational ordering principle in western society from at least the classical Greek period forward to the present. While the rationale has changed during the past two thousand years from mystical beliefs of one sort or another to science, at a meta-categorizational level it is merely a predictable evolution. Dualism as a philosophical system has continued because of its usefulness for cultures whose predominant societal project is based upon the domination of nature or other peoples. The scientific basis of the dichotomization of the world stems from Cartesian divisions and this has been assumed and reinforced by representationist models of perception.

Social-psychology has internalized the Cartesian framework and has additionally assumed the hidden anthropology of the isolated individual further reinforcing the dichotomy between individual behaviour and all forms of social interaction (Tolman, 1994: Jackson, 1988). In addition to primarily treating social aspects as stimuli and then examining individual behaviour as the result of social stimuli, social psychological knowledge has generally been used to predict and
control individual behaviour (Danziger, 1990; Lethbridge, 1992). Catering to state and corporate institutions' consumption of such knowledge products has provided the discipline with its primary raison d'être (Danziger, 1990). Personal agency becomes a problematic concept not only because of the assumption of theoretical assumptions antithetical to a coherent explanation but because the extra-scientific societal context of knowledge production and consumption make explication of agency an under-funded, unprofitable and (given the morays of the main consumers of such knowledge) an undesirable subject of investigation. This present chapter will outline a contextualized history of the development of mainstream North American social-psychology and discuss the philosophical, scientific and socio-economic conditions that have shaped the discipline.

Social psychology as a sub-discipline of psychology, inherited the philosophical incongruences of the parent with respect to dualism. This has caused many commentators and critical social scientists to question the ongoing project of research and to posit that social psychology is flawed at a basic level because of a general lack of relevance in relation to the actual needs and experiences of normal people (Jackson, 1988; Parker & Spears, 1996). This crisis of relevance stems in great measure from the unsolved problems of dualistic systems of categories in mainstream psychological science (Tolman, 1994; Lethbridge, 1992). These categorizational systems have seriously hampered coherent explanations of psychological phenomena as experienced in everyday life and are particularly evident in the representationalist theory of
perception that in turn has solidified the hidden anthropology of the isolated individual. Investigatory methods based on the ideological foundation of individualism have seriously undermined coherent explanations of cultural phenomena such as human collective agency and communicative interaction (Harre & Gillet, 1994: Shotter, 1993: Strong, 1984)

Modern mainstream social psychology, particularly in North America, has evolved an identity that is deeply intertwined with the hegemony of the objective natural-scientist tradition that takes physics as its model. The lingering philosophical issues that have made the research of psychological phenomena problematic (such as the relation between sensation and perception, individual experience and culture, process and structure and a myriad of other thorny issues) have been partially obscured by the appropriation of the mainstream North American model of scientific psychological investigation that sidesteps these fundamental uncertainties. Questions that have been the central concern of psychological thought from the dawn of western philosophical investigation remained unsolved when they were hidden from view with psychology's break with departments of philosophy in the late 19th century. Considered a branch of philosophy for the early years of its modern academic life, precisely because the investigation of consciousness and the psyche intrinsically revolved around such difficult philosophical questions, psychology was abandoned by departments of philosophy in many European schools. At about the same time psychologists wanted to embrace a "truly" scientific stance to investigation: one that assumed
and built upon the tenets of natural scientific methodological orthodoxy. This change was hastened by the fact that the fledgling discipline could not yet exist independently but had to look for another suitable mentor-discipline. The changes faced by the emerging discipline were different depending on the particular cultural and economic arrangements in different countries but eventually North American cultural hegemony prevailed, leading to a redefinition of psychological subject matter that used the natural science methodological toolbox.

Similar to other culturally constructed phenomena, social psychological investigative practices use categorizational principles that function in and rationalize the over-arching social projects of industrial society. The choice of investigative subject matter and the methods utilized in their investigation are those that can provide knowledge understandable and/or useful within the paradigm of western industrial and consumer culture (Jackson, 1988; Danziger, 1990). Even at an early stage in the development of the discipline it can be shown that extra-scientific, economic and cultural concerns interacted with logical and scientific matters to produce the particular form and direction that psychology and social psychology would take in the years ahead (Danziger, 1990).

In England, the redrafting of the political, economic and social landscape occurred earlier and with more ease than anywhere else in Europe. The Tudors stripped ecclesiastical institutions of many of their traditional power as early as
the middle of the 16th century. The middle classes gradually became more expert in exerting their economic and political muscle and by the 19th century an industrialized society was a fait accompli. The scientific and philosophical underpinnings of the new industrial order did not owe its existence to the pitiful state of the University system in Britain. Both Oxford and Cambridge, the only two until the founding of the University of London in 1838, were peripheral to the rising dominant scientific paradigm owing to their ecclesiastical conservatism (Littman 1979). Loose associations of "amateurs" outside the elitist university system were undertaking the important scientific work. Most scientific work therefore was completely within the paradigm of an emerging "radical" industrial ideology. While higher education in England became largely irrelevant to hegemony of industrial culture, the same was also true in France. In both nations (and especially in France) research and teaching were separated entities thus there was no development of an organized self-perpetuating system of research (Littman 1979).

The German situation, in contrast, was more organized. Universities combined teaching and research and therefore science developed along institutional lines within the University system (Barnes and Feldman 1980). The niche that German higher education had garnered and the idealist tradition that evolved therein was due to an entirely different political atmosphere that slowed the development of industrialization. Whereas in England those challenging the old order were also working in the vanguard of scientific practice, science in
Germany was conducted within an existing system that placed a high value on a plurality of philosophical considerations. Therefore, academic practitioners tended to adopt a less negative reaction to a more traditional established regime. The philosophical idealism that flourished in the German socio-political milieu that encouraged romantic and nationalist reactions to the industrial project maintained a more skeptical position towards an all-encompassing embrace of a radical, empirical individualism.

Unlike England and France, who had long since solidified their national identity, Germany in the first half of the 19th century was a loose affiliation of states and principalities that felt overshadowed by both Austria and France. In England, the void left by the failing medieval systems were filled by an understanding of a "freedom from authority" while in Germany freedom could be achieved by a collective effort to establish a German speaking nation-state. The attempt to create a freedom through a nationalistic collective enterprise solidified the adoption of a less individualistic version of scientific inquiry (Blumenthal, 1975). For instance, Johann Gottfried Herder made the distinction between the primary community of a shared culture formed through language and the secondary bond founded upon power or contract (Danziger 1983). The idea that a shared cultural identity is primary and that the individual is a product of the "cultural spirit" was highly influential in the birth of a unified Germany and was reflected both in artistic and intellectual development.

For psychology in Germany, unlike the British empiricist tradition, it was
not enough merely to collect data from experimental situations: a more encompassing form of explanation was necessary. The German philosophical tradition that included Leibniz, Kant, Fichte, Hegel, Schelling and Herbart expounded persuasive arguments against an abstract, one-sided psychological materialism dominant in British Empiricism (Robinson 1982). From the German philosophical standpoint the empiricist and "associationist" psychological model of Lock seemed incompatible with findings concerning the totality of conscious experience. The formulation of Leibniz that postulated the necessity of a receptive and creative mind in the production of ideas seemed far more plausible. The influence of the idealist tradition was evident in the German model as exemplified by Wundt's psychological publications, from the beginning (Robinson 1982).

Although important, historians have until recently overlooked the fact that Wundt explicitly stated that experimentation could never amount to the sole legitimate method in understanding human psychological functioning (Danziger 1980). According to him, experimental psychology should only be considered a minor, secondary enterprise because the most important aspects of the human psyche, such as higher mental processes cannot be adequately investigated without the construction of a predominantly social-anthropological method (Rappard, 1979, Danziger, 1980). His conception of "Volkerpsychologie" which would investigate these higher mental and peculiarly cultural processes (such as memory, cognition, etc.) owes a great debt to Herbart whose model of the
relationship between intra-personal and interpersonal processes is similar to some 20\textsuperscript{th} century versions of systems theory. His indebtedness to Herbart in this connection is through the writings of Lazarus and Steinthal who modified the Herbartian position into one that was amenable to psychological explanation (Danziger, 1983). Wundt did not see the use of historical and comparative methodology in Volkerpsychologie as being any less objective or scientific than experimental methods. So opposite were Wundt's formulations to the British tradition, that he posited \textit{volition to be a primary psychological category} and reflex activity to be a special adaptive evolutionary development from volitional action.

Certainly the importance of volition is deeply involved with ethical issues, one of the reasons Wundt envisaged that psychology should remain a sub-discipline of philosophy. Unfortunately, the success of psychology's growth resulted in its eventual abandonment by philosophy in German universities. As more psychologists were given chairs within philosophy, a revolt was ignited resulting in the birth of psychology as a separate discipline. Because of the relative newness of psychology as an academic field and without an amiable tie to the larger and respected departments of philosophy, the orphaned infant of psychology needed to look to, and formed an unsuitable allegiance with the natural sciences (Danziger, 1990). This would have far-reaching future affects on the conceptualization of the subject matter and methods considered appropriate in the investigation of psychological phenomena.
The Leipzig laboratory attracted many students from the United States. However Americans would find it difficult to understand the tradition of idealism in Germany because their culture was based upon very different philosophical foundations. The American constitution was, and continues to be heavily influenced by laisser-faire, liberal economic philosophy and particularly the empirical individualist philosophy of John Locke. Many of those who returned home to the U.S. from Leipzig were not able to transcend their own ideological and cultural blinders. Experiences of the German model were filtered through empiricistic assumptions, leading to the development of an individualist version of psychology that is prevalent in North America today. Even leaving aside the immense barriers of culture and language, Wundt's most influential students were responsible for the virtual disappearance of his system by means of sheer willful misrepresentation. This tendency for recasting in accord with one's own cultural values was exemplified by Titchnerian attempts to manipulate and recast Wundt's psychological formulations and harmonize them with the additive, elementalist inductive assumptions which form the foundation of North American scientific orthodoxy grounded in the philosophy of Mill. Boring, Titchener's student, compounded the erroneous view by declaring Wundt's system to be a version of mind/body dualism combined with a very narrow anti-voluntaristic system of mental chemistry (Blumenthal 1980). Boring's view fully harmonizes and recasts Wundt's conceptual programme so that it appears that the individualist paradigm of British and North American science can be portrayed as
a seamless and uncontested pedigree emanating forward from the first experimental psychological laboratory. In fact, nothing could be further from the truth.

The particular philosophical and ideological environment of continental European rationalism bred a psychological project with a particular object of investigation, allied investigative techniques and a particular harmonious mode of experimental interaction. The transplanting of psychology into the totally different ideological atmosphere of North America had far-reaching effects on the development of all these aspects of psychological investigation. Whereas, the German intellectual climate evolved through a three-stage development (reminiscent of Comte's evolutionary schematic) that started with theological allegiances, followed by a period of intense philosophical pluralism out of which science evolved, North American intellectual endeavours evolved from a two-stage development that skirted any serious experimentation with pluralities in philosophy.

In the United States everything was geared to the appropriation and domination of the natural and cultural world. North American cultural and economic systems refined the concept of humanity as individually autonomous, competitive, rational, self-directed individuals (Moscovici, 1985). Although there was some resemblance to classical intellectual pursuits, it was the world of industry that increasingly shaped the development of the universities and the direction of scientific inquiry. Psychology, transplanted from Europe, had to
adapt to an atmosphere that demanded economic rationalism. Forced to prove it- self in the marketplace of knowledge products if it was to survive and garner status for its practitioners, any alliance with philosophy and the investigation of subjective experience was likely to doom psychological scientific practice to a rapid demise. (Danziger, 1990). Not only were philosophical ruminations generally viewed as unscientific, but unnecessary, unproductive and perhaps even subversive.

The different approaches to the new industrial order and the history of each nation-state led to different understandings of the nature of the relation between individual consciousness and society, the object of investigation for the emerging discipline of psychology and the legitimacy of scientific methods that should be utilized. As discussed in Chapter 2, the different conceptions of meaningful, scientific theoretical systems led to a division of psychological approaches. In North America and in Britain psychological practices followed from the empiricist tradition of Bacon, Hobbes, Locke and Mill gave predominance to the objective world and an individual that was to be conceptualized as a receptacle of separated variables. This model, later paved the way for the legitimation of the measurement of abstracted aspects of individuals, in mass aggregate studies which was a project that was seminal in assuring the continuance of the discipline. In the competitive market-oriented culture of North America, the knowledge products resulting from the mass measurement of society would make psychology a useful tool in the evolution of
industrialism and garner funding and status for its practitioners (Danziger, 1990).

In continental Europe, but especially in Germany, a rationalist tradition continued that stemmed from Descartes, giving primacy to the ordering principle of rational ideas. As was noted previously, it is paradoxical that the empiricist tradition that was a reaction to the Cartesian position regarding the primacy of the internal ordering principles only exacerbated the division between subjective and objective aspects by emphasizing the opposing pole. Empiricism and rationalism together actually consolidated the Cartesian notion that the individual is separated from the world and should be considered the seminal unit of psychological analysis. In addition, it led to the development of a perceptual theory of representationalism, which radically divided sensation from perception. This duality has been a major stumbling block to an understanding of everyday human experiences, including coherent explanations of individual consciousness, human agency, communicative interaction and the relation between individuals and cultural institutions.

The vast majority of mainstream psychologists today do not recognize themselves to be "Cartesian" because they rightly proclaim that they do not support the separation of mind and body. However, substance dualism can be shown to be a relatively unimportant facet of Descartes system and that the lasting relevance for psychological practices is greatly misunderstood. As previously discussed in chapter 2, Descartes gave two differing renditions of perception: one in article XXXV of The Passions and another in The Optics.
(Tolman & Robinson, 1995). The problematic dualism for psychology, and which deepens the substance dualism given by Descartes in The Passions, is the radical separation between the experiencing subject and the objective world. According to the more sophisticated discussion of these matters, we are tragically separated by the play of nervous energy and we can experience little of the true qualities of the “world outside”. It is these assumptions of dualism as described in The Optics that has led modern psychologists to generally subscribe to the three-moment scheme of perception (Input - central processing module - output). In addition, the components are generally connected by a process of one-way mechanical causation. This is the first example of and reference point for modern representationalist theories of perception.

At a meta-theoretical level another important duality stemming from the acceptance of Cartesianism was imported into psychology and from there affected the development of social-psychological investigation. This was the further separation of scientific and philosophical realms under positivism. According to this doctrine, science alone supplies the only rational explanation of the world and is defined in opposition to “anti-rationalism” common to many strands of philosophy (Boeselager, 1975). This movement started with Comte in the 1830’s, was influential into the mid 1940’s evolving through some different versions during this time. In general, this appeal to science was seen as a “positive” move out of the philosophical stalemate engaged in by “the negativists” involved in the
doldrums of metaphysical and philosophical debate. Such ruminations were seen to be ensnaring "real" progress towards the social good. In later developments of positivism, the combination of J.S. Mill's inductive empirical model and Spencer's sometimes totalitarian evolutionary positivism resulted in the acceptance that science should be limited to empiricism and neutral on any moral or metaphysical issues (Kolakowski, 1972).

After several reformulations, later particularly virulent versions emerging in logical positivism claimed that a divide should be drawn between language (considered a fitting object of scientific investigation) and objects and experiences. In an effort to overcome the duality caused by the barrier of the senses, this school had created another duality by erecting a formalist barrier of language. Although different members of the Vienna Circle proffered differing views, the position eventually adopted sought to unify scientific inquiry. This unification was thought to be accomplishable with the reduction of chemistry and biology to physics and the reduction of psychology to neurophysiology (Feigl, 1969). This reformulation had a lasting affect on psychology as it introduced yet another source of dualistic foundations providing a foundation for behaviorism, particularly in the way important subjects such as cognition and imagination were negated as fitting areas for investigation. In the scientific project of behaviourism, everything could (at least theoretically) be reduced to behaviour.

Additionally, positivism had a further and longer lasting affect on social-
psychological investigatory practice as it provided a template for scientific research that could exclude all "unscientific" moral and ideological considerations. It helped to create the myth of an "objective", value-neutral scientific experiment by hiding the extra-scientific, economic and cultural embeddedness of investigative practices. This belief helped promote the discipline to view itself as removed and above the ordinary messiness of everyday life, thus allowing scientific social psychology a privileged position from which to make objective observations. It is this conceit, among other problems, which incurred the wrath of critical psychologists and other commentators throughout the 20th century.

In North America, during the early twentieth century, "social" was prefixed to individual psychological processes and social psychology was born as a sub-discipline (Jackson, 1988). Social actions were approached as being just a continuation of the types of processes that explained individual actions, only there were some further complications that required qualitatively similar explanations with the help of abstract and reductionistic research methodology (Billig, Condor, Edwards, Gane, Middleton and Radley, 1988). North American experimental social psychology combined the individualistic paradigm of Locke and Mills with a harmonious base in certain continental European conceptions rooted in "crowd psychology". In the nineteenth century, Sighele and Le Bon theorized on the divide between the "rational" individual and the irrational emotional automaton that individuals apparently appeared to be transformed
into, when part of a crowd (Danziger 1992). It is interesting to note that Le Bon saw the crowd as partaking in activities that were contrary to "their most obvious interests", as individuals. This particular view can perhaps be at least partially explained by the relatively sheltered social position of philosophers and scholars at this historical juncture. Academics and philosophers were considered part and parcel of an elite, whose interests were opposed to the predominantly proletarian composition of crowds within industrial cities and their rising discontent with the economic status quo. As Europe became more urban and living circumstances deteriorated in industrial cities, the under-privileged became increasingly militant in support of their claims for just treatment. It is quite understandable that such commentators would see "the crowd" as "irrational" and needing diffusion and control by those whose interests are supported by the predominating system of social relations. It must have been confusing to these commentators that such irrationality witnessed in crowds was so opposite to the more usual observation of "rational" acquiescence to their "betters", when common people were approached alone.

Later, Moede derived many of his ideas for experimental work from these conceptions and attempted to measure this assumed contrast between individuals and individuals in groups, in artificial laboratory situations (Danziger, 1992). This conceptualization of social life harmonized nicely with the North American individualist paradigm. At Harvard, F.H. Allport continued this model in laboratory experimentation, measuring performance of individuals in completing
what were to become, the prototypical "meaningless" tasks. The future thrust of the sub-discipline could be encapsulated by his statement that "There is no psychology of groups which is not essentially and entirely a psychology of the individual." (Allport, 1924).

Experiments of this type, measuring abstracted "variables" in experimental situations came to be accepted as the way to conceptualize and investigate social relations. Social relations were generally viewed as merely the action of individuals as stimuli to each other. To exert the necessary controls and to reduce as much "error variance" as possible these studies were increasingly carried out in artificial situations, comparing only a minimum of operationally defined behaviours at any one time. Using methods common in the parent discipline, social-psychology adopted the method of operationalizing and abstracting variables that were amenable to quantification. According to the mainstream view, social psychologists regard their discipline as an attempt to understand and explain how the thought, feeling and behaviour of individuals are influenced by the actual, imagined or implied presence of others (Allport, 1985). The promotion of the "rational" individual as a receptacle of measurable "variables" became a template for a conception of social life. The dubiousness surrounding the confrontation of the "irrationality" of social processes is evident in the large body of investigation within the paradigm of social influence or conformity (Coughlan and Johnson 1991). Here it seems most obvious that social psychological investigative practices and theoretical assumptions are
conceptualized in terms of the effect of social stimuli as generally corrupting influences on individuals. In addition, the contextualization of the investigation of social interaction by the predominant socio-economic culture helped to define social relations merely in terms of instrumentality. Conceptions of social relations were being gradually impoverished by the extension of cultural metaphors that applied an "exchange value" logic to human interaction and this too was internalized by theoretical narratives of social-psychological explanatory paradigms.

The end of World War II and the defeat of the Fascist and Nazi project which relied heavily on the scientific "discovery" of general laws of behaviour in order to manipulate a collectivist conformity, created a backlash in North American social science. Given this context, it was for very good reasons that the post-fascist North American social scientific project mounted a critique on the irrationality of organized collective behaviour and reinforced the individualistic tenor already existing in North American culture. It is paradoxical to note that the individualist reaction to the evils of fascist conformity would be used for practical purposes of prediction and control of individuals living in a mass society. The group was conceptualized as opposed to the individual with the tacit assumption that it was the group that created a negative influence, corrupting the higher rational nature of the individual in a one-way process. (Coughlan and Johnson, 1991; Stephenson, Bavelas, Coughlan and Johnson, 1993).
Of all the attempted unitary explanations of human social
behaviour, suggestion and imitation are the most direct ancestors
of contemporary social psychology. The problem of social
influence... is pervasive throughout (social psychology); in fact it
has been proposed that social psychology is the study of
influence.

(Jackson, 1988, p.19)

Social aspects were generally seen as yet another form of stimulus,
devoid of context, history, culture and function. From this point forward, the
mainstream of North American social-psychological practice continued within this
paradigm, assuming the anthropology of the isolated individual and constructed
ways to measure elementalized behaviours as separated "variables" (Solano,
1989; Sampson, 1988; Senn 1989; Tolman, 1994). The norms of a certain kind
of experimental practice were now equated with the essential nature of the social
reality to be investigated (Danziger, 1992).

In a socio-economic climate that relied heavily on individual
competitiveness, labour mobility, efficiency and productivity, social-psychology
could find itself a valued identity by catering to the knowledge needs of
bureaucratic agencies by finding ways to engineer a conformity of individualism
(Danziger, 1990). A collateral result of this client-producer relationship was a
general atrophy in knowledge that might promote collective efforts of resistance
and emancipation. An industrial mass society needed mass information to
improve bureaucratic control and the "efficiency" of the economic system. If psychology could build a scientific model that included the prediction of human behaviour, its success would be assured. It was these needs, which provided a market for the disciplines of psychology and social psychology and psychological research was reorganized in order to harmonize psychological knowledge products to suit the needs of the cultural and economic marketplace.

Discussions concerning the meaningful explanation of the genesis and reality of consciousness, especially social consciousness was considered secondary, mostly irrelevant and in some quarters, probably subversive. Knowledge that assumed the identity of humans as individuals and could measure certain attributes of individuals, en masse, could produce technologies that measured predictability that augmented bureaucratic control. In the overall social project of the appropriation of natural and human resources, such technologies could demand wealth and status for its practitioners (Danziger, 1990).

Out of several existing models of psychological investigation it was the Galtonian statistical model that would fit the bill in terms of providing a way that individuals could be reified, compared, standardized and measured (Danziger, 1990). This led to the relative increase in data that was derived from aggregate studies of individuals' scores on abstract "variables" (rather than single-subject investigations), and the generation and application of sophisticated statistical comparisons. It is ironic that the model of psychology that adopted an understanding that legitimated the individual as the unit of investigation, ended
up with a measure of abstracted decontextualized mean scores and deviations on particular operationalized behavioural variables. The living individual subjects disappear in this reformulation. Most of the important facets of individuals are now "controlled" within the experimental design or parcelled out as "random error". Increasingly, research data were generated from questionnaires that internalized this model. Primarily, their use was at first designed for the benefit of military and educational bureaucracies and later governmental and corporate institutions increasingly used such methods. (Danziger 1990, Jones, 1985).

While mainstream North American psychology increasingly identified its interest with the success of the relationship with bureaucratic institutions those on the front-line in industry were making startling discoveries. Taking subjectivities into account in the mass production process helped to ameliorate workplace social problems that were interfering with the efficiency of the accumulation of industrial capital (Taylor & Brown, 1979). In this regard, the work of W. Edwards Denning demonstrated that the improvement of quality in the manufacturing process depended upon the acknowledgment of the centrality of co-operative relations among industrial workers. Such workplace co-operative relations were found to be linked to worker self-esteem which was an important facet in the attempt to maintain high production quotas along with the manufacture of products of a uniformly high quality. His findings are in direct contradiction to the elementalized mass-industrial production-line methods typical of Taylorism. However, these findings did not greatly affect social-
psychological theoretical models or research methodology. Even in industrial psychology, the goal remained to gather information concerning the external correlates of such findings rather than an explication of underlying intersubjective processes that explained such phenomena (Taylor & Brown, 1979, Coughlan, 1995).

We have lost contact with ourselves, and our own natural being, and are driven by an imperative of domination that condemns us to ceaseless battle against nature both within and around us... with its sharp sense that human beings had been triply divided by modern reason - within themselves, between themselves, and from the natural world.

(Taylor, 1991, p 94)

Social psychologists, at least those who are historically minded, now refer to the 1970s as a period of crisis. There are differing explanations of the roots and validity of the criticism and reappraisal that took place after what has been called social psychology's "Golden Age" from 1947 to 1970 (Apfelbaum, 1992). This period of expansion after World War II resulted in the creation and demarcation of different fields, each busily collecting data and guarding intellectual "property". Only a few practitioners were engaged in attempting to develop coherent theoretical frameworks that could make sense of the enormous expansion of knowledge claims generated by predominantly empirical experimental and quasi-experimental research programmes (Jackson, 1988).
While it would seem a practical necessity that individual investigators should concentrate on a manageable area (Buxton, 1985), this had a tendency for the separation of schools of thought and for each new school to focus on certain aspects, while ignoring important scientific findings in other schools (Hilgard, 1987). The development of a coherent field of scientific knowledge should require more than "mere fact gathering nor isolated hypothesis testing but thoughtful systematic approaches" (Hilgard and Bower, 1966).

The absence of a single scientific system that would embrace and combine all of our contemporary knowledge in psychology results in a situation in which every new factual discovery . . . that is more than a simple accumulation of details is forced to create its own special theory and explanatory system. In order to understand facts and relationships investigators are forced to create their own psychology - one of many psychologies.

(Vygotsky, 1956, p 57-58).

This "piecemeal" or "jigsaw puzzle" approach to creating the discipline and the claim to scientific respectability, in the minds of many critical psychologists, eventually started to crumble under the sheer weight of unconnected and often divergent conclusions. Social psychology, by the late sixties, was also roundly criticized from both within and without for the growing divergence between the existing theoretical frameworks and the new realities of the post-war social and sexual revolutions as well as for other epistemological,
methodological and ethical incongruencies (Jackson, 1988; Leary, 1989). Critical voices were attempting to save the discipline from a relevancy crisis that stemmed in part from the construction of a self-serving "angelic" public relations persona that attempted to deflect any criticism (Hurtig & Pichevin, 1986). It was certainly an important progressive move that ethical shortcomings in research practices were addressed vigorously. However, such improvements were made at the expense of a more comprehensive re-evaluation of underlying methodological and theoretical concerns. Eventually, with the end of the 1970's, the crisis was happily consigned to the past with the mainstream of the discipline claiming the crisis averted, even solved. Many problematic areas highlighted in this decade (e.g. relevance issues, individualistic methodology) were swept under the rug, and in the view of many critical voices, the underlying conditions of the relevancy crisis remained intact (Jackson, 1988, Danziger, 1980). Apart from peripheral critical voices, the mainstream re-embraced the abstracted individual as the natural unit of analysis and the continuation of psychological measurement in terms of abstracted operationalized variables continued unabated.

In the case of North American mainstream social science the use of the label "value-neutral" regarding these empirical practices was reinforced. Results provided by designs that assumed the anthropology of the isolated individual tended to be understood as positive "evidence" of the reductionist, individualistic and hierarchical nature of both physical and social reality (Solano, 1989).
However, theoretical assumptions and methods accepted as bona-fide in terms of these assumptions, along with the results of such designs, can and often do, form a self-perpetuating tautology. Such circular logic can perpetuate itself because it is seldom recognized that the same ideology can be present in the theoretical foundations of all these stages of the investigative process. If one believes that the social experiences are essentially concerning the mutual stimulation of individuals who are receptacles of discrete behavioural, cognitive, emotional and personality variables this will be assumed in the methods used to test this assumption. It should be no surprise that the results will tend to support this belief. Over time, continued reproduction tends to promote this invisibility (Foucault 1984, Dant, 1991). However, more critical commentators on the periphery of the discipline have described this self-referential system as "the shame of social-psychology" (Folger, 1987).

The final stage in the harmonizing of psychological investigation with the modern industrial project was the appropriation of the history of science. Particular "histories" of psychology were offered for consumption in which the values of industrial culture were inserted into the narrative either as the culmination of technical progress or the culmination of the progression of the work of a succession of great "heroic" technicians (Jackson, 1988). Thus, these particular narratives obscure the relatively recent plurality and relative equality of psychological systems, choices of objects of investigation and methods. To many mainstream practitioners, a study of the history of social psychology can
be justified only if it shows the relevance of historical backgrounds to present-day foregronds. Certainly this was Allport’s (1985) view and one which has received more than a smattering of support. Such views have had an unfortunate influence on the teaching of the history of psychology and psychological theories at the undergraduate level, especially since this subject is often considered a luxury during these times of economic rationalization and cost-cutting in higher educational facilities.

The result is that the social embeddedness of scientific inquiry has become hidden from view and the particular methods used in particular projects have become the only scientifically defensible methods. The study of concrete culturally embedded consciousness was generally replaced with the investigation of behaviour (in its raw form or later translated as connected to inferred cognitive structures), biological and/or physiological aspects of perception or brain functioning. As important as these types of investigation are, the natural scientific paradigm and the accredited methods linked to this tradition are not completely adaptable to the wholly different subject matter of an intrinsically cultural organism, without producing knowledge that is incomplete. Redefining the subject matter of psychological and especially social-psychological phenomena to be consistent with the toolbox of available methods as imported from natural science, more often than not impoverishes the kinds of questions that can be asked as well as limiting practical applicability in the field of human need satisfaction.
Human psychology exists at the intersection of biological, physiological, individual and cultural realms and to do justice to this unique object of investigation, we need to carefully preserve the natural relations and inter-penetratedness of these co-constituting aspects without using technologies that simply reduce to one or another of these terms. The potential explanatory power of social-psychological investigation has remained largely unfulfilled, owing to the continuing attempt to simplify the subject matter to make it amenable to the inherited toolbox of methods. Instead of broadening discussion to investigate the insufficiency of predominant conceptions of the subject matter of psychology and tackling the underlying mismatch of subject matter and methods, mainstream practitioners erroneously conflate the particular model of scientific investigation that assumes reductive methods, with science itself. This has serious repercussions in terms of the sufficiency of social-psychological formulations to provide reasonable discussions of personal agency and communication, both of which are largely beyond the reach of presently accepted reductionistic and operationalist, variable models of investigative practice. In addition, the complicity of social psychology in projects to discover knowledge that would be of greatest interest to institutions of social control tends to make it more unlikely that any coherent conception of agency would take shape because of the discipline’s commitment to prediction. The immense emancipatory potential of social-psychology is thus mostly neutralized as the sub-discipline has become unwittingly complicit in the agenda of dominant extra-scientific and especially
socio-economic interests that are not especially supportive of the ordinary persons' desires to gain greater insight and control over their lives.

The dualistic foundations of mainstream North American psychology, in particular representationalist models of perception, have provided the template for theoretical and methodological developments in social-psychological formulations. These foundations have been reinforced and have interacted with other dichotomies, most notably the separation of individual from cultural and socio-economic aspects. These contexts have been artificially separated from an abstract operationalized model of the individual conceived as a container of discrete variables. These conceptions bare little resemblance to actual human experiences. The allegiance of mainstream North American social psychology to dichotomization has interacted with extra-scientific commitments of the sub-discipline to consumers of its knowledge products to create an impoverished model of socialness that is primarily focused on the prediction of individual behaviour for the benefit of elite factions in society. This model is not only insufficient to explain the phenomenon of social and cultural behaviour, it actually mitigates against a coherent account of human agency and an emancipatory psychology. The following chapter will extend a discussion of the influence of dualistic trends by tracing holistic and dualistic aspects of conceptions of health and medicine. This historically contextualized discussion will show that as medicine has evolved into a predominantly scientific enterprise it also tended to internalize and reinforce a basic Cartesian antipathy between mind and body. In
addition, the professionalization of scientific medicine also tended to preserve
the power of practitioners while simultaneously abrogating the agency of patients
in their desire to gain information and to act in their own health interests.
Chapter 5

Health, medicine and service delivery: Dualistic and holistic trends

Ancient conceptualizations

According to ancient Greek cosmology, Hygeia was a goddess that represented health in the broad contextuality of the overall quality and enjoyment of life. Health in this early conceptualization was considered holistically and as the inter-penetration of many factors including environment, activities, diet, artistic involvement as well as individual physical aspects. In addition to this religious embodiment of health, the Greek system of deities also included Aesculapeus, a god that was concerned with diagnostic and curative powers once illness was recognized as being present. Thus, early Ancient Greek cosmology showed that there was a general understanding of health linked to social and psychological variables as well as to individual behaviour and that the holistic understanding of health was differentiated from the diagnosis of disease.

Hippocrates is generally considered the father of Western medicine and in his view health was primarily about balance: the interplay between the inner and outer world and the relation of the individual to their environment. This view is consistent with the understanding as represented by the goddess Hygeia. In his opinion, the maintenance and restoration of health should focus on balancing and harmonizing physical, mental and spiritual aspects of individuals and this total ecology of health was linked to the inter-penetration of many personal, social and environmental factors. His system not only discussed a balanced diet
as important to good health but also noted that a fulfilling sexual life, sufficient exercise, bathing, artistic involvement and the ability for self expression, sleep and even dreams were important for medical practitioners to investigate and discuss with patients. Problems or deficiencies in any of these aspects of living could cause illness if they put the totality of experience out of balance. Such an imbalance would translate into physiological effects via the four humors of the body (black bile, yellow bile, phlegm and blood). Clearly, psychological, social and societal aspects were understood to influence the physical and biological level of individual human functions in this view.

However, the holistic medical philosophy of Hippocrates was appropriated and modified to support a contrary dualistic modern scientific system of medical practice. While Hippocrates has some minor symbolic power in modern western medical establishment with the continuing acceptance of the Hippocratic oath, the holistic aspect that was at the heart of his system has mostly disappeared in mainstream practices. Instead, western systems internalized and built upon the dualistic Platonic and Aristotelian frameworks, reinforced by modern forms of dualism (notably Cartesianism) in much the same way as other scientific fields. In interpersonal physician-patient relations, Hippocrates, with his more holistic approach recognized the need to work democratically with the patient. By entering into a long process of discussion, any problems would be discovered in a co-operative manner.

Plato had a dualistic understanding of the universe and in accordance with his vertical class-based views on society had a differing attitude on
physician-patient relations depending on the class of the patient. With regards to
slaves and the lower classes (which included all women) he recommended a
very authoritarian approach to the diagnostic enterprise in the manner of a
dictator who maintained complete control of health knowledge and the diagnostic
situation. With the higher castes (a very small minority of males in society) he
recommended a more collegial and co-operative relation. It is Plato's master-
slave relation, that is a dichotomization of the roles of patient and doctor, which
provided a template of the power-differentiated relations current today (Mullett &
Coughlan, 1998; Suchman, 1994).

The modern project of medicine

Since Aristotle, drawing on these dualistic formulations, health has been
mostly interpreted as the absence of disease and by extension legitimate
intervention became the utilization of various technologies in response to the
symptoms of illness rather than intervention to support continuing good health
(Feldon, 1999). Illness, rather than health became the major subject matter of
mainstream medical practices and gradually the physical and biological level of
human functioning became the prime focus of these technologies of intervention
as the scientific era reached maturity in the late 19th and early 20th centuries
(Tarlov, 1992).

This formulation of medicine as "diagnosis and treatment of illness"
occurred at the site of physician-patient consultation at an early stage of western
practice but it wasn't until the second decade of 20th century that physicians
tended to treat their patients in a non-holistic manner. The class-based
hierarchical systems of Europe provided the meta-categorizational principle for a continuance of a Platonic authoritarian interpersonal style in consulting situations. However, at least physicians tended to treat the individual patient as an integrated organism, something that would change as the model of medicine changed from an ambivalent category of art/science into an experimental science. This trend became particularly noteworthy after the great successes of various technological advances in medicine discovered after World War 2.

It was with this change to a predominantly scientific enterprise that the level of specialization increased. This transformation occurred because of a wholesale appropriation of the natural scientific paradigm by medicine and through the steadily increasing specialization of both biological sciences and medicine, the body increasingly began to be investigated as separated organ-systems. Many aspects of environmental, social and economic forces were poorly understood until fairly recently and because of conservative tendencies in modern medicine such research is still barely beginning to be translated into health service policies and practices at the site of patient treatment. Thus, with the separation of illness from health and the separation of the psychological, social and societal aspects of human experience from the human sufferer, the art of medicine slowly transformed into an entirely biological science (Harrington, 1999). This combination of dualism and reductionism as translated into modern scientific medicine has led to the general acceptance that illness, and by extension its absence (health) to be factually described as a purely biological phenomenon (Tarlov, 2000; Tarlov, 1999).
This tension between the view of medicine as concerned with health of the whole person in the context of all sorts of cultural and environmental factors and the view of health as the treatment of physical and biological illness is with us today. Alternative practitioners and a minority of allopathic physicians have viewed the biologically reductive model as unhelpful and outdated. It still is generally accepted to be correct even by the majority of the population, owing to the enormous success of the natural scientific paradigm in ordering and contextualizing everyday experiences. There are good reasons for this faith. This model has enjoyed overwhelming success in improving standards of living and our ability to fight infectious disease (Harrington, 1999). This dominant reductionist model of medicine, even though successful in a major area, is incomplete, dehumanizing and represents a rather extreme example of the consequences of taking Cartesian dualism seriously. Whereas Descartes himself provided counter arguments to naïve mind-body dualism, it seems that modern scientific medicine has not only separated the mind and human consciousness from illness but has separated the body into ever smaller units and separated these biological units of investigation from each other and from most other environmental, social and societal contexts (Tarlov, 2000).

The continuous influence of dualistic systems provided the meta-categorizational principle behind the practices of modern medical interventionary techniques. There were also other pragmatic reasons related to the immense love affair with natural scientific methods and technology. Certainly the separation of biological from psychological aspects could be partially owing to
the failure of scientific psychology to form any coherent and widely supportable positions about the workings of the psyche (Harrington, 1999). Different psychological schools had developed entirely incommensurable definitions of the subject matter of psychology and divergent methods of investigation (Jackson, 1988: Danziger, 1990). It would be a long time until any coherent understanding of any connections between psychological and physiological systems, and the important discoveries would not come from psychological investigations (Harrington, 1999; Stemberg, 1997).

While the study of psychology became fragmented, and each separated school or system became ever myopic in an often inappropriate attempt to justify itself as scientific on natural scientific terms, biological technology was not unsure about its mission or its methods (Coughlan, 1995). As a result it became wildly successful in creating new knowledge with practical implications for medicine during 20th century. The advances in technological medicinal practices were reinforced in turn by the professionalization of medicine in medical educational establishments as a strictly biological science, rather than the art it was previously considered. Some aspects of therapeutic psychology had a beneficial effect on certain individual sufferers but nothing to compare with penicillin, antibiotics and surgical interventions (Harrington, 1999).

We have benefited immensely from the biologicalization and specialization of medicine with regard to threats from infectious diseases during the last century, however the prosperity of this model has also created some major pressures on the management of western health systems. Owing to the
enormous success of the introduction of various technologies there has been a tendency to develop an uncritical faith in any technological medical intervention (Lomas, 1998; Rachlis & Kushner, 1989, Evans 1984). Whereas vaccines and surgical procedures are vigorously tested before wholesale introduction, such a process is a rare occurrence with enormously expensive scanning technology. In many cases the wrong criteria are being used to judge the efficacy of such machines. They are judged primarily using purely technological criteria such as the production of better pictures (which can be a valuable improvement) as well as on other non medical variables such as reliability. However, unlike the testing of medicines and procedures, random controlled trials are rarely if ever carried out to judge medical outcomes of their introduction (Feeney, Guyatt & Tugwell, 1986). In other words are the improvements minor or major and if the latter do these technical improvements in newer scanning machinery get translated into better decisions for treatment?

Even in the management of scientific institutions there is an overwhelming and unscientific willingness to believe that the newest technology will unfailingly lead to better results. Critics have lamented this tendency claiming that there is a balance that needs to be struck between judging the actual medical significance of newer machinery and the costs which will be taken away from non high-tech areas of medical care (Barer, Morris & Lomas, 1996; Lomas, 1998). Labour intensive forms of personal caring such as nursing, therapy, and home support, which may have a far greater effect on actual medical outcomes are now in increasing competition for money with increasingly expensive technological
diagnostics. In a great many jurisdictions budgeting strategies have led to a situation where the capital costs associated with technology have generally displaced funds earmarked for these labour intensive areas. (Evans & Stoddart, 1988; Harrington, 1999).

The love affair with science and the fruits of scientific specialization in the form of technologically-advanced screening systems, like many affairs of the heart, has other bitter aspects. Medical institutions, practitioners and political organizations can garner public support and increasing funding in a technologically advanced industrial society, if medicine can be equated with the latest tangible fruits of "science" (Harrington, 1999). The symbolic value of this increasingly expensive machinery can sometimes have the effect of leading health authorities to become involved in technology competitiveness. If hospital x or health district y has a particular machine, other health authorities won't want to be left behind and have people say they are out of date (Charles & Lomas, 1997; Lomas, 1998; Rachlis & Kushner, 1989).

The belief in the biologicalization of medical practice has also led to the meteoric rise in the power of the pharmaceutical industry over the last half century (Chappell & McClure, 1998; Evans & Stoddart, 1988; Lexchin, 1984; Mullett & Coughlan, 1998; Rachlis & Kushner, 1989). This biologicalization of medicine has enjoyed success but it has created some major problems for patients and the overall functioning of health services. In 1979, 8.6 cents of every dollar spent on healthcare in Canada was spent to pay the costs of pharmaceutical therapies and this has risen in 2000 to be nearly double as it is
now measured at 15.2 cents of every dollar. The money spent on pharmaceuticals has been the fastest rising cost to health systems over the last decade and now outstrips the total amount of money paid to physicians. (Statistics Canada, 2000). Whereas the early years of the development of pharmaceuticals resulted in some revolutionary leaps in our battle to improve the overall health of populations, the last 15 years has seen an incredible rise in the number and cost of pharmaceutical medicines for sale, without a proportionate improvement in the health of the population (Townson 2000: Lomas, 1998; Rachlis & Kushner, 1989). This has been accompanied by sky-rocketing profit margins for this sector of the economy (Duncan, Miller & Sparks, 2000).

The same period has actually seen very little real advances in the effects of prescriptive medicines compared to older and much less expensive products nor any marked reduction in occurrence of the chronic types of illness that are the major problems today (Duncan, Miller & Sparks, 2000; Mullett & Coughlan, 1998; Lexchin, 1984). Owing to the extension of copyright clauses, subsequent to Canada's acceptance of Free Trade agreements, many pharmaceutical companies have invested a great portion of their windfall profits not on research and development (which is already mainly financed through public money) but on marketing newer products only marginally different than those already existing (Klein & Lee, 2000; Townson, 1999; Rachlis & Kushner, 1989, Mullett & Coughlan, 1998).

Now that we have been successful in treating and in some cases eradicating many previously devastating infectious conditions we are left with
increasing rates of disability and suffering due to chronic diseases (Brundtland, 2000; Feeney, Guyatt & Tugwell, 1986. While we are getting less value in terms of health outcome from the expenditure on pharmacological treatments, this increase is threatening to bankrupt socialized systems and the overuse of many pharmaceuticals is actually having deleterious effects on the population's health. Not only are side-effects and drug interactions leading to an increasing amount of hospital admissions throughout western industrialized nations, the overuse of antibiotics in human and farm animal populations has left us vulnerable to biological organisms that are drug-resistant (Townson, 1999; Brundtland, 2000; Rachlis & Kushner, 1989).

**Biologicalization and the case of depression**

An example of how a complicated phenomenon can be reduced to an individual biological problem and reformulated in terms that make it amenable to the hype of "magic bullet" marketing by medical and pharmaceutical sectors is the case of depression (Duncan, Miller & Sparks, 2000). Pharmaceutical corporations can promote certain products as quick, easy cure-alls because the general public has been convinced of the credibility of anything associated with science and technology. Years of media saturation have reinforced the general belief that anything labeled as "new" must also be better. However, the prescription of selective serotonin re-uptake inhibitors (SSRI’s such as Prozac and its descendants) as the modern cure for depression may be good news for medical corporations and family physicians but these highly profitable preparations are not anywhere near as magical as the popular media and
pharmaceutical advertisements claim. In fact, research has shown they can be a
great deal more dangerous (Duncan, Miller & Sparks, 2000; Elkin, 1989; Murlow,

For instance, a Federal U.S. government research review of 338 clinical
trials conducted between 1980 and 1998 found that this new class of
antidepressants were only reported to be effective with 50% of participants and
outperformed placebos by only 18%. This study also looked at 206 trials which
directly compared the older tricyclic class of drugs with SSRI's and found no
difference in overall efficacy (Murlow, 1999). Woelk (2000) found in a clinical trial
that St. Johns Wort (a naturally occurring, easily available and inexpensive herb)
was equally as effective if taken at the recommended dose as tricyclics in
managing the symptoms of depression but had far fewer and less severe side
effects. Whereas a 25% drop-out rate owing to severe side-effects was
measured for those taking tricyclics there was only an 8% rate for those assigned
to St. John's Wort. A more recent study funded by a conglomerate of
pharmaceutical corporations attempted to dispute this finding but their
methodology was flawed at a basic level because the number of participants was
very small and they only reported the effectiveness comparisons in treating long-
term, severe depression. No study has ever claimed that St. John's Wort was
effective against this most severe and chronic level of suffering. There is also the
concerns regarding the credibility and objectivity of such a test when the
effectiveness or safety of a profitable pharmacological intervention is questioned.
Another meta-study conducted in 1989 found that pharmaceutical interventions were slightly less effective in the short run as compared to therapy and were far worse over the long haul (Elkin, 1989). Shea (1992) found that in her analysis that 24% of therapy clients recovered without a subsequent major relapse compared to only 16% of those given only pharmaceutical intervention and those receiving the antidepressants fared worse on every outcome measure.

Lambert and Berkin (1994) state as an explanation of these findings that those who are treated with pharmaceuticals tend to give up at least a portion of their personal agency by accepting that drugs may succeed where they are unable to help themselves. Those in therapy not only don't give up on their abilities to cope, they are given strategies to enhance their personal and social situation and any change is therefore attributed to their own efforts, bolstering overall confidence and self esteem. Research at Duke University comparing an exercise regimen and a common SSRI (Zoloft) found that exercise alone has an equal benefit as the pharmaceutical preparation to patients over the short run and most importantly, without any side-effects (Blumenthal, Babyak, Moore, Craighead, Herman, Khatri et al, 1999) but is superior over the long term (at six, twelve and 24 months) (Babyak, Blumenthal, Herman, Khatri, Doraiswamy, Moore, et al, 2000). These results were also explained in terms of patients' ability to be agents in their own interests in recovering from their depression (Blumenthal, Hart, Sherwood, Doraiswamy, Herman, Watkins et al 2001).

SSRI's as compared to cheaper tricyclics seem not to have fewer but different and often more dangerous side-effects. SSRI's were measured to
produce greater reports of diarrhea, nausea, insomnia, and headaches. The more severe side-effects included sexual dysfunctions in 30% to 70% of participants (depending on the particular study), liver damage, seizures, akathisia and (most importantly) suicidal behaviour (Duncan, Miller & Sparks, 2000). Worse still, SSRI's are at least 10 times more expensive than tricyclics. The only advantage that SSRI's have over any other class of drug is that the preparation itself cannot be used for purposes of suicide.

Meta-research designs such as that carried out on pharmaceutical preparations for depression show that the biologicalization of illness can often lead to poor outcome measures. Depression is a special case because it is an affliction of individuals' subjective experience, perceptions and moods with consequences for the sufferer and those with whom they are in close contact. The standard treatment is one that relies on a redefinition of this complex phenomenon to a maladaption of the individual's biological systems and the standard pharmacological treatments tend to merely mask certain symptoms. Many alternative practitioners, a minority of medical physicians and a great number of academic and public health investigators believe that even with illness that is normally understood to be physiological and/or biological there needs to be a consideration of psychological, social and societal factors if we are to be successful in the treatment of illness, especially chronic conditions. Moreover, this broader focus including social contextual variables entails both a theoretical and methodological reconceptualization from illness intervention to health and healing.
The peculiar category of placebo

One of the important aspects of the scientific biological model of treating illness that is often ignored, actively avoided and poorly understood is what has often been referred to as the placebo effect. According to the scientific conception the placebo effect is something that is seen as a possible error which can invalidate the evaluation of medical interventions and as much as possible should be avoided. In actuality, it can be seen as the physician's and patient's best friend as recovery can occur fortuitously. However, the reasons behind the recovery are somewhat of a mystery to mainstream models of biological causation (Harrington, 1999). Many commentators and physicians have noted that part of this effect is linked to the patient belief in the treatment process (a psychological variable) and this belief can be augmented by many aspects of medical and other social relationships. These include the trust the patient has in the physician, the physician's belief in the treatment protocol, a will to recover because of a religious belief, or love of or support by family or friends, to name just a few examples (Gordon, 2000). All of these possible reasons for this effect are social and psychological variables. If physicians give time to their patients, respect them, include them co-operatively in decisions regarding treatment, patients learn to have respect and trust in themselves. This trust in their own ability to heal is part of the placebo effect (Gordon, 2000; Kaptchuck, 1998a; 1998b). The interesting aspect of this is that all of these aspects point to communicative and social means of augmenting the patient's agency and this has an influence on outcome through psychological processes.
Randomized control trial evaluation protocols became the gold standard for medical research of efficacy after World War 2. Before this time efficacy of illness management was judged by whether or not the patient recovered. The focus was the patient. After approximately 1945 the ground shifted from this “beneficent model” to an “informed consent and autonomy” model (Kraptchuck, 1998b). The evaluation questions and criteria changed from “will this work?” to “how does it work?” This different approach is less interested in the absolute effects on recovery and more in terms of its relative effects in comparison to something else (Gordon, 2000). There is an assumption of a scientific judgment because treatments have to work by a method that is commensurate to a biological model of mechanical causation and quantification. It remakes medicine from an art into a replication of an experimental science (Harrington, 1999).

Evaluations are asking whether treatment protocols work by a legitimate or a non-legal legitimate method (Kraptchuck, 1998a). These are fine questions to ask of medical responses to illness and they can be immensely useful in differentiating between effective and ineffective biological interventions. However, this model often delegitimizes many psychological, social and societal aspects of individuals’ lived experience that have been demonstrated to be important in patient recovery.

It is well known that in medical trials, of those getting the placebo, approximately 30% of people will report some beneficial effects (Wolsh, 2000). According to the scientific model of evaluation, in practice, ambiance, context, environment, doctor-patient relationship, belief system of the practitioner or
patient are all non-legitimate forms of intervention or measures of efficacy. This
delegitimation of these aspects as "merely placebos" can be viewed as an
ideological proposition designed to deflect doubts about the over-biologization of
medical practice (Krapchuck, 1998b). In addition, it also presents the individual
sufferer contextualized by their culturally embedded experiences, as practically
immaterial to the evaluation. Such evaluations use aggregate research designs
and make pronouncements on effectiveness comparing abstract measures of
means and standard deviations contextualized by measures of probability. The
individual experience of illness, recovery, and suffering has little if any
importance in this model. By extension an argument could be made that human
agency to regain health is not only deligitimated but becomes almost implausible
in the experimental medical model that attempts to map how the treatment
independent variable causes changes in the organism.

Placebos are the ghosts that haunt our house of bio-medical
objectivity, the creatures that rise up from the dark and expose
the paradoxes and fissures in our own self-created definitions of
the real and active factors in treatment”

(Harrington, 1999)

The emergence of alternative medicine

Alternative medicine of varying types is becoming more and more
fashionable and a number of the reasons for this increase in respectability are
linked to patient desires for respectful treatment and to perceptions of the
diminishing efficacy of allopathic therapies on many chronic complaints. People
who go to alternative practitioners have generally tried mainstream allopathic regimens and many have experienced them to be alienating, disempowering, ineffectual or various combinations (Gordon, 1996). At the turn of the 20th century and accelerating after World War 2, the main Zeitgeist in western industrial nations involved a romance with the future, science and technology as the panacea for the eradication of natural and social problems. Many people have become disenchanted with this paradigm and are seeking to re-establish a relationship with a romanticized interpretation of a pre-technological world vision (Harrington, 1999). With regards to health, this romanticization of the past has led many people to dally with some very exotic interventions even though the general motivating force for most has been a desire to discover treatments that don’t artificially segment human experience into discrete compartments (Astin, 1998). A major allure of alternative medicine is that it is seen by many as much more holistic. Romantic movements have happened in various forms throughout history but now we are seeing that many dissatisfied patients are turning to ancient treatment regimens in the hope of, if not a miraculous cure, at least some symptom relief (Harrington, 1999).

Science has been very successful in representing itself as ideologically and culturally neutral and this is one of the reasons that any messages couched in the language of science have credibility with the general public. Such an argument can be shown to be unsupportable on logical grounds but nevertheless, this has been one of the central ideological messages that have become part of the general belief system in western industrial culture. The
acculturation to, but dissatisfaction with scientific medicine has resulted for many in a pull in two directions at once. Some patients desire the mystique of the ancient world but would prefer that any exoticism be translated into the language of science (Harrington, 1999). Such a blend is even having small effects on the cutting edge of experimental medical investigation in some jurisdictions. For example, in British Columbia a new programme has recently been approved for a long-term scientific study of the blending of Chinese and western medical techniques, in the hope that each system might be able to learn from a very divergent paradigm of diagnosis and intervention.

However, in general many alternative practitioners have broken with and may actually be inimical to mainstream scientific practices whereas some others prefer to work in combination with conventional western medicine. Some adherents of alternative medicine often maintain a hostility towards scientific medical practices and intervention evaluations because they see the scientific model as reductionist and alienating (Gordon, 1996). On this count there is much to support in their view. However, they also may see that alternative medicine is incommensurable with modern practices and that ancient and exotic therapies don't have to be tested because they have "worked" for 4000 years. Such a view disagrees with scientific criticism that testimonials and anecdotal evidence can't really be accepted as sufficient evidence. Testimonials are often considered as sufficient reason to believe for many people and therefore their publication can be against the broader public interest. The mistrust between alternative and allopathic practitioners is reciprocal as many alternative practitioners criticize the
scientific basis of mainstream medicine for the quasi-religious belief that the scientific paradigm has greater credibility because it is not culturally or historically contingent.

For instance, Angell (1999) who is a critic of alternative practices is adamant that randomized comparisons are value-neutral and objective because “the rules of science are forced on us by nature”, which would seem to be a very naive argument that stands in contra-distinction to a great body of research in philosophy of science and medical anthropology. However, mind-body therapies of virtually every type (meditation, yoga relaxation, different body-work and massage therapies, music therapies) may be expensive but are not invasive and have little in the way of negative side-effects. According to many alternative or complementary practitioners, randomized control trials as utilized in allopathic evaluations are not ethical (Cassileth, 1999; Vickers & Zolman, 2000). Instead, the often preferred investigative method is a comparison of treatments using a “Case Control Study” design which requires matched controls voluntarily taking different therapies and who are virtually identical in terms of various socio-economic, demographic and diagnostic aspects. Such a design is however cumbersome, requiring more time and energy in order to find adequate matches (Vickers & Zolman, 2000).

According to Casileth (1999) a distinction should be made between complementary and alternative medicine. Alternative therapies are generally invasive and biologically active, often expensive and sometimes dangerous. Some may be dangerous in and of themselves or because they interact with
Other conventional treatments. There is a danger if the belief in alternative therapy results in people not seeking conventional allopathic intervention when such intervention has been proven to be effective. Complementary therapies are generally not promoted on the basis of curative qualities but rather to enhance feelings of well-being, to control symptoms and promote quality of life and are generally used as adjuncts to conventional treatments (Cassileth, 1999). Such a differentiation may well be helpful for the gradual acceptance of certain valuable forms of alternative interventions such as chiropractic therapy, massage, and some mind-body therapies because it diffuses the perceived threat to conventional western medicine, while contributing to the social good.

Many alternative therapists view themselves as more concerned with promoting health by educating people to care for themselves, rather than encouraging people only to seek help after the occurrence of illness (Gordon, 1996). This focus on promotion and education is linked to finding that most illnesses are chronic and usually related to stress and other lifestyle problems. In addition, the experience of many patients is that standard biological medical science is sometimes unable to fit symptom profiles into the pre-existing categories of diagnosis often resulting in the invalidation of patients' real experiences of illness as psychosomatic or even worse, as evidence of malingering. Patients who have had this experience are looking for someone who will understand, pay attention and care for them as human beings, not just to make them fit existing, and often problematically defined legitimated diagnostic categories (Gordon, 1996).
Patient interactions with allopathic physicians are not only limited by currently existing diagnostic categories but by the very nature of the entrepreneurial structure of “fee for service” medical consultations (Mullett & Coughlan, 1998). Physicians tend to develop aloof discursive strategies to maintain control of diagnostic interactions and to artificially curtail patients' choice of narrative style (as will be demonstrated in the next chapter) not only to maintain a power differential but because the system rewards them economically for shorter interactions. Without adequate time to take a patient's history and to get to know them in terms of the myriad of psychological and social aspects, practitioners can often be perceived as unreliable and unhelpful therapists (Gordon, 1996). Alternative and complementary practices often take the patient-practitioner relationship more seriously at a fundamental philosophical level and this is translated into a relative lack of constraints in terms of time in consultation (Astin, 1998). This augmented relationship is promoted by some alternative therapists because it promotes patients' abilities to care for themselves in avoiding disease, thus supporting a sense of personal agency with regard to their health needs. The overwhelming majority of alternative practitioners promote a holistic model of treatment that assumes the inter-relationship of physiological, psychological and social aspects and believe that this model of caring will not only improve diagnostic procedures but will also tend to augment patient agency. The patient's view of themselves as an integrated psychological/physical being along with their active involvement in their own care is viewed as central to encouraging natural and therapeutic efforts for recovery (Cassileth, 1999).
Pharmacological treatments available for many chronic complaints can sometimes provide relief but they are often ineffective as well as making patients vulnerable to the probability of experiencing side-effects. Alternatively, patients can also learn relaxation techniques, Yoga, self-hypnosis, experiment with nutritional regimens, or change their attitudes and these changes may sometimes significantly reduce their experience of pain. In addition, such changes are interpenetrated with the patient experience of gaining a greater sense of control and mastery over their affliction (Cassileth, 1999). Such a conceptualization is different to allopathic models that generally transfer power and agency from the patient to the medical professionals or to the medical intervention. With many simple alternative mind-body types of strategies the patient no longer is tempted to believe that their bodies are their enemy (Gordon, 1996). Once a person experiences some power over their afflictions by their own efforts they cease orienting themselves to their illness as a victim. Psycho-immunological research has demonstrated that being a victim is not conducive to recovery or to maintaining good health. This research will be outlined shortly.

The standardization in evaluating mainstream allopathic interventions for illness has led to a standardization in how medicines and procedures are defined. One of the main thrusts of western medicine is to make everything uniform as well as measurable (Harrington, 1999). Every pill is touted as having exactly the same amount of active agent in it (though this may be in doubt as recent research concerning the manufacturing processes of pharmaceutical corporations in the U. K. has discovered that this is often not true in practice).
This can be seen as a valuable safeguard for patients and something that many commentators have suggested should be legislated for herbal remedies that are at the moment under-regulated (Fugh-Berman, 1997; Gordon, 1996). Mainstream scientific medicine emphasizes uniformity whereas it can be demonstrated that the effects on a particular individual are idiosyncratic: a finding that alternative medicine seems to have a better understanding of (Fugh-Berman, 1997; Harrington, 1999). We are missing the larger opportunity here which is to explore the ways in which context, expectation, and interpersonal dynamics play a role in augmenting or directly facilitating all treatments, complementary, alternative and mainstream (Harrington, 1999).

The mind-body connection

To heal comes from old English, haelen that means, “to become whole”
To cure comes from the Latin “curare” which means, “to get rid of disease”.
Conventional medical practices work with the latter, more dualistic version connected with biological interventions intended to cause recovery from illness and a return to an absence of disease. Many critical commentators believe we have been working in a one-sided paradigm (Felton, 1999; Fugh-Berman, 1997; Gordon, 1996; Harrington, 1999; Koenig, 1999).

Research has shown that a sense of community can have important effects on recovery and protection from disease. For instance, it seems that having a religious belief has some important effects on immune functioning. In a study of 4000 randomly sampled people it was found that of those who professed some sort of religious affiliation had much better immune functioning
in terms of the amount of interleukin 6 in the bloodstream (Koenig, 1999). The author did not explain these findings in terms of divine intervention but in terms of the community support, interdependence and improved agency that those who belonged to stable communities enjoyed. The social activities and the support that are found in membership of churches improve psychological health that in turn has an effect on physiology, especially the immune response. In conclusion Koenig suggested that doctors should encourage those who are members of organizations to use this support as way of coping with their illness because respecting the patient belief system helps in recovery. This means that doctors need to take the time to get to know their patients and have meaningful conversations with them as well as being competent biological technicians (Koenig, 1999; Sloan, Bagiella, & Powell, 1999). Research has shown that people want to believe in their physician and it is clear that physicians exert significant influence over their patients that derives from their medical expertise (Mullett & Coughlan, 1997).

To focus on maintaining health, we need to cure illness using the best fruits of the scientific paradigm and help the individual to reassert their wholeness which means additionally focusing on all the contextual aspects that have been abstracted and ignored under the category of placebo (Koenig, 1999). However, this is not necessarily an easy approach to take, especially when medical institutions and the understanding of the general populace are rooted in and depend on conventional western understandings of medical intervention (Felton, 1999; Tarlov, 2000).
Once we understand that a patient's brain can have a profound impact on the immune response and on healing, the focus of healing becomes the patient. The doctor is just an adjunct. It involves body, mind and spirit. A person's sense of spiritual and psychological well-being has an impact on their physical well-being.

(Felton, 1999, p.173)

There has been a tension between the scientific community who want proof that there is an interaction between body and mind, society and the individual and those who have long believed this to be true. The dichotomy between thinking and emotions and getting physically sick has been long cherished by the medical research community (Sternberg, 2000; Harrington, 1999; Felton, 1999). The problem remained that while primarily alternative practitioners believed there was a way that a whole host of psychological and social stressors could impact physical health, until approximately thirty years ago medical specialists and biological scientists were unequivocally certain that such a position was completely unsupportable (Glasser, 1999).

It had been observed that those who had the economic clout to garner a better diet and living arrangements were less likely to become ill because this seemed to lessen their vulnerability to infectious disease (Townson, 1999; Taylor, 1986; Evans, 1984). There was also the troubling but highly fortuitous placebo effect that seemed to work in the patient's favour. Nevertheless, the general view was that there was as yet no compelling reason to reconsider the
robustness of the biological model of health services and the concentration on treating illness with biological intervention. Following in the assumption of a naïve Cartesian mind-body dualism, mainstream scientific medicine's understanding was that subjective appraisal of experience was a phenomenon of the brain as a separated organ but the physiological phenomenon of sickness was a malfunction of the immune system and these functions are separated (Sternberg, 2000). For any of these more radical claims regarding the effects of many social and cultural variables to be true, scientists would have to discover a biological interface between the brain and the immune system (Glaser, 1999; Glaser, 1998).

The advent of the study of this interface, which became known as psychoneuroimmunology was inspired by a serendipitous discovery by Robert Ader who was investigating the Pavlovian conditioning of a taste aversion in rats. Without knowing it he was conditioning an immunosupressive response so that the stronger the aversive response, the more susceptible the animal was to any environmental pathogens. The only problem was that this didn’t make any sense in relation to the knowledge at the time that flatly contravened any connection between the brain and the immune system. It just wasn’t possible. Subsequently, nerve endings were discovered deep inside the spleen (a major organ in the immune system) nestled in among a forest of lymphocytes and macrophages. A similar mixture of nerve endings and immune cells were soon found in every part of the immune system along with ten different neurotransmitters, demonstrating that communication between the brain and the immune system was two-way
(Felton, 1999; Sternberg, 2000). Stress responses can be activated by physical signals and emotional distress. When a person becomes sick as well as undergoing stress, the whole system (brain, hypothalamus, sympathetic nervous system) is on overdrive and has a reduced ability to fight infection as compared to just being sick. On the other hand if the system is tuned too low to begin with then this tends to be expressed with chronic inflammatory conditions such as arthritis and lupus.

Now that science had identified the physiological pathway that allows subjective experience to affect the immune system and vice-versa, we can say that a vast array of stressors have a huge potential to be considered health hazards. It is possible to map how cultural, societal, political and economic stressors affect individual occurrences of illness and perceptions of health through psychological processes. Every day research is providing increasing evidence that the dualistic and reductionistic paradigm of biologized medical practices as reflected in mainstream health policies are at best only partially effective. In fact, without addressing psychological, social and societal aspects of patients experiences it is now being demonstrated that biological interventions in illness management can be seriously compromised, if not entirely neutralized (Baron, Cutrona & Hicklin, 1990; Kiecolt-Glaser, 1998; Benson, 1997; Wilkinson, 1996).

A person's social interactions or lack of them can have serious effects on their health. There is a great deal of epidemiological evidence to show that people who are socially isolated face greater health problems and increased
morbidity (Kiecolt-Glaser, 1993; 1987). Baron, Cutrona and Hicklin (1990) investigated a relation between social support and immune system functioning among spouses of cancer patients. The results showed that all six components of social support as assessed by Social Provisions Scale were strongly related to immune response. The greater the perceived social support, the more efficient the immune system becomes. People who self-report lack of support are measured to have much less efficient immune systems (Kiecolt-Glaser, 1996; 1995).

There is a great amount of new support for these findings from research in the cancer treatment field. For example, Kugaya, Akechi, Okamura, et al (1999) using multiple regression analysis found that advanced disease, being unmarried, feeling helpless and feeling hopeless, were significantly related to depressed mood and that these factors should be targeted for psycho-social intervention. Benson, (1975) and later, Benson and Stark (1997) have spent many years investigating the connection between thought and brain activity and physiological functioning. They found that relaxation training and the changing of thought patterns that is remarkably similar to ancient meditation techniques have profound changes on the efficiency of many physiological systems. In addition, support and a sense of community aids in the improvement of physiological variables including improving the immune response. In another study, group music lessons (specifically drumming) was found to have a statistically significant positive effect on the amount of lymphokine-activated natural killer cells in the
bloodstream as compared to those who did not receive the drumming workshops (Benson, 1997).

De Leeuw, De Graeff, Ros, and Hordijk (2000) investigated the psycho-social aspects of patients with head and neck cancer and found that those patients who actively chose support had a far lower rate of depression and also survived significantly longer than those who had mandatory support programmes provided to them or received no support at all. Patients who chose support were more in control of the amount and type of support services they could access. It was found that those who were "given" mandatory support did significantly worse than those who were provided information and the means to access these services and who then decided to choose which ones they wanted to access. In addition there was no difference in the rates of depression between those who were "given" (rather than choosing) support and those who had no support at all.

A relation between the ability to heal from a small wound and stress was found in caregivers of Alzheimer's patients who tended to take an average of nine days longer than non-stressed controls to heal than normal well-balanced controls (Kiecolt-Glaser, 1995). This same author investigated the relation between style of spousal interaction and the working of the immune function and found some profound connections between psychological variables and the probability of getting physically ill because of a lowered immune system response (Kiecolt-Glaser, 1998). A difference in the effect on the immune system was measured to be related to the level of acrimony of a disagreeable discussion between spouses and in terms of how powerless they reported feeling. The
nastier the argument was, and the less power they felt they had to affect
changes to overcome the disagreement, the more depressed their immune
system was measured to be performing during the conversation. In addition, this
suppression of the immune response was also found to be significantly reduced
24 hours later.

In a study of women with operable breast cancer Tjemsland, Soreide,
Matre and Malt (1997) measured various psychological variables (including
distress measured with Impact of Event Scale, depression with Montgomery-
Aasberg Depression Rating Scale, coping with the Mental Adjustment to Cancer
Scale, emotional suppression with Courtauld Emotional Control Scale and
neuroticism with EPQ-N Scale). The measures were taken one day before
surgery and then compared to immunological measures of the amount of
lymphocytes in the bloodstream one day before surgery and seven days after
surgery. It was found that there was a statistically inverse relationship between
anxious pre-occupation and intrusive anxiety with the amount of lymphocytes at
both measurement times. In other words, the more anxious the patient was, the
smaller the immunological response. In addition, depression had a statistically
significant effect on a poorer immunological response pre-surgery and a much
poorer rating seven days after surgery. These studies demonstrate that stress
has immediate effects on the immune system but that such social stressors even
when finished can lead to long-lasting physiological and biological vulnerabilities.

Feelings of helplessness as well as emotional stress can evoke a
physiological response that causes the natural healing functions to be disrupted.
McCaul, Sandgren, King and O'Donnell (1999) measured 61 women participants soon after they were diagnosed with breast cancer. The most consistent predictor of distress and poor outcome was Avoidant Coping Behaviour. People who adopt this reaction to threats pretend nothing is wrong and tend to give up their ability to actively work themselves out of their predicament. Those that perceived themselves as having an ability to affect the course of their cancer felt much better and had better prognoses. Similar findings in the field of cancer treatment have also been discussed by Nordin and Glimelius (1998) who investigated reactions to gastrointestinal cancer as well as Akechi, Okamura, Yamawaki and Uchitomi (1998). Schnoll, Harlow, Stolbach and Brandt (1998) used the term “fighting spirit” to describe the approach to cancer that was measured to have a better prognosis than other forms of coping such as helplessness or anxious pre-occupation. Moorey, Greer, Bliss and Law (1998) found that with a diagnosis of cancer an attitude of “fighting spirit” was greatly improved by an eight week course of cognitive/behavioural therapy which attempted to get people to focus on confronting the diagnosis and training them in specific ways they could help themselves. Those who received the supportive counseling not specifically focused on developing active coping strategies were more likely to report greater feelings of anxiety and hopelessness. Support itself was not linked to lessened anxiety and feelings of hopelessness but was measured to be inversely related to training that engaged with patients need for personal agency.
Lilja, Smith, Malmstrom, Salford and Idvall (1998) found that patients diagnosed with highly differentiated gliomas were far more likely to be people who had personality profiles marked by compulsive inhibition whereas those who were active in reaction to their diagnosis seemed to have less severe diagnoses. In a comparable investigation of agency-enhancing strategies with cancer patients, These results were supported by similar studies by McQuellon and Wells (1998), and Todarello, Casamassima, Marinaccio, La Pesa, Carradonna and Valentino (1994).

In a qualitative research design, Gray, Fitch, Davis and Phillips (1997) investigated the experience of 24 women who were enrolled in breast cancer self-help groups in Ontario. The reported benefits included practical and emotional support. Of particular mention was the benefit in co-operative helping strategies to help each member receive what they needed from the various health and social programmes available. In addition, the support network facilitated the women to work together to change the systems they were now subject to. Agency is thus seen as an important need of patients and that community building tends to improve perceptions of the ability for each to act in their own interests.

Fredrickson, Furst, Lekander, Rotstein and Blomgren (1993) found that the form of treatment and the treatment environment can affect immune system functioning, levels of anxiety and that these may be related to the patients' sense of control over their environment. They investigated immune function in women undergoing chemotherapy for breast cancer treatment and made measurements
of immune function as well as measurements of psychological variables, including anxiety. Patients admitted to hospital tended to have a higher anxiety level and lower immune system functioning as compared to those in day surgery, supporting other research detailed here. It can be concluded from all the above research that the perception of agency by people diagnosed with serious illnesses such as cancer can be affected by a huge number of variables including their style of coping, inter-personal relations, and other social variables.

Health promotion

To attempt to counteract the abstracted and reductionistic approach of western allopathic medical systems many practitioners and researchers have been working from the early seventies to change the emphasis of health policies from “illness care” to “health promotion”. This less dualistic and reductionist understanding fueled greater discussion of the management of health systems so that health and illness included a whole host of environmental, social, cultural, political, psychological and economic factors in addition to traditional disease management techniques (Frank & Mustard, 1991; Evans, 1988, 1984, Evans & Stoddart, 1988). However, to many in the field this move to highlight the societal determinants of health was viewed as too radical and threatening to medical, governmental and corporate bodies alike. In response, a redefinition of health promotion began to appear in the 1980’s that stressed individual responsibility rather than social culpability and reinforced the redefinition of health in terms of personal choices and lifestyle (Townson, 1999, Evans 1988).
According to the health promotion view, the leading causes of preventable
disease, disability and premature death are primarily associated with chronic
rather than infectious disease and much of the population’s chronic complaints
can be linked to “lifestyle”. Thus, any further major advance in the health status
of populations is more likely to come from the behavioural and social sciences
rather than from biotechnology. Some commentators suggest that education and
communication advances have been primarily responsible for the great
increases in indicators of public health, especially for the general increase in life-
span over the second half of the 20th century (Kroger, 1994, Evans, 1988, Taylor,
1986). These aspects can be expected to be even more important into the new
millennium. This is a supportable position, however, Kroger’s (1994) views on
improving health and utilizing the great advantage of communication technology
are flawed at a basic level because of two specious North American
assumptions.

The first is both naïve and individualistic. In his view, behaviour is
assumed to be a lifestyle issue primarily driven by freely acting individual agents
exercising personal “choice” rather than the result of an inter-relation of many
psychological, social and behavioural variables. According to a critique of this
naïve position, the inter-relation of such factors are mediated by divergent
experiences of agency or disempowerment (or alternatively, restricted action
potence) stemming from structural social and economic inequalities (Townson,
1999). The avoidance of any link with societal structures and relations provides a
cynical rationale for government and other elite interests to side-step
responsibility and to make health and illness an individual responsibility and when necessary to attribute blame for poor health onto individual sufferers. The individualization of health status is an ideological position that supports certain elite interests.

Bittman and DeFail (1999) have identified that there is a serious downside to all this individualistic view that assumes a connection between lifestyle, individual psychological variables and getting sick. The problem is that should this belief become a widespread phenomenon people will tend to blame themselves should they become ill. In addition, others will increasingly blame those who get sick for their affliction. If we take the research showing a connection between psychological and physiological variables seriously, the problem with this "blame the victim" mentality is that it could then make people less likely to recover. The depression that is likely to follow self-blame will then make it harder for the immune system to function properly, thus they will have a harder time recovering or staying well. In addition, this view provides ammunition for mean-spirited public policies which seek to withdraw social service and health funding because it is seen as an individual problem, perhaps even one of "choice". The assumption of this model can lead to an increasing tendency to erroneously downplay the value and efficiency of socially organized therapeutic programmes.

The other flawed assumption is that the efficient provision of health services can be linked to the adoption of "free" market forces and metaphors related to the dubious language of "Total Quality Management", as applied to
medicine. This virulently retrogressive administrative paradigm redefines all human interaction and administrative systems in terms of instrumental relations. Human personal relations of instrumentality mimic and draw upon market metaphors for their context. These are impoverished relations that tend to depersonalize human empathy to a distinct calculus of means and ends. It reinforces the “naturalness” of market economics while simultaneously obscuring inherent structural and interpersonal power differentials between different levels of “market operatives”. This view conveniently ignores that people of different means will have a heightened or restricted horizon of market possibilities. In such a paradigm, “the patient” (which is itself a problematic category designation) is transformed into “the client”. Such a transformation does not represent an improvement in terms of agency to the majority. Rather, it preserves all the power differentials of current traditional authoritarian medical relations while exposing the patient to an additional set of pressures and technologies of manipulation from market forces. This further limits the perception of personal agency for those at the bottom of the economic ladder in the interest of a corporatist agenda (Townson, 1999).

In addition, such a market-oriented management programme is at odds with the fundamental aims of providing equality and humane treatment to sectors of the population who are suffering ill health. It is those at the bottom of the socio-economic scale that tend to experience poorer health as well as greater restrictions on their agency in market relations (Mustard & Frank, 1991; Evans, 1988). Thus, the application of such an ideologically suspect paradigm is hinged
upon increasing inequality gradients which has a tendency to also lower performance indicators of overall population health (Townson, 1999). Therefore such a model of health care fails in terms of the humanitarian values it propounds to support as well as failing in terms of overall health system efficiency in terms of cost-benefit measurements.

However flawed, at least the individualistic version of health promotion is somewhat empowering as the discussion of "life-style" has encouraged the more well-heeled in society to ask more questions about the maintenance of good health and to demand a greater say in institutionalized medical care. While economic, political and social determinants of health are only widely recognized and discussed by experts in health promotion, the rhetoric of an individualized health promotion emphasizing personal responsibility has had a measurable effect on the more affluent in society to use their market advantage to access information and to flex personal agency with regard to their health relationships.

Population health

In recent years the Canadian policy emphasis has shifted from health promotion to "population health". Although quite different, both (at least rhetorically) acknowledge that socio-economic factors have a profound impact on health status. There are divergent ideological implications to this shift that include a shift from a personal agency-augmenting based policy that attempts to empower patients to become more knowledgeable about health matters and to limit the amount of illness experienced by individuals to a predominantly quantitatively oriented approach that seeks to find worthwhile interventions from
"after the fact" population health data (Townson, 1999, Evans, 1988). Such aggregate data analysis is viewed as having a good probability of producing statistically significant effects on future collective indicators of health functioning. While the type of health promotion strategies that were generally accepted, tended to assume and directly mimic market-oriented societal relations of client-purchasers operating in a giant medical marketplace, at least it accepted the notion of some sort of personal agency as an important variable in attaining the best possible health experiences.

Population health, as it is currently practiced by bureaucratic organizations, is a far cry from the original intent of the founding figures such as Fraser Mustard and other researchers at the Canadian Institute for Advanced Research (CIAR). The original vision was that a population focus would be a way to jettison the "individual choice" perspective endorsed by governmental health organizations in favour of research that would lay bare the structural social and economic determinants of health (Mustard & Frank, 1991). In fact, many commentators agree that Fraser Mustard coined the phrase "population health" to describe his approach (Townson, 1999).

At first, even the CIAR seemed to have problems actually investigating many important aspects associated with the underlying social, political and economic causes of differential health experiences. The initial research staff at CIAR tended to come from a medical, natural science background and were not conversant with the social scientific perspective. Although many social and economic determinants of health were investigated there was a distinct lack of
expertise and commitment to find a cohesive theoretical framework that could investigate and explain the genesis of social and economic factors affecting health (Hayes & Dunn, 1998). Too few articles discussed power, race, gender, communication, agency or identity. However, as the organization increased in numbers, so did the breadth of research so that such issues are now discussed in terms of some more central underlying causes.

There is now a very extensive literature on health inequalities and their connection to social and economic aspects that appear to be at least partly responsible. Researchers have long documented the impact on health of poverty, unemployment, poor housing, lack of education, and problems in early childhood development. They have also noted how all these elements are interconnected (Evans, 1984; Hayes & Dunn, 1998; Mustard & Frank, 1991; Evans, 1984; Townson, 1999). A meta-investigative paper, conducted for the Social Development Research Programme of British Columbia, examined a number of published papers to see if there was any overall evidence that health status is linked to income and social status in Canada. The analysis based on 1977 data indicated that lower income groups have poorer health than those in higher income brackets. Although as expected, older Canadians experience poorer health than younger residents, those who are poorer also experience much poorer health and much earlier. In addition, a change in income is also related to a consequent change in health status and although this report concluded that these changes are mediated through a variety of social variables,
much more research into these mediators is needed to lay bare the connections
(Hay, 1993).

Child poverty in Canada has increased rapidly to affect 20% of the
population over the 1990's and many population health studies have
documented how poverty is linked to child ill-health (McIntyre, Connor & Warren,
2000; Ross & Roberts, 1999; Shah, Kahan & Krauser, 1987). For instance, low
birth weight in infants is often associated with consequent poor child health and
also with low socio-economic status (Currie, 1995). The largest and most serious
health problems are associated with consistently low income over a protracted
period which seems to direct the future investigation of connections between
poverty and ill health to take into account the average income over a child's life
rather than a snapshot of income at the moment of measurement (Curtis,
Dooley, Lipman & Feeney, 1999). The odds for a child from a low income family
in Ontario between the ages of 4 and 11 to be diagnosed with one or more
psychiatric conditions is three times that of those not categorized as poor
(Offord, Boyle Jones, 1987). There is also a similar link between low income and
morbidity (Lippman & Offord, 1994) and rates of chronic physical health
problems (Cadman, Boyle, Offord, et al 1986).

While more radical health researchers are increasingly able to document
the psychological, social, political and economic determinants of health,
population health perspectives, especially in Canada, still do not recognize the
impact of personal agency as an underlying factor. In this regard the approach of
British population health investigators has probably helped to set the tone for the
construction of a hybrid model that combines the best of the health promotion and population health perspectives.

One of the first attempts to adequately demonstrate the importance of these aspects both empirically and theoretically was accomplished in the book "Unhealthy Societies: The Afflictions of Inequality" (Wilkinson, 1996). Wilkinson's version of population health combines a social scientific orientation to investigating the underlying causes of health but not at the cost of ignoring personal agency. His understanding of personal agency is one that is inter-penetrated by societal relations and social processes so that it is not the abstract bourgeois, market metaphor versions so often prevalent in North American health promotion. In his view, at the heart of any coherent attempt to use population health is the necessary discussion of equality, agency and power as viable explanations for the differential health experiences in vertically divided industrial societies.

All industrial nations now have the capability of providing the entire population with all important material and economic needs. Most choose not to do so but this choice imposes an intolerable burden on the whole society. Inequality and lack of personal agency are psycho-social stressors that interact with and reinforce the problems engendered by lack of material resources in endangering the health of those who experience the greatest relative privation. Political and economic policies favourable to free market corporatism widen the gulf between rich and poor, reduce naturally occurring social supports, that in turn reduces individual experiences of personal agency. Those at the bottom
with little ability to feel in control of their lives and with little material resources suffer a worsening health status.

Such policies actually engender wide-ranging and devastating consequences for society as a whole because those who are relatively well off will suffer psychologically in the attempt to insulate themselves from the experiences of those suffering at the foot of the socio-economic ladder. In addition, the middle classes as the major contributors to the tax-base paying for socialized medicine will tend to suffer financially when there are worsening overall population health indicators. They will be further burdened by decreasing buying power from their salaries as the bill for health and social services increases (Wilkinson, 1996). This has prompted some members of the upper middle classes to politic for the abandonment of the universal system.

The effects of ignoring the agency of those also suffering material impoverishment means a compromised efficiency in terms of overall health indicators and increasing psychological and economic costs to be born by the shrinking middle classes. An explanation of health status linked to perceptions of personal agency demonstrates that inequality in wealth and agency together tend to worsen the overall functioning of a society not only in terms of healthcare but also in terms political stability and the economic cost of poor health. Such arguments also provide support for the contention that ameliorating middle-class requirements to cut taxes and spending less on health and social welfare by introducing private for profit healthcare will tend to worsen rather than improve the situation for anyone in society.
Material and economic indicators may partially describe why some people are less healthy than others but they don't begin to explain why the populations in some countries appear to be healthier than the populations in others. They can't explain why countries such as Greece, Iceland and Italy, for example, have better overall population health than Canada and the U.K. (Brundtland, 2000; Townson, 1999). In the developed world it is not the richest countries that have the best overall health but it is the countries that are the most egalitarian (Townson, 1999; Marmor, Barer & Evans, 1994). Public policies which seek to reinforce or institute a class system so that there is a considerable gap between a minority of those who enjoy a prosperous life-style and the majority of those who don't, tend to be measured to have a worse overall experience of health (Wilkinson, 1996: Frank, 1995; Mustard & Frank, 1991).

The analysis of population indicators in Britain over the course of the political life of the Conservative government of Margaret Thatcher provides stark evidence of this tendency. Economic and social policies of monetarist marketization increased the economic performance of the U.K. but at the same time they further polarized the country so that the percentage of those with less than half the average income trebled over these years. The general health indicators of the nation showed an inverse relationship to the rising G.D.P. (Wilkinson, 1996). The United States adopted similar social and economic policies during the 80's with similar results.

Canada has adopted a weakened version of these policies but started to introduce them approximately 8-10 years later. At a time when many nations (the
U.K. in particular) were realizing that the social costs of monetarist economic policies and social programme cutting were too onerous to bear, and were embarking on a change of direction, Canada was accelerating social programme cost cutting measures. For example in 1999, 1.5 million children were measured to be living below the poverty line whereas in 1989 the figure was slightly in excess of 1 million (Stephens, 1995). These measurements represent an increase of 47% in child poverty over a decade.

Investigating the determinants of health and assessing the functioning of the Canadian health system, The National Forum on Health (1996) concluded that governments and public administrations have not demonstrated in their decisions any appreciation of the impact of social and economic determinants on the health of individuals and communities. The results of a two year investigation of Canada’s health system in the 70’s entitled “A new Perspective on the Health of Canadians” and more generally known as the” Lalonde Report” (1974) identified that there were a whole host of social and economic determinants of health. However, it also noted that the general conclusions and tone reflected in government policy to this day, emphasizes individual choices rather than any structural aspects. Current figures have demonstrated that nothing has changed in the intervening period. To actually change the inequities of Canada’s health system, particularly for native populations, would require a wholesale redistribution of power within society. However, present political and medical institutions tend to be structurally and ideologically opposed to re-balancing power, wealth or in consequence, health asymmetries (Hayes & Dunn, 1998).
This is particularly ironic because Canada hosted the first international conference on health promotion in Ottawa in 1986. The document produced at the conclusion comprised of a pledge for all attending nations to create supportive physical, social, economic, cultural and spiritual environments, to strengthen community involvement into health policies, develop personal skills in agency, and to reorient health provision to take into account the "whole" person (rather than just abstracted biological variables) (Townson, 1999).

Given all this evidence regarding the determinants of health it remains to be explained why at the basic level of health system management and physician-patient interaction that much of this knowledge has yet to be implemented (Marmor Barer & Evans, 1994). There are a number of inter-connected reasons for this lack of action in the face of overwhelming evidence linked to political power, will and expediency. According to some of Canada's leading health economists (Marmor Barer & Evans, 1994; Evans, 1984; Evans & Stoddart, 1988) it is possible to view the present times as not really representing a crisis in healthcare even though we are bombarded with messages that it is. According to their arguments, in retrospect since the beginning of Canada's Medicare system there has always been a crisis according to some or all major stakeholders. There was a "crisis" when it came into being, another one in the late sixties, again in the seventies, and yet again in the eighties and again, now. It seems that it must be portrayed in crisis to get any attention. This does not necessarily mean that everything has been a bed of roses or still needs some major overhauls.
One oft cited problem concerns an increasing need for new physicians that is linked to the greying of Canada and to an increasing level of specialization and sub-specialization and the increasing use of complicated and expensive technology (Evans, 1984; Epp, 1986; Rachlis & Kushner, 1989). All of these pressures continue to make the provision of healthcare more expensive.

The problems with refocusing the system have a great deal to do with the relative power of the stakeholders and a whole lot to do with the design of the political system. With elections every four or five years and the need for the political classes to demonstrate that something is being done, most of any monies ear-marked for health tend to be apportioned to areas of high visibility. Thus, primary care and hospital requirements all related to the treatment of disease tend to be at the front of the line and it is clear that the media must shoulder some of the responsibility for this as they provide the impetus and context for such decisions based on political expediency. Projects that are related to the determinants of health or policies, which if implemented, would take longer than five years to yield measurable results become low priority. It is clear that the glamour is with acute rather than preventative medicine (Feeney, Guyatt & Tugwell, 1986).

Another major problem with the current system is that because of the problems engendered when medicare was being introduced, federal and provincial governments agreed to leave physicians ostensibly completely in charge of the direction of healthcare. This protected against the over-bureaucratization of medical care by governmental institutions because only
qualified medical personnel were to judge what was medically necessary for any particular patient. However, as physicians were the only gatekeepers to the system, it also meant that medical necessity became defined as any procedure that a physician was willing to provide and the patient was willing to accept (Charles & Lomas, 1997). There were no checks against the power of physicians and although that has meant the system worked reasonably well up to a point, it has worked extremely well in terms of the hegemony and economic interests of physicians (Mullett & Coughlan, 1997; Mustard & Frank, 1991; Lalonde, 1984; Epp, 1984). Physicians' organizations are very powerful and very conservative. In general, physicians cherish their identity as entrepreneurs (Mullett & Coughlan, 1998) and governments are very reticent to embark on any structural changes in the public interest because they know the damage that can be done to electoral chances should medical associations mount a media or political campaign. The tendency to cater to these powerful interests can be witnessed in British Columbia where physicians seem to be able to garner considerable increases in salary from successive governments, whereas most other sectors have experienced a drop in their overall standard of living.

Taken collectively it would seem that all the evidence from epidemiology, psycho-immunology, psycho-oncology, population health, health promotion and alternative medicine indicates that psychological, social and societal aspects are intimately connected to and may determine health. While the majority of the scientific research has focused on support, interpersonal relations, stress (in its various definitions) various psychological states and economic variables as
explaining the differential health and recovery from illness, there is generally only
a hint that personal agency may be the central variable that underpins and
parsimoniously explains this large body of research.

Some alternative researchers and practitioners seem to understand that
patient agency is a very central concept in relation to maintaining and
overcoming illness (e.g. Wilkinson). Perhaps this may be related to their holistic
While the alternative paradigm seems to have a basic understanding of the
importance of personal agency, this comprehension is often naïve because this
paradigm has a distinctly individualistic understanding of agency that does not
recognize the interpenetration of personal agency with socio-economic structures
and relations. Wilkinson seems to have combined the best of the alternative
paradigms with a population health perspective that explains that the underlying
concept behind different experiences of health and illness is societally
contextualized, personal agency. At a basic philosophical level, a holistic meta-
categorizational system can support a more sophisticated understanding of
agency contextualized by societal structures and cultural relations whereas
dualistic orientations either ignore such issues, actively work to limit agency or
struggle to adequately account for its existence. Dualistic systems tend to make
a coherent understanding of human agency problematic because they also tend
to become reductionistic in that we generally want to explain one of the poles by
reducing it to the opposite term or configure the relation in terms of one-way
mechanical causation. The practical abrogation of patient agency in modern
industrial-scientific medicine undermines not only the efficacy but also the fiscal efficiency and humanity of the system.

The following chapter will discuss how dualistic medical structures and relations at the site of patient-physician interaction tend to separate and valorize the physical aspects of medical intervention from psychological variables that research presented here has demonstrated to be very important to maintaining health and recovery from illness. The social-scientific investigation into relations between physicians and patients has consistently shown that many physicians use all manner of structural and discursive props to consolidate their power and to limit the agency of their patients as well as acting as if a mind/body separation is a natural fact. Many physicians have accepted that there is great value in attending to psychological variables in medical intervention but in practice the structures and discursive strategies that are actually used tend to undermine the credibility of such pronouncements. Should such matters be translated into practices at the site of diagnosis and intervention, both physicians and health researchers generally appear to be most interested in aspects of health psychology that will further augment the power of the physician. This is usually couched in language that shows the importance of psychological strategies in gaining patient "compliance" to physician-determined treatment protocols. The discussion of research in this area will show how such relations interfere with medical outcomes.
Chapter 6

Clinician-Patient Relationships

All his apothecaries in a tribe
Were ready with the drugs he would prescribe,
And each made money from the others' guile.
They had been friendly for a goodish while

(Geoffrey Chaucer, *The Canterbury Tales*)

Historical and structural perspectives

In the overwhelming majority of cultures, healers have enjoyed a distinctly respected place. While many people tend to live as though they will live forever, this immortality belief is often punctuated by the realization that the constitution of body, mind and spirit is frail in relation to an unforgiving ecology. Healing arts have evolved within particular meta-systems of belief concerning the relationship of humans to the terrestrial and spirit world and within these broad parameters, different models of the internal functioning of the body developed. Some of the more esoteric and ancient systems of healing arts continue to this day and a few (for example, acupuncture) have been somewhat successfully integrated into at least the margins of the modern scientific paradigm.

The relations between healer and patient (for want of a better word) are central to the maintenance of good health and the diagnosis of illness. Similarly to the evolution of philosophical positions on the etiology of health, conceptions of these relationships are intimately connected to the development of dominant
societal modes of existence and the overarching meta-categorizational paradigms in particular cultures.

The study of health relationships is intricately tied to styles of communicative interaction. Models of appropriate interaction are simultaneously an embodiment of societal relations while forming the living experiential mode by which such relations are internalized and reinforced as normal. The study of communication, especially in health-related contexts is a relatively new investigative area although ancient suggestions can be readily found. For instance Hippocrates, long considered the grandfather of medicine in the Western tradition, considered effective communication central to the extended and very personal aspects he believed were linked to health.

One must learn from the common nature of all and the particular nature of the individual, from the disease, the patient, the regimen prescribed and the prescriber - for these make a diagnosis more favourable or less; from the constitution, both as a whole and with respect to the parts, of the weather, and of the region; from the custom, mode of life, practices and age of each patient; from talk, manner, silence, thoughts, sleep, absence of sleep, the nature and time of dreams, pluckings, scratching, tears.

(Hippocrates, 460BC/1984)
Hippocrates not only identifies the importance of the communicative situation in the diagnostic interview but also the whole context of a patient's life in its particulars but also in relation to the whole living person. There is only one way for a physician to become conversant with all these particulars and contexts and that is to become intimately connected to the patient and garner the requisite trust through communicative means. Plato on the other hand (as would be expected) has a dualistic view of the physician-patient relationship with differing approaches to communication depending on the class of the particular patient. From his master-slave formulation of health communication we can see the root of such relations today. According to Plato "the physician should never give to the patient any account of his illness" if the patient should be a slave. Instead the physician should "give some orders gleaned from experience with an air of infallible knowledge in the brusque fashion of a dictator" (Hamilton & Cairns, 1961). The attitude towards the free man (a minority of people he would have considered colleagues) is rather more democratic in nature and requires a different communicative style. This version is the type of relationship many patients desire from their doctors today, but are often disappointed (Grace, 1991; Greenfield, Kaplan, Ware, Jano & Frank, 1988; Harrigan Heidotting & Fox, 1990; Mullett & Coughlan, 1998; Stewart, 1995).

The physician who usually cares for free men, treats diseases first by thoroughly discussing with the patient and his friends, the ailment. This way he learns something from the sufferer and simultaneously instructs him. Then the physician does not give his
medications until he has persuaded the patient; the physician aims
at complete restoration of health by persuading the patient to
comply with his therapy

(Hamilton & Cairns, 1961, p.720)

The two models of communication offered by different periods in Greek
history reflect not only divergent philosophical beliefs concerning the nature of the
consultational relationship but the wider societal project within which these
relations take place. The latter Greek period in which figures such as Plato and
Aristotle were influential had developed in a culture that was predominantly
organized by means of conquest, and this warrior culture instituted strict class
divisions at home and abroad (Tamas, 1991). The dualistic nature of
philosophical ruminations by both Plato and Aristotle are intricately linked to this
development of the overarching societal project and to the class-based
differentiation of diagnostic relations as outlined above (Coughlan, 1995). This
dichotomous meta-categorizational principle would be found as valuable for
explaining European medieval warrior societies' "reality" and the hierarchical
social relations as natural and pre-ordained.

The modern version of scientific medical practice evolved out of a system
of medieval class and property relations and a distinctly Christian conception of
the body in relation, and often in opposition to, a superior spiritual realm. Monastic
orders organized and preserved many aspects of herbalism which were originally
developed by previous "heathen" cultures. While ministering to the needs of the
physical body was not seen as important, the church was the dominating force in
the compilation of knowledge of early western medical techniques. In this pre-industrial age, European healers were either linked to traditional pre-Christian practices that gradually withered under periodic purges by church authorities, or more usually connected to the Church, privilege and property.

With the advent of the scientific revolution the privileges of medical practices were preserved. As technological interventions became more sophisticated the old herbal-based system of remedies were actively discredited as ineffective. Seen as quaint anachronisms, they were gradually delegitimated. With the change from a medieval to a scientific-industrial society, the ruling elite and the basis of European hegemony changed from an entrenched land-based aristocratic system deeply interconnected with Catholic and/or Protestant churches, to a more fluid mercantile, capital dominated entrepreneurial system. The change from a Christian to a scientific world-view also encouraged proto-scientific healing practices to bloom. In this new socio-economic paradigm those associated with elite interests were able to claim a stake in the flourishing "business" of medicine by way of a scientific education.

In these early days medicine was an ambivalent category that straddled the divide between art and science. This meant that there was also some ambivalence in the identity of early scientific medical practice in terms of treating patients in a holistic manner or accepting a more dualistic orientation to healing practices. As medicine became more scientific and as interventions became ever more reliant on technology, the dualistic assumptions of the scientific paradigm were more rigorously expressed.
In the early days, allopathic treatments were available only to other members of the elite with the financial capability to pay the considerable fee. Later, some religious orders embraced scientific medicine and together with other charitable organizations cared for the chronic ill-health of the burgeoning industrial classes. Such charity-work was often dependent on the demonstration of "correct" behaviour by supplicants who were oft-times persuaded to agree that their misfortune was in large part owing to their lack of moral fortitude. The vestiges of such attitudes exist today in some circumstances (Morrow, 1997, Ratzan, 1984). Pity and charity in the industrialized version of Christian ethics could be bestowed on those considered "deserving" poor. Much later, many European governments saw the need for some kind of generalized medical services for the masses as it could be increasingly recognized that reliable industrial productivity depended on a reasonably healthy labour pool. However, it still required many decades of popular militancy and radical political maneuvering to secure a certain entrenched rights to reasonable protection from the impoverishing effects of sickness (Barnes & Feldman, 1980).

In many countries that either chose or were forced by proletarian movements, to accept some form of socialized medical system, major aspects of the old entrepreneurial, "fee-for-service" models carried forward. In the case of Canada and the United Kingdom, the community of physicians were overwhelmingly opposed to the institution of Medicare as they viewed such policies as an interference in the normal operation of their practice (Evans, 1984). It was politically expedient for the government to assure the clinical community
that there would be no unnecessary corrosion of the traditional “fee for service” system of remuneration nor any interference with regard to control over medical practices. Clinical practitioners were able to maintain their position as an elite group in terms of class status, relative standard of living and most importantly as a self-regulating and self-governing body throughout the transition from pre-industrial to scientific medical practice and again from individual payer to national Medicare configurations.

As the practice of healing changed in the transformation from medieval to industrial society the procurement of remedies changed and became increasingly critical for the legitimization of scientific allopathic medicine (Lexchin, 1984). As scientific interventions developed, so too did a differentiation of medical consultancy from the discovery and manufacture of medicines and diagnostic technology. The practice of medicine was able to preserve an elite status while adapting itself to the modern industrial practices. Physicians, pharmacists and manufacturers of curatives were previously very intimately connected to and dependent on one another (as any Chaucerian scholar would agree). Although developing industrialization and mass marketing affected medicine in a similar manner to other sectors of the economy by increasing task specialization, these groups maintained an inter-dependent relationship: a relationship of entrepreneur to entrepreneur (Lexchin, 1984). Each was invaluable to the financial viability of the other. The maintenance of control over “production” within the economy of healthcare by physicians’ associations, pharmaceutical manufacturers and retailers predisposed these major stakeholders to a distinctly ambivalent
relationship with other non-entrepreneurial health workers such as nurses, administrators and technicians. This hierarchical structure of healthcare together with fee for service physician remuneration contributed enormously to complicating physician-patient relationships (Ben-Sira, 1990, Evans, 1984).

Power and communication

This hierarchical configuration of relations within this sector of the economy, although broadly accepted at first, contained too many contradictions to remain isolated and uncontested. Since the third quarter of 20th century, government institutions, some physicians, salaried health workers and patients have increasingly voiced misgivings concerning the configuration of power differentials in the health system (Maeside, 1991; Grace, 1991). Many believe that health delivery systems need a reconfiguration more relevant to patient health outcomes and should be more sensitive to the changing needs of patients (Morrow, 1997; Pendleton & Hasler, 1983). In addition, many patients are feeling increasingly less satisfied with current relationships with their family physician and in great measure this is linked to interpersonal experiences of differential power (Mullett & Coughlan, 1998; Walker & Waddington, 1991; West, 1984; Mishler, 1985; Anspatch, 1988; Grace, 1991).

The power differentials in medical interactions stem from a broadly legitimated societal separation of entrepreneur and labour and exaggerated by the authority given to experts in relation to lay persons (Hornburger, Haruka & Wilson, 1997). Certainly, knowledge is linked to power, but to be translated into actual practical authority such expert knowledge must be sanctioned and
legitimated by similarly powerful elements of society and then accepted by a broad spectrum of the population. In other words, such a power differential is reinforced by important cultural values (Hughes, 1982; Maeside, 1991; Ten-Have, 1987).

In western industrialized nations one of the great ordering mechanisms is the acceptance of the scientific paradigm. The credibility that medical practitioners enjoy is supported by the great value that both elite institutions and the general population place on a scientific medical degree (Mizrahi, 1984; Mishler, 1985; Ten-Have, 1987). Medical schools have insisted on high academic achievement for admittance into their programmes and in particular achievement in biological sciences. In medical schools, trainee physicians learn about the physiological, biological and chemical aspects of medical diagnosis and intervention but they will also be socialized into a unique sub-cultural system of beliefs and practices (Liederman & Grisso, 1985; Mizrahi, 1987).

The literature on doctor-patient interaction suggests that practitioners tend to adopt the Platonic master-slave model and consequently restrict the flow of information to patients, often withholding critical elements of the patients health records and pertinent facts regarding diagnosis and treatment (Davis, 1988; Lipton & Svarstad, 1977; Waitzkin, 1985). The medical interview as a social phenomenon internalizes and reproduces the general hierarchical structures of society. Diagnostic interactions tend to be characterized by hierarchically and sequentially arranged phases of physician-initiated questions, patient responses and optional commentary by physicians which show the dominance of the clinical
professional (Fisher & Groce, 1985; Liederman & Grisso, 1985; Mishler, 1985; West, 1984). There is an unsymmetrical power differential in such interactions and physicians tend to tightly control such consultations using various conversational means to redirect the process to suit their ends (Anspatch, 1988; Mullett & Coughlan, 1998; Mishler, 1985; West, 1984).

Many social scientific commentators on health issues and communication practices have noted that the communication between patient and clinician can often be conceptualized as the interface between two different sub-cultural meaning systems (Mishler, 1985; Waitzkin, Britt & Williams, 1993; Waitzkin, 1985). One of the reasons behind this clash of paradigms (often referred to as an incongruency of speech genres: the “voice of everyday” contrasted with the “voice of medicine”) may in large part be owing to the peculiar nature of physician training throughout most of the industrialized world (Ainsworth-Vaughn, 1994; Anspatch, 1988; Mishler, 1992).

Those that enter into medical training are often primed to exist in a stressful competitive atmosphere as many schools still accept applicants on the basis of scholastic aptitude in a few narrow scientific areas and personality variables congruent with competitive, Type A behaviour. Physicians in training are gradually acculturated into a medical belief system which tends for many to be very corrosive to their own ordinary sense of identity and self-esteem (Lella, 1988). Some commentators have described medical education as a rather lengthy abusive hazing ritual which can strip medical students of their prior value systems replacing it with a medicalized sense of authority and a detached
technocratic communicative style (Anspatch, 1988; Mishler, 1985). Often, residents are deprived of sleep, contact with their family members, suffer from a poor diet because of their long working hours, communicate in a stylized form that is incongruent with the larger world outside of medicine and are given a uniform that marks them as different from the rest of society (Leila, 1988). Without over-dramatizing this situation it should be noted that all the above are key elements of indoctrination used by military organizations and religious cults (Dyer, 1988; Hunter, 1998; Schwartz & Kaslow, 2001; Zablock, 1999). Such strategies are very effective in providing an organization the means to re-programme new members thus establishing and/or reinforcing the organization’s hegemony (Dyer, 1988). There are those who do make it through the medical training intact but the vast majority who graduate are often forced by their training and acculturation to become distant and cynical as a survival strategy (Leila, 1988). Although there are more progressive schools (such as McMaster University Medical School) that attempt to recruit on the basis of a more well rounded psychological profile, unfortunately the training rituals tend to be very much unchanged, at a basic level.

While many studies have looked at the problems of how physicians talk to patients (which will be discussed shortly), very little has been accomplished in the area of how physicians talk about them and how medical training leads to certain attitudes towards patients. Any learned disposition doctors have internalized towards patients in their interactions with other doctors will affect how they communicate in medical consultations. Physicians rarely directly reveal
their assumptions about their patients in diagnostic interviews although the deployment of certain communicative strategies may betray underlying attitudes. It is in the investigation of how physicians talk about patients to other physicians that cultural assumptions, values and beliefs become much clearer and the link to professional socialization processes can be made (Coombes & Goldman, 1973; Lella, 1988; Liederman & Grisso, 1985).

The largely ethnographic literature on how medical clinicians, residents and students adapt to the stressful conditions of their everyday experiences has uncovered some troubling behaviours. The “unofficial” culture existing in many medical schools and hospitals may use a fair amount of gallows humour (Coombes & Goldman, 1973). This humour includes derogatory slang labels used in reference to certain “types” of patients that are considered to be of questionable social worth. Patients are too quickly dismissed as being time-wasters if they suffer chronic complaints that evade existing tools for diagnosis (Liederman & Grisso, 1985). Other pejorative labels are attached to those who are suspected of self-inflicted illness, being psychologically disturbed or of having diminished mental capacities (again usually prompted by an inability to make a recognized diagnosis). Words used for such “problem” patients may include “gomers”, “turkeys”, “crockets”, “gorks”, or “brain-stem preparations” among others (Liederman & Grisso, 1985; Mizrahi, 1984; Mizrahi, 1987).

Different explanations exist to the meaning of such depersonalization by clinicians. Some investigators believe that such behaviour might be in response to the need of physicians to establish a collective sense of identity (Bosk, 1979)
or to the suspension of an idealistic world-view (Mizrahi, 1984). Other commentators have argued that this is symptomatic of a healthy psycho-social mechanism that recognizes the limits of present medical expertise (Leiderman & Grisso, 1985) Some have argued that an inability to label symptoms can often be stressful for physicians. This realization of inadequacy needs defusion and one way this can be accomplished is by the projection of inferior qualities onto patients thus allowing physicians to distance themselves from the conscious apprehension of the technical shortcomings of their chosen profession (Mizrahi, 1984; Scully, 1980).

Renee Anspatch (1988) has investigated the indoctrination of medical residents to certain approved value-systems. This qualitative investigation sought to explain the genesis and mechanics of corrosive discursive forms utilized by trainee physicians as learned behaviours. The presentation of medical case summaries by trainees and interns to their colleagues and medical authority figures is a major part of the medical training process. It is also a discursive form that continues into professional life through such means as informal communication between clinicians, case notes communicated between clinicians, formal conferences, and daily rounds. The case history follows an almost ritualized form whereby the patient is introduced only in terms of relevant medical “facts”, which include presenting symptoms followed by a history in medical terms and a list of other problems given in descending medical importance (Anspatch, 1988). Social and other personal contextual aspects are rarely if ever given: a finding supported by an earlier investigation by Frader and
Bosk (1981). The depersonalization of patients is considered necessary and attending to this format is considered by senior staff to be an important part in the evaluation of trainees. Senior medical staff will look for any opportunity to aggressively challenge junior staff or medical students and this was often reported to be perceived as ritual bullying by many physicians that were interviewed. Its aim is to reinforce authoritarian values in terms of seniority through humiliation and to reinforce the biological nature of diagnosis. The case presentation is an opportunity for trainee self-presentation and to demonstrate their acculturation to the rules of medical discourse which rewards the avoidance of challenges by the use of medical jargon as well as authoritative and controlling discursive strategies. Thus, behaviours learned in training not only diffuse doubts concerning diagnostic skill but reinforce forms of interaction that depersonalize the subjects of discourse and restrict questioning from others: strategies that are generalized to physician's consultations with patients (Anspatch, 1988).

Anspach found that depersonalization is evident in impersonal vocabulary that purposely removes the human agent from discussion. Biological and physiological processes "happen" in the abstract rather than happen to somebody in particular. The language used by physicians makes a sharp contrast between the subjective symptoms that are apparently experienced by the patient and the objective signs as measured by the clinician. The discursive forms clinicians often use regarding their own medical practices can also give the impression that their interventions are abstracted from any subjective decisional processes. These interventions are discursively transformed to appear as if they
merely “happened” without any person actually being present. This strategy was found by Anspach to be particularly evident when the intervention was unsuccessful or had a high probability of being problematic or controversial. This reformulation allows an evasion of responsibility when the outcome may be unfavourable to the clinicians' reputation. Similar occurrences of discursive reformulation deflecting responsibility for agency have also been reported in other areas, notably in criminal proceedings where sexual assault perpetrators, their lawyers, and even judges adopt a passive tense referring to the assaults as apparently “agentless” occurrences (Coates, Bavelas & Gibson, 1994).

The utilization of the passive voice in some cases has the effect of removing agency one step further when it is used in a discussion of medical diagnostic procedures carried out by professional clinicians. Here, the passive voice has the effect of alluding to the diagnostic machinery itself as being the agent rather than the clinician or technician who interpreted the often ambiguous results. These strategies protect clinicians from scrutiny and simultaneously make a claim for their authority (Bosk, 1979).

Anspach found that patients' subjective accounts are marked discursively by physicians in case presentations as if they are probably untrustworthy or fictional. In some cases the patients' comments are reported in a form that marks them as a negative version. For example, if a patient had volunteered that they have never experienced certain symptoms before, this statement might be reported as “the patient denies that there were any previous symptoms”. This discursive form is not only devious because it casts extreme doubt on the
patient's ability to be believed and makes the physician a moral interrogator of their patient, but can be used if necessary to evade responsibility. Thus blame can be apportioned to the moral vicissitudes of the patient.

The language of case presentations also offers a unique view of the distinct hierarchy in medical practice that favours high technology (Anspatch, 1988). Technology is discussed in terms of its ability to "reveal", "measure" or "show". Physicians, when referring to their own thoughts often "state", "observe" or "find" whereas patients merely "claim", "admit" or "deny." This is a finding that supports Reiser (1978) who identified that the problems inherent with modern western medical practices as stemming at least in part from a "technology idolatry" by physicians. The public has also generally accepted this belief. This is no doubt owing to cultural socialization and the continual reinforcement of this pattern that they experience in their communication with clinicians in diagnostic consultations.

The summary effects of these discursive techniques tend to reinforce a substance dualism which separates when necessary, the agent from actions. The patient's agency is nearly always removed but the physician's agency is often only discursively denied when the situation requires the physician to gain distance from the results and responsibilities associated with actions. In terms of the patient, this dualism renders the subject of experience as separate and immaterial to the separated biological organs of the body which are the objects of investigation for the physician. Thus, although the most important contribution of Cartesianism to western industrial culture has been the separation of subject
from object, it would seem that medicine has internalized both this dichotomy along with mind/body dualism into its central assumptions and practices.

Austin (1975) has analyzed the functions of discursive strategies as having three dimensions. Speech acts have a referential function in that they impart information, an illocutionary function in that they accomplish actions but they also have a perlocutionary action because they have certain effects on the listener. The perlocutionary aspects of medical discursive are designed to exploit dualistic tendencies assumed in modern society and to augment the agency of professionals when convenient and to deny agency to non-professionals. Thus, according to Lakoff (1987) in a restatement of the Whorf hypothesis, when such discursive forms are used to accomplish certain practical and ideologically saturated goals we are being used by language as much as we are using language.

In general the medical practitioner exists in a professional culture that stresses the assembling of chronologically ordered “relevant” data as an account of the patient’s experience of illness (Charon, 1989; Sharf, 1990). The difference in terms of how the physician has been socialized through a medical school education to report and understand this “relevant” information is one that is in stark contrast with how most people, including patients, understand and organize information (Clarke & Mishler, 1992; West, 1984). Patients ordinarily do not view themselves as a collection of abstracted biological systems and temporally ordered symptoms but as culturally and contextually embedded persons. However, the overall effects of the continual reinforcement of the model of
allopathic scientific medicine sometimes leads people to adopt this stance to their own experiences of health and illness and to others in their social milieu.

Health professionals and ordinary people alike do not necessarily accept claims of illness at face value. In ordinary conversations such issues, if discussed, will require some evaluation of symptoms and an understanding of whether the symptoms are "legitimate". The calculus of legitimacy with regards to forms of illness is accomplished with reference to social norms (Skelton, 1995). One of the most important social norms is the acceptance of allopathic diagnostic tests as equal to an objective fact (even though many medical tests are based on probability) whereas claims that are based purely on reported subjective experiences have much less validity (Kraemer, 1992). It seems that the bio-medical model is central to the ordinary persons' understanding of illness. According to Skelton (1991), people who described symptoms of a sore throat and also described some other personal life difficulties were seen as less credible than those who only reported the physical problem alone. Participants in this study tended to disbelieve that persons under emotional stress were truly suffering a physical illness whereas it has been demonstrated scientifically that the perception of emotional problems makes it more likely that a person will succumb to a physical ailment (Laudenslager & Reite, 1984). Professionals often harbour and sometimes express doubts concerning a patient's report of illness and instead attribute it to emotional distress or psycho-somatic causes (Salmon, Stanley & Milne, 1988; Jennings, 1986). According to social psychological research, patients who wish to be believed that they are suffering a
bona-fide illness need to mask psycho-social or emotional problems in order to be perceived by others that their claim to enter past the gatekeeper (general practice physician) into the realm of medical treatment, is valid (Skelton, 1995; Bishop, 1987; Purvis, Brandt, Rouse, Vera & Range, 1988). This may help explain why in some cases physicians do not take some subjective accounts of illness as seriously as they might (Skelton, 1995).

Most patients have a sense of their problem and in most cases have been grappling with the meaning of their symptoms for several days before seeing a physician. They have their own appraisal of relevant information ready to hand because they have been attempting to find relationships and causes behind their health problem. They have perhaps embarked on some research and spoken with their family and friends. In general, a visit to the doctor is initiated by the patient and for many this decision and their subsequent actions to travel to the office may be the limit of their perceived agency in their interactions with medical institutions (Clarke & Mishler, 1992; Schoor & Rodin, 1982). The patient will probably wait for a considerable time with others also wishing to see the same physician and when they are eventually called they know that there is usually a stringent time allocation to the interaction (Davidson, Molly & Bedard, 1995). These aspects reinforce their awareness that the physician enjoys socially legitimated power as a medical expert (Schoor & Rodin, 1982). Patients initiate the encounter by making an appointment to see the doctor but after that the interaction is grounded in a technological-medical agenda that is centered
around a particular model of diagnosis and treatment (Ainsworth-Vaughn, 1994; Charon, 1989; Clarke & Mishler, 1992; Scharf, 1990).

Patients may find themselves in a situation where they would like to enter into a conversation about their own thought processes concerning the origin of their illness but find that the structures surrounding the interaction make this very difficult (Bartholome, 1992; Clarke & Mischler, 1992; Frankel, 1984; Mintz, 1992; Schoor & Rodin, 1982; West, 1984). From the physician’s perspective the encounter is essentially a structured interview where the majority of the questions are initiated by the physician and are “closed” so that the patient is limited to yes/no or other fixed alternative answers (Frankel, 1990; Mintz, 1992). Generally the physician organizes this discursive form to keep the patient “on task”, providing answers relevant to the physicians’ abstract biological view of medical intervention (Clarke & Mischler, 1992; Simpson, Buckner, Stewart, Maguire, Lipkin, Navack & Till, 1991). Physicians often actively inhibit patient questioning by either ignoring such questions, interrupting patients in the middle of formulating a viewpoint, or by asking questions of their own and re-establishing the authoritative medical agenda. (Davis, 1988; Mischler, 1984; Ten-Have, 1987; Tuckett, 1985; Weijts, Widdershoven, Kok & Tomlow, 1993).

West (1984), using micro-analysis discourse analysis techniques, found that physicians interrupt patients when they are attempting to provide a medical history or other contextual information 67% of the time. In some cases the patient attempts to introduce extra material to contextualize their answer to the physician’s closed question or to discuss related concerns. In most instances
they are either ignored, interrupted or the original question is reformulated for a fixed alternative response (Frankel, 1984; West, 1984). Later research supports these findings (Clarke & Mischler, 1992; Mullett & Coughlan, 1998; Simpson et al, 1991). Similar results have been obtained in other conversational research in political situations, demonstrating the general proposition that those whose power is supported and legitimated by societal institutions can interrupt others of lesser status with impunity (Molotch & Boden, 1985).

Byrne & Long’s (1976) pioneering investigation into verbal interaction analyzed the form of medical consultations and found six distinct phases. They are (in order of occurrence) relating to the patient; discovering the reason for attendance; conducting a verbal or physical examination; consideration of the patient’s condition; detailing treatment; and termination of the consultation. In their analysis of over 2000 diagnostic interviews they found that the physician has control over the movement from one phase to another and accomplishes this by verbal and nonverbal means. In the overwhelming majority of interactions the phase where the physician presents diagnostic information to the patient (consideration of the patient’s condition) is very limited and in many instances this phase does not take place at all. The communication of information concerning the logic of discerning the patient’s condition and facts relevant to the patient’s understanding of their illness is omitted. The authors explain these findings in relation the needs of the doctor to maintain control and authority at all times (Byrne & Long, 1976).
Similar results were obtained by Heath (1992) who investigated interactions and found that patients often seem reluctant to respond to the diagnosis and in many cases this is managed by the tendency of physicians to combine the diagnosis with treatment instructions. This strategy of combining the two aspects without allowing patient involvement has the effect of presenting the diagnosis as an "objective fact" by maneuvering the patient to the task of paying attention to instructions concerning the remedy. In a previous study, Heath (1986) also described how physician nonverbal actions undermine patient involvement in consultations by the use of different body postures, and gaze. Physicians are able to use such controlling interpersonal strategies because both patient and physician understand the societally legitimated authority the physician enjoys in these interactions (Heath, 1992; Byrne & Long, 1976).

Mishler (1984) refers to this struggle in the diagnostic interaction as a battle between the "voice of medicine" which is concerning abstracted and ordered biological and technological intervention and the "voice of the life-world" which reflects the patient's contextually enriched perspective, communicated in ordinary language. Usually, the voice of medicine dominates the interaction. It can be seen that this struggle of the two paradigms tends to dissipate over the course of a clinical interview as the patient tends to conform to the imposed technical-medical agenda if the physician is unwilling to allow the patient to tell their story (Clarke & Mischler, 1992; Mishler, 1984). All of these structural aspects interfere with the interaction, tilting the power differential against meeting the patients' needs (Frankel, 1984; West, 1984).
Patients tend to use laughter as a tension-reducing strategy in diagnostic consultations but physicians decline to join in 94% of the time (West, 1984). In most social situations laughter is normally found to be the appropriate response as it is understood to be an invitation to sociability and to refuse would be generally interpreted as rude. The refusal of physicians to participate could be viewed as an effort to increase the social distance and preserve the power differential (West, 1984). In general, patients tend to be very attentive to the physician's needs and answer questions in a form appropriate to the discursive template as initiated by the physician.

**Power, communication and gender**

Societal structures and meta-categorizational systems in industrial cultures have reinforced power differences between patients and medical institutions in general but the unequal gender relations between women as patients and male physicians represents a further barrier to patient agency. A common finding in investigations of the effect of gender on medical communications is that female patients tend to ask more questions of physicians (Roter, 1991; Pendleton & Bochner, 1980). However, compared to male patients, women's comments and questioning are twice as likely to be ignored (Tuckett, Boulton, Olsen & Williams) and their questions are much more likely to be interrupted (West, 1984). Physicians tended to discount the subjective accounts of female patients' experiences with symptoms twice as often as they reject male patients' narratives (Fisher & Groce, 1990). Concerns that women brought to the attention of the doctor were also more likely to be ignored (Davis, 1988; Fisher,
Women who asked a great deal of questions were often labeled as "difficult" or "neurotic" by physicians and this labeling tended to reduce the credibility of the female patients' experiences of illness in physicians' opinions (Porter & McIntyre, 1989; Porter, 1990). Women tend to offer more contextual variables and discuss "health" whereas men tend to adopt to the bio-medical agenda and report symptoms of illness, and this may partially explain the greater respect paid to male patients (Meeuwesen, Schaap, & Van der Staak, 1991; Davis, 1988).

Many studies have investigated the effects of patient gender but because most physicians have traditionally been male, fewer studies have varied the gender of physician and patient. However, those that did found that in general female physicians have longer diagnostic interviews than their male counterparts and tend to take a longer time discussing the patient's history. Female physicians tended to be more positive in their comments, seemed more interested in forming relationships with their patients, were more responsive to requests for information and asked more questions (Weijts, 1994; Roter, Lipkin & Korsgaard, 1991). Same sex medical interactions have been reported to be more lengthy consultations than cross-gendered dyads and the longest interviews tended to be between female physicians and female patients. Female physicians seem far more interested in psycho-social aspects of patients' health regardless of whether the patient is a man or a woman. Patients of both genders and physicians exchanged more information and were much more active when the physician was female (Roter, Lipkin & Korsgaard, 1991; Meeuwesen, Schapp, &
Van der Staak, 1991). Female physicians also tend to have a greater desire to work with other professionals in the health system, reported that they were less interested in status interests and are far more willing to form partnerships in the public interest than male physicians (Mullett & Coughlan, 1997).

A qualitative analysis of recorded interactions of women patient and male doctor interactions by Borges and Waitzkin (1995) extended techniques from narrative analysis to investigate physician-patient communication. Their perspective assumes such interactions to be embedded in larger socio-cultural meaning systems. Drawing on the concepts of Bakhtin (1981; 1986) and Wertsch (1991) they attempted to uncover the effects of social control and ideological positions in medical interactions. They investigated “speech genres” to see if there is evidence of a clash between the everyday language of patients and the language of their physicians which typically employ the speech genre of bio-technology, as identified by Waitzkin (1992). Borges & Waitzkin believe that speech genres are evidence of the ideological crystallization of unequal material societal relations but the effect of the routinization of culturally embedded medical encounters is so pervasive that interactants rarely become conscious of the source of their experiences. This process of “reification” camouflages the impact of power (Lukacs, 1971; Taussig, 1980). Borges and Waitzkin's qualitative focus materialized as a consequence of several years of investigating patient-clinician interactions and realizing that subtle aspects of the relations could not be adequately explained by questionnaire designs. They found that women generally allude to problems that are intricately tied to their life and the
lack of power they have as urban housewives and/or working women. However, the voice of medicine translates socio-economic concerns into medical-technical events. Although similar strategies of redefining socio-economic as biological problems were noted in interactions with female and male patients, this occurs more frequently when the patient is female and the physician is male (Waiztkin, Britt & Williams, 1993).

**Power, communication and ageism**

In addition with the deforming effect of power differentials based on legitimated expertise and gender, there are also power differentials that are connected to ageism. Communication between health care professionals and more elderly patients seem to be fraught with difficulty (Mullett & Coughlan, 1997). Qualitative analyses have demonstrated that physicians often take a very stereo-typical view of older patients and assume that their mental faculties are dwindling when in many cases this is not the case (Mullett & Coughlan, 1997). The patients are not oblivious to this increased lack of respect from their physician and tend to resent the patronizing tone taken by their doctor. Most of the research in this area concerns the problems engendered when the cognitive abilities of seniors interfere in treatment (which is often inappropriately assumed by physicians to be poor) and in terms of gaining compliance to physician-initiated treatments. (Kreps, O’Hare & Clowers, 1994; West 1984; Stewart & Roter, 1989). Gray (1983) found that physicians reported greater problems interacting with older patients whereas Harris, Rich and Crowson (1985) found that physicians reported that they were predisposed positively towards middle-
aged and senior patients. Such contradictory findings may indicate the problems of self-report questionnaire designs with regard to the part other questions play in contextualizing particular answers and/or priming participants. DiMatteo, Prince and Taranta (1979) reported that older patients are less interested in the physician’s attentiveness to their needs as compared to younger patients.

Buller & Buller (1987) believe that the physician’s age may mediate patients’ evaluations of their health care. Younger physicians may well provoke more anxiety because of their relative inexperience in technical and medical matters and because they will be perceived as having less status than older physicians. However, Waitzkin (1985) found no differences between the amount of information provided by younger as compared to older physicians during diagnostic interviews.

Morrow (1997) discusses the health benefits of clear physician communication and “adapting the physician message to the abilities of elderly clients who may have declining cognitive resources” with regard to increased attention to doctors orders. In his article Morrow also notes that clinical professionals talk more than elderly patients in interactions. Thus, when referring to physicians or other health professionals he explains that he will use the term “speakers” whereas elderly patients are merely “listeners”. To be fair, this author is at least theoretically interested in “collaboration” during dyadic medical communication but his first premises betray an assumption of a power imbalance as normal. Such an assumption mitigates against a truly democratic interaction. “Collaboration” does not require an even playing field as we know from the use
of this term in 20th century political history and particularly in the context of capitulation to Nazism.

Mullett and Coughlan (1997) found evidence from both physician and patient focus groups that there is a generalized negative attitude by male physicians towards elderly patients in British Columbia and that this may be especially true when the physician is older, white and practices in urban settings. In other words, physicians who enjoy higher status in the profession tend to treat seniors with insufficient respect.

Power and cross-cultural communication

The North American mainstream scientific view of culture is often generalized wholesale and applied in medicine. The decision to assume that culture can be operationally defined as one or a number of intervening “variables” in an input-process-output model is in fact itself a culturally saturated opinion. Such a construction trivializes the subject, reifies instrumental relations as normal and has far-reaching consequences for medical practices and ethics (Stephenson, 1999). Western medicine is particularly notable for the general practice of considering itself an experimental science (rather than the art it once was) and for promoting models of health that measure biological and physiological variables in the treatment of illness. The ideology of medical scientism is primarily concerned with individual aspects as opposed to social issues and tends to obscure relations of power from view. The focus on extending individual lives at all costs through a biomedical “war on disease” has ramifications to patients’ families and communities that are mostly ignored.
Mostly, it reinforces the hegemony of the entrepreneurial-scientific complex and the authority of allopathic physicians as gatekeepers to the system of care. In actuality, a careful consideration of this conception may reveal that such a meta-categorizational scheme can also be understood to mean the war against the reality of embodiment and thus, ourselves (Stephenson, 1999). Some of the consequences of this ideology of supporting individual rights to care are that we spend increasing amounts of the health budget on treating older, ethnically European residents in urban areas whereas rural and especially native communities are left without services (Stephenson, 1999). Older people have more life-threatening health issues and the health institutions they attend tend to be in urban communities. Native populations not only have worse overall health, sufferers are younger and often the types of illnesses are also different.

Communication between patients and clinicians who speak the same language and who are culturally similar can be problematic enough but in modern multi-cultural societies such as Canada, many medical conversations will ensue between peoples of differing ethnicity, perhaps with differing languages. There are of course the obvious problems with conversations where one or both of the interactants have a limited grasp over the everyday use of another's language. In addition, the language of medicine is rather specialized which causes greater potential misunderstanding for people whose first language is not English. The problems can also consist of differing ways of interacting interpersonally.
For instance, Chinese and Japanese cultures consider it polite for those with less socially sanctioned power (for example, patients) to avert their gaze. Interactants not familiar with this show of respect might misunderstand that they are being ignored. Nodding in Chinese culture signifies continued attention, not as would be understood by Anglo-Saxons and North Americans, as agreement to propositions being communicated (La France & Mayo, 1978). Chinese patients may inadvertently be communicating to physicians that they agree with the diagnosis and that they understand the treatment regimen when in fact they do not. Research shows that information communicated between interactants in medical situations can often become content-impoverished. Critical information may not only be misunderstood, it may actually be lost altogether (Li, 1999a; 1999b).

The use of intonation, gazing behaviours and turn-taking during conversation are extremely variable across cultures. As meaning is negotiated interpersonally, this can cause confusion if interactants are from different cultures (Gumperz, 1992; Ickes, 1984; La France & Mayo, 1978). In order to collaboratively construct meaning, conversants need to develop a shared understanding of how communication will be co-constructed during any communicative interaction (Clark & Brennan, 1991). Communication of content cannot be accomplished properly unless interactants negotiate both interactive process and content rules. As would be expected, these aspects are critical and possibly problematic for cross-cultural interactions. Communication requires an establishment of prior common ground (as would be expected by people of a
shared culture) and continual grounding (the ongoing process of interactive cross-checking to verify meanings are understood). In the case of cross-cultural conversations, because the prior common ground is lacking, actual ongoing grounding is doubly critical. More time and effort is required of physicians in diagnostic interviews with patients from different cultures. However the structure of “fee for service” remuneration (which tends to reward physicians who spend little time with each patient) mitigates against such grounding processes being adequately explored.

Differing cultures hold divergent beliefs concerning the meaning of their lives in relation to material and social contexts and thus they are also reflected in the meanings given to illness and death. For example, Hutterite people (common across the Canadian and American prairies) have not internalized the common cultural “fact” of individualism because of their agrarian and collective culture. They also do not have the same fear of death that has been postulated by some psychologists as a human universal (Stephenson, 1985). Individual illness and death is often a means for socializing and renewing bonds within and between communities. For example, in Hutterite culture women are intricately connected to the general well-being of the colony and do not suffer the same stereotypical problems common for women in mainstream western culture. Their place in society and their links to the means of production (agrarian) is on a par with men but after their youngest daughter has finished giving birth to her first child, their place in Hutterite society is problematic. Hutterite women of this age, unlike the men, then have very little social connection and become increasingly isolated.
For women in particular, illness is a means for reunification with friends and family. In general, the ideal death for Hutterites is long, lingering and social rather than the mainstream ideal conception of a quick and painless demise (Stephenson, 1985). Often medical practitioners and institutions are poorly equipped to understand these very different conceptions.

Homburger, Haruka and Wilson (1997) investigated such issues using a self-report questionnaire design and found that communication was reported as being augmented in diagnostic interviews with the use of a remote translator. They found that in California, 21% of visits to doctors involved patients who did not have sufficient skills in English and in 27% of visits, the physician could not communicate in the patient's language. In 20% of the encounters the interpretation was done by a staff member without training, in 36% a family member or close friend accompanied the patient and in 6% a remote interpreter was used. Both patients and doctors were measured to be more satisfied with the interview if there were translation services available where the translator was mediating conversations but they were not in the consulting room nor known by either patient or doctor. Patients who used the "remote" service were more satisfied that their communicative needs were being met and yet their privacy issues were better protected. Of course, while providing valuable information, this study did not identify the particular cultural heritage of patients nor did it investigate the numerous cultural belief systems surrounding conceptions of illness. Such an investigation would more than likely find that only certain
cultures would be more concerned with privacy and that others might prefer family members to be included in discussions (Stephenson, 2000).

**Power, communication and patient compliance**

To counter the problems with the way many physicians communicate with their patients, many medical schools have included at least some modules on interview skills. In general however, the way communication has been conceptualized by medical education in universities has been to problematize communication as the failure of the communicative process to convince patients to follow physicians’ treatment plans (Bertakis, 1977; Comstock, Hooper, Goodwin & Goodwin, 1982; Ley, 1983). Non-compliance was viewed as one of the major problems faced in healthcare and any such remedial actions with regard to the poor communication skills of physicians were designed to tackle the ability of the physician to be clear about the benefits of the treatment. Communication is thus addressed as purely “one-way”. The great majority of research of doctor-patient relations is therefore “doctor-centred” in that it is chiefly concerning the discovery of better strategies for physicians to exert greater control to gain compliance to legitimate medical authority. Not only is communication assumed to be a process in which the physician is “the actor” and the patient “the recipient”, inherent societally based power differentials are not seen as problematic. On the contrary, most of the “progressive” models of diagnostic communication seek to exploit this power differential even further.

Kreps, O’Hare & Clowers (1994) contend that although most industrialized nations have the capacity to offer technologically advanced health care, such
advances are of limited value if these systems thwart the effective use of communication in diagnostic interviews. Communication is a primary process used to collect relevant information before any of the technologically advanced mechanisms of modern western allopathic medicine can be applied. It is also the means to provide the patient with prescribed treatment strategies for which they will chiefly be responsible (Kreps, 1988). However, with the odd exception (e.g. 1998; Greenfield, Kaplan & Ware, 1985; Stewart & Roter, 1989) there has been no focused, systematic examination of the relationship between communication strategies in health relationships and health outcomes (Kreps, O'Hare & Clowers, 1994; Pettigrew, 1988).

In addition there appears to be a great debate as to what the measured outcomes should be. Some researchers prefer to define important health outcomes in terms of temporal benefits important more to health bureaucracies' evaluation techniques (Stewart & Roter, 1989). Other ways of investigating the relation of outcomes to communicative strategies has looked at alternatives taken by patients and physicians (Mully, 1990). However, Kreps, O'Hare & Clower believe that a better measure of outcome would result if we were to look at the actual effects on the individual patient. According to them such effects can be categorized as either cognitive, behavioural or physiological. To this end, they have attempted to construct a health communication model that is somewhat useful but is based on an artificial intelligence model. This model follows the flow of "inputs" (antecedents of healthcare such as risk, attitudes, beliefs and expectations), "processes" (communication issues such as particular physician-
patient pairings and the strategies used) and “outputs” (outcomes such as those mentioned above). The use of the AI metaphor is unfortunate because it conceptualizes the “flow” as one-way from inputs to outputs while assuming that “processes” are merely unimportant intermediary steps and transitory means to the end. Here the focus is on “goals” to the detriment of processes. The orienting assumptions to this model are both linear and only cursorily social. Societally legitimated power differentials seem to be outside the purview. In addition, they ignore the inter-penetration of attitudes, expectations, communication strategies and outcomes in this rather linear model.

More recently it has been recognized that the success or failure of diagnosis and treatment to achieve a successful health outcome is affected by the attendance of physicians to the needs, expectations, definitions of problems and requests for information as communicated by patients (Brody, 1987; Cassell, 1985; Charon, 1986; 1989; Helman, 1990; Weijts, 1994; Mullett & Coughlan, 1998). In general, compliance is viewed as the main criterion for judging the effectiveness of communication in medical consultations. More enlightened and newer research has discovered that even though compliance to doctors’ orders can be increased by better and more democratic communication, compliance becomes a moot concept if the patient can feel that their informational and communicative needs are met. In other words, if both patients and physicians overcome the power differential to work co-operatively for an agreed upon course of action then “compliance” is not a correct interpretation of patients’ decisions.
It is important to address and harmonize the patient-physician relationship during diagnostic communication so as to achieve a harmonization of world-views or explanatory models (Weijts, 1994). In this view, communication in diagnostic settings is properly viewed as a two-way dyadic phenomenon whereby the effective communication of both parties is seen as a necessary precursor to understanding symptoms in the context of the whole patient. Such a democratic construction of patient-physician communication has a greater potential to enable the diagnostic process and to solicit the support of the patient thereby gaining greater treatment co-operation than would be expected by authoritarian coercive strategies (Winefield & Murray, 1991; Mintz, 1992).

**Patient satisfaction**

There are at least two factors that encourage the success of communication in diagnostic interviews and both are related to better health outcomes and patient satisfaction. One factor that has been found to have a positive influence on the satisfaction of the patient and their appraisal of health outcomes was the degree of patient exposition of patient illness experiences in their own words (Stewart, 1984). Patients who reported being able to more fully discuss their feelings and expectations as well as their symptoms and were given the time to fully explore these aspects tended to be more "compliant" to the treatment regimen 10 days later. However this study was again primarily interested in the rate of compliance to the doctor-directed treatment plan rather than fully exploring the dynamics of a dyadic harmonization of perspectives. Similar results were reported by Winefield and Murrell (1991) regarding the
satisfaction of patients who were able to respond to their physician by communicating their feelings and expectations following the doctor's recommendation for treatment.

Jacob and James (1985) found that the ability of patients to communicate their stories about their illness was correlated to their satisfaction with the interaction but that this was not related to the rate of compliance to the doctor-directed treatment plan. Orth, Stiles, Schenwitz, Henrikus and Vallbona (1987) discovered in their investigation that the ability of patients to discuss experiences of their symptoms to their doctor was related to a substantial reduction in blood pressure two weeks later. Their findings also reported that patient satisfaction of communication with physicians reduces patient symptoms associated with stress. Similarly to the conclusions of Jacob and James (1985) they also found that such satisfaction was not related to rates of patient compliance.

According to an investigation into satisfaction among patients with their stay in Canadian hospitals (Charles, Gauld, Chambers, O'Brien, Haynes & Labelle, 1994) the most important problems are connected with communication. This study investigated hospital stays in six provinces using a questionnaire format and found that 90% of patients were satisfied with the relation of trust they had with their physician and reported that they had been involved in the decision-making process as much as they wanted. However, satisfaction with other communicative aspects was not as positive. Forty-one percent of patients said they had not been told about hospital routines, 20% had not been told about side-effects associated with medications given during their stay, 20% said they
were not given test results or not in a way they could understand and 36% of patients who underwent tests were not told how much pain they would experience. Similar problems ensued during the discharge planning as 39% of patients were not told of danger signals to look for after their stay, when they could expect to resume normal activities (reported by 32%) and what activities they could or could not do at home (29%). All of these issues were highly linked to patient satisfaction.

In a qualitative/quantitative study of British Columbian seniors' perceptions and preferences in their interactions with medical personnel, it was found that the great majority wanted a more democratic relation with their physician. Patients did not like being ignored or interrupted by their doctor and wanted a greater amount of time to fully discuss treatment options. They preferred to be involved in any clinical decisions and wanted their family physician to be informed regarding possible side-effects of medicines. It was seen as important for physicians to be aware of and communicate information regarding coverage for any pharmaceutical treatments under Pharmacare plans (Mullett & Coughlan, 1997). Physicians were reported as being uneducated on the many issues regarding side-effects, prescription interactions and as maintaining an authoritarian stance in relations with their patients. Patients reported that they often have to rely on pharmacists for checking medication and in some cases they have to revisit the physician to get a new prescription that reduces the danger of interactions. However, doctors believed that any administrative duty was not in their job description and in general seriously
underestimated the dissatisfaction of their patients. In fact, physicians seemed to have a very poor grasp on the opinions of patients on a wide-ranging number of medical and interpersonal issues (Mullett & Coughlan, 1998; Brunt, Chappell, McClure & Cassells, 1998).

In another study conducted in the Victoria Health Region in British Columbia, senior participants expressed concern regarding communication and care they received while patients in the district’s hospitals. Some patients reported good care but contextualized these observations with considerations of how overworked the staff were, owing to cuts in funding. Others were made to feel as if they were “problem” patients because they needed assistance and sometimes this was unforthcoming from staff. Many patients perceived themselves to be helpless while in hospital and felt that it was up to them to try all manner of strategies to avoid confrontations with brusque, impatient or uncaring staff. Their lack of power in this medical setting compounded the vulnerabilities they felt because they were ill. Patients expressed a desire to be treated in a more caring and respectful manner (Stephenson & Holmes, 2000).

Clarke and Mishler (1992) investigated the interactional communicative content of two case studies of doctor-patient interviews and looked at how doctors communication had profound effects on the relationship and medical outcomes. In one of the case studies, the physician continually interrupted the patient in their effort to tell the story of their symptoms and continually reinforced the structural power differential between the clinician and patient. Whereas in another, the physician and patient communicated democratically allowing the
history to be given in the form that met the patient's needs to communicate in their chosen narrative form. According to the findings, patients in an interaction need to set the scene to give a full account of their problem including important contextual variables. They also need to negotiate the topic and towards the end of the encounter, clarify the meaning of the medical action to be taken and understand the consequences (Clarke & Mischler, 1992).

In a phone survey of 219 patients, regarding the link between patient satisfaction with their healthcare and satisfaction with physician's communication, Buller and Buller (1987) found a high positive correlation (r = .84). In addition they found a highly significant correlation (r = .80) between reports of patient satisfaction and a highly affiliative style of physician interaction as well as a medium negative correlation (r = -.34) between satisfaction and a controlling style of interaction. Several mediators were discovered including severity of illness, gender of patient, age of patient, length of time waiting for appointments and frequency of physician visits. Less severely ill patients rated non-affiliative physician communication styles much more harshly than severely ill patients. Patients with more severe illness are less concerned with the physician's communicative style and tend to elevate the importance of technical competence. Gender did not affect reports of satisfaction with regard to communication style but females were far more satisfied than males, overall. Younger physicians were judged more harshly than older physicians with regard to communication style and older physicians therefore were rated higher overall. The investigators interpreted this to mean that older physicians are perceived to
have more status than younger physicians and thus patients allow them more latitude in their communicative behaviour. The physicians' communication style was more important to overall ratings of healthcare by less frequent visitors and patients who endured extended periods of waiting were also less satisfied (Buller & Buller, 1987).

The amount of time spent by physicians with their patients is positively correlated with evaluations of the doctor. This is explained as influencing patient perceptions regarding the physician's caring attitude and giving patients greater opportunity to receive more information (DiMatteo, Prince & Tantara, 1979; Smith, Polis & Hadac, 1981). However, a surprising finding of the investigation by Buller & Buller (1987) was that patient satisfaction was found to be inversely related to the amount of time physicians spent with patients. People tended to rate the physician's competence based upon whether they liked their style of communication, which means that overall competence perceptions are based heavily on whether the doctor communicates a caring attitude which is not necessarily linked to the amount of time spent in interaction (Buller & Buller, 1987).

While Norton (1983) has described nine styles of communicative interaction (namely dominant, dramatic, contentious, animated, impression-leaving, relaxed, attentive, open, and friendly) the literature on communication styles has identified two styles that seem to be especially important in forming patient perceptions. One of these is "affiliation", characterized as behaviour that establishes and maintains a positive relationship. Behaviours linked with an
affiliative style are friendliness, empathy, warmth, genuineness, compassion, honesty, humour and authenticity. These behaviours were found by many studies to be linked with patient satisfaction with their physician (Ben-Sira, 1980; Collins, 1983; King, LaGrone & Miller, 1984; Street & Wieman, 1987). The other communicative style that figures prominently in the literature is “control” which is deployed to maintain the physician’s authority during an interaction. This is characterized by a power differential fueled by lack of information-sharing by physicians as well as communicative behaviours that circumvent patient agency such as question-asking and opinion-giving. Such a style builds upon status differentials and tends to increase patient anxiety and socializes patients to become passive (Ben-Sira, 1980; Waitzkin, 1985; Lane 1983; Lavin, 1983; Street & Wieman, 1987).

It has sometimes been remarked that in many research investigations the rate of dissatisfaction with health care in general and especially communication with clinicians may well be considerably higher than results portray. Reasons offered include the internalization of social norms that has the effect of socializing patients to redefine an unsatisfactory experience as “acceptable”. Patients may believe that such experiences are “par for the course” and/or their internalization of other social norms tend to make them reluctant to criticize the “legitimate” authority figures such as medical practitioners (Street & Wieman, 1987; Buller & Buller, 1987).

Ben-Sira (1980) explained that patients’ perceptions of a physician’s caring attitude (referred to as “affiliation”) is linked to the communication of
"emotional" variables through non-verbal means. While this investigator may well be correct to include emotional aspects to communication as being important to patient perceptions, his link of non-verbal means to emotions is rather tenuous and can be viewed as dualistic. Such a view that separates emotional aspects from content factors and then correlates verbal communicative acts with content and nonverbal communicative acts with underlying emotional contexts is following from communication theories consistent with Ekman (1972;1973), Ekman and Friesen (1975) and Burgoon, Buller and Woodall (1988). However, many more progressive and rigorous investigations of face to face communication have demonstrated that this dualistic view linking verbal with the rational and non-verbal with the irrational (or emotional) is not empirically supportable (Coughlan, 1995; Chovil, 1992; Bavelas, Black, Lemery & Mullett, 1986; McNeil, 1985; Kraut & Johnson, 1979). Verbal communicative channels have been demonstrated to be equally adept for the communication of emotional contexts as non-verbal channels are at communicating content. The conclusion of many communication investigations is that there are not two separated channels but one communicative process that uses all available means to communicate divers aspects, depending on the particular communicative and environmental contexts as well as personal style (Coughlan, 1995; McNeil, 1985).

Mitigating factors against patient agency

As has been demonstrated in the preceding section many patients are dissatisfied with the relationship with their physician and prefer to be treated as
“whole” people contextualized in their lives and want a more democratic interaction with health professionals. However, it is interesting to note that although the research demonstrates that patients generally lament the poor relationship between themselves and physicians, several studies have concluded that there seems to be a reticence for patients to become more actively involved (Beiseker & Beisecker, 1990; Tabak, 1988). Other health communication research has shown that infrequent questions directed towards physicians are often accompanied by different speech disturbances and nonverbal behaviours that seem to demonstrate a feeling of discomfort for patient-initiated questions (Heath, 1992; Frankel, 1990; West, 1984). While patients often feel they need to accept the social script for these power saturated interactions, they betray their dissatisfaction in these subtle ways. This seems to be especially true when questions are concerning actual medical information such as the results of tests or an explanation of the causes behind symptoms (Weijts, Widdershoven, Kok & Tomlow, 1993). One of the reasons posited for this reluctance is that it may be perceived as threatening or disrespectful towards the physician to be insistent on matters of medical expertise and such behaviour carries with it some risk of sanction by the physician (Ten-Have, 1991).

The lack of explicit behaviour by many patients to become more vociferous in diagnostic interactions should not be confused with a general trend towards satisfaction with the status quo. While some patients may well feel satisfied with the traditional power imbalances and accept such interactions as “normal”, one needs to look beyond some more narrow definitions of
communicative behaviour to understand the nuances indicative of dissatisfaction.

Some studies (either more observational or qualitative in approach) have widened their purview to include an analysis of behaviours that might be more explanatory of patient experiences and desires for communicative interaction. For instance, an ethnographic analysis conducted by Stimson and Webb (1975) found that although it was true that many patients were indeed reticent to become more active, a lack of direct communicative behaviour was also accompanied by grumbles, moans and barely audible comments. Thus it could be concluded that patients are perhaps aware of the rules in this power-saturated interaction but are not altogether comfortable with them. They have internalized a model of this form of interaction and realize that this situation allows few opportunities for resistance strategies. Other studies have demonstrated that some patients whose issues are ignored by their physician react to this situation in indirect forms: showing their impatience in ways that do not directly bring them into conflict with the physician (Weijts, Widdershoven, & Kok, 1991; Davis, 1988). Other research demonstrates that more direct resistance strategies, if utilized to gain some form of control in the interaction often led to physicians labeling patients as “problem patients” (Mullett & Coughlan, 1997; Porter & McIntyre, 1989; Porter, 1990; Street, 1992; Ten Have 1991).

Patient agency

According to Waitzkin (1985; 1984), patients have a general tendency to be very passive in diagnostic interviews and rarely initiate discussion or interrupt
physicians to make their opinions known. In his research he found that over 24% of patients believed that important topics had been discussed when in fact they had not. This could be interpreted as a warning against an over-reliance on self-report data in the investigation of satisfaction with medical institutions and personnel. However, these results also raise several questions not addressed by the author. How much does patient faith in the physician colour perceptions about physician behaviour? Are patients assuming that their inability to recall information is due to their poor memory rather than stemming from the physician's omission? Either of these two possibilities, alone or together might lead to a reasonable explanation. If any of them were to prove valid it would tend to demonstrate that many patients have internalized the role of passive patient relative to models of an authoritative physician and reconstruct communicative encounters in which they abdicate personal agency.

People tend to only seek medical advice and become subjects of the healthcare system when they are sick and are generally viewed as primarily passive - hence the use of the word "patient". They are strangers in a system which is unusual in terms of their everyday life and their normal level of stress is heightened by illness: both of which are factors that will tend to make them more accepting of passivity in interactions (Schoor & Rodin, 1982). They feel a diminished capacity to exert normal control over their physiological and mental well-being as well as their environment (Bandura, Adams, Hardy & Howells, 1980). When patients seek the assistance of a medical practitioner they are conveying the message that they feel they do not have the competence to deal
with the situation of illness on their own. Thus, feelings of reduced agency are a natural consequence. Medical practitioners have learned they have informational power as well as power derived from their position as insiders within the administrative structure of healthcare organizations (Brody, 1980). Thus, all structural and interpersonal factors contribute to the construction of patients as passive.

The literature regarding the consequences of loss of control indicate that those who endure stressful situations where they have little control over their environment will as a consequence endure deficits in both psychological and physiological health (Schoor & Rodin, 1982). Early laboratory experiments on stress have shown that objective measurements of actual control and measures of perceived control both affect stress but that perceived control seems to be the major determinant of negative outcomes. (Bowers, 1968; Geer, Davison & Gatchel, 1970; Kanfer & Seidner, 1973). Having little control over situations tends to lead to either increased anxiety while the person attempts to re-exert control or to a generalized reduced capacity to affect changes even in situations which are easier to control, a situation often referred to as “learned helplessness” (Seligman & Maier, 1967).

Some studies have found that simply increasing the amount of control a person has will not always reduce stress and thus improve psychological and physiological variables. Having control for some people can in itself be stress inducing when it is not seen as desirable (Averill, 1973; Thompson, 1981). The beneficial effects of personal agency occur within the overall context that a
particular example of control is embedded. In addition, the overall context is judged in terms of the appraisal of a particular situation with the meaning system the individual has developed about similar situations. Thus, the benefit of control may well be linked to an appraisal of how agency is likely to reduce the perception of danger in any given situation. If agency or personal exercise of control is likely to be perceived as changing the meaning of an event from one that is unendurable to one that is manageable, then it will be viewed as desirable (Thompson, 1981). Alternatively, if control over a situation will not reduce the perception of danger associated, it will not lower stress and therefore not be seen as desirable. In such a situation the person would see it as quite rational to give up power to others or the situation. Any move to cajole an individual who has such an appraisal will actually result in an increase of stress and will render them susceptible to poorer outcomes (Rodin, Rennert & Solomon, 1980).

It is important to distinguish between the belief that one has an opportunity to exercise personal agency and the perception that one is well equipped to deal with the control effectively. The difference exists in a situation where somebody perceives that some control is effectively open for them but decides not to accept the responsibility because they feel they are not competent. Alternatively, somebody may assess their skill level in an area quite highly and yet find themselves stymied by structural and/or bureaucratic means from exercising their agency (Schoor & Rodin, 1982). In general, a great deal of the literature has confounded this difference. The perception that one has the competence to avail themselves of control has been discussed in terms of a
concept of "self-efficacy" (Bandura, 1997;1977). It has been demonstrated that greater feelings of self efficacy lead to greater efforts at coping with an aversive situation and that greater self-efficacy is associated with lowered levels of fear (Bandura, 1997). Thus it could be concluded that those who are given some form of control but don't feel competent to take advantage would then experience this as aversive and react with fear which in turn would lead to poorer health outcomes. However, this situation could be ameliorated to some extent if self-efficacy is bolstered by the provision of greater information. In a health-related situation one of the factors which is crucial to whether a person would desire greater control or not is sufficient relevant knowledge, as provided by clinicians. Those with little knowledge may well be content to enter into a "traditional" relationship with their medical practitioner, where the practitioner has a more authoritative relationship with a relatively passive patient. This is particularly true for those who have been socialized to expect little agency in general. Indeed, because of general socialization, structural institutional barriers and interpersonal communicative strategies, this perception of patient inadequacy has become a reality for many patients and is assumed by the majority of clinicians. Generally, this works against the best interests of patients and against efficacious clinical intervention but supports the hegemonic interests of clinicians.

In conclusion the research in the area of physician patient interaction shows that there are inter-personal and structural barriers to supporting the agency of patients to be the best proponents in their own health interests. In practice, at the site of interaction between patient and health institutions,
scientific medicine tends to assume a model of the patient that divorces the separated biological systems from psychological and social/cultural contexts. Thus a dualistic model is employed both in terms of the abstracted biological model of intervention as well as in terms of the separation between expert medical authority and compliant patient. Physicians tend to apply Plato's master-slave version of interaction by employing discursive strategies that augment their own interests in maintaining a power imbalance between elite professional practitioners and lay persons experiencing illness. Patients generally only come into contact with health institutions and professionals when their health has deteriorated and thus they tend to feel heightened levels of stress and limited power because of their illness. This is often exploited further by the institutions and their personnel, in part because communicative strategies that preserve elite power are rewarded under "fee for service" remunerative structures. The research presented in this chapter demonstrates that health outcomes are improved and physicians can be more effective practitioners if patients can exert a greater expression of their agency. However, the structures and social relations within health systems in the industrialized west (which assume a dualistic meta-organizational paradigm) seem mostly impervious to restructuring on the basis of scientific findings from both psycho-immunology and social-science.

The situation in the case of the medical management of child-birth appears to be little different than the management of other health concerns with regards to the structure of intervention or social relations. However, there exists a striking difference in the situation as child-birth can not properly be classified
as an illness even though medical procedures assume this to be the case. Physicians and medical institutions tend to simultaneously reduce the agency of the labouring mother and augment the power of medical professionals even in the case of the natural occurrence of a low-risk birth (Pallas, 1992). Labour and delivery is organized around and subject to the same medical interventionary agenda which stresses the power of medical institutions and personnel utilizing technological monitoring and diagnostic tools even though a great deal of scientific evidence does not support this model (McNeil, Hodnett & O'Brien, 1992).

The following chapter will outline the design of the qualitative investigation into the experiences, opinions and levels of satisfaction/dissatisfaction of expecting and new mothers with the health care they received in the Capital Health Region in Victoria, British Columbia. The participants interviewed in this investigation received pregnancy and labour care from different types of practitioners with sometimes divergent assumptions concerning the relation of biology, psychology and society, as well as different structural, ideological and interactional aspects to their models of practice. The major comparison under study concerns differences in experience for mothers who chose midwifery (which assumes a more holistic model of health along with a more democratic relationship between patient and clinician) and those who chose physician services (which tends to assume the dualistic model of medical intervention and a more authoritarian model of interaction). A qualitative design was used in order to partially redress the power imbalances inherent in many social-scientific
designs by allowing the participants to fully explore issues that are of interest to themselves. This empirical investigation expects that perceptions of personal agency will feature prominently in the participants' narratives and such a research design that attempts to promote participant agency is best suited to the full exploration of their experiences.
Chapter 7
Method

Rationale for Method

An investigative approach is needed to explore patient issues that reduce investigative power imbalances often encountered in mainstream research practices, and allowing greater agency to participants. A more anthropological orientation to social and cultural meaning creation tends to reduce unequal power relations between researcher and subject of research. The use of in-depth, open-ended, semi-structured interviews with participants substantially reduces the power imbalance between researcher and participants because the interviewees are encouraged to discuss their own areas of concern in as little or as much depth as they choose. Participants are also free to contextualize their experiences and opinions as they see fit. Therefore, this technique provides data that is vastly enriched by the participants' agency. Participants provide data on the substantial areas of concern as well as insights into how they construct the meanings of the concepts they use to understand their reality. In many cases the participants themselves may find the discussions cathartic.

The present research project attempted to overcome the problems of administrative and medicalized biases that assume certain constructions of patient opinion and experience, by utilizing a qualitative open-ended interview protocol. Consequently, while ideological commitments and orienting preconceptions cannot help but be present in any design, there is less of a tendency for open ended qualitative analyses to be guilty in merely replicating
the uneven power dynamics of medicalized or government sponsored healthcare research (Grace, 1991). Interviewee participants in these partly structured discussions are encouraged rather than constrained in voicing opinions in as much depth and regarding as many aspects that seem important to them.

General Overview

The purpose of this study was to elicit the opinions of new mothers in the Greater Victoria Health Region regarding their satisfaction with the present health delivery system and how medical relations and the utilization of communicative strategies either promote or interfere with patients' perceptions of agency. This investigation was interested in examining the experiences and opinions of new mothers with regard to the care they received surrounding the birth of their most recent child and their views on the healthcare system in general.

Previous qualitative research (e.g. Mullett & Coughlan, 1997) suggested that patients may be more satisfied with physicians who are female as opposed to male and with physicians who have more time to interact with their patients. The latter finding may indicate that satisfaction would be higher with physicians paid by way of salary rather than fee for service. In addition, since January of 1997, prenatal, birthing and postnatal care as provided by midwives (including home and hospital births) have been included in the services covered by B. C. Medical Services Plan. Thus, in addition to comparing the experiences of patients of male and female physicians, physicians who are remunerated by salary versus fee for service, a further comparison was made to investigate the
experiences and opinions of expecting mothers who chose midwifery services under the new plan.

Participants

Participants were contacted through various means. Signs inviting participation were posted in public places frequented by new mothers and some participants answered these requests. Other recruitment means included approaching personal acquaintances to volunteer and posting requests for participants at various pre-natal classes, post-natal classes and mothers' drop-in centres throughout the Greater Victoria Health Region. The intent was to interview as broad a spectrum of new mothers as possible. The patient group was a convenience sample and consisted of 40 new mothers who gave birth in the Greater Victoria Health Region between the introduction of paid midwifery services in January 1997 until January 1999. The participants' ages ranged from 19 to 45, were of divergent socio-economic status and the sample included both married and single mothers. Ten mothers were recruited in each of the following four categories: those who consulted male physicians who were paid via traditional fee for service; those who consulted female physicians paid via fee for service; those who consulted with physicians of either gender who were paid via salary; and those who consulted licensed midwives.

Patients were fully briefed beforehand regarding the general subject matter of the interview in order to facilitate their informed consent to participate and all were volunteers. Their expressed written consent to the interview, the purposes and a declaration by the researcher regarding the use of their data was
obtained (see Appendix B). All participants were also debriefed at the end of the interview and given information concerning how their interviews would be used as well as information concerning how to contact the researcher should they have any further questions or wish to add supplementary information.

Research protocol

The design was approved by the ethics review panel at the University of Victoria. Once prospective patient/client interviewees had volunteered to make contact with the research office, each was provided further details of the research project and informed that the interviews would take approximately an hour and a half. Participants interested in volunteering were invited to decide on a time and place of their own choosing for the interview to take place. All participants chose to be interviewed in their own homes to accommodate their unique infant care schedules. The shortest interview lasted 45 minutes and the longest, approximately 2 hours. Prior to the interviews, participants were informed that they were free to end the interviews at any time should they so choose. The protocol encouraged the discussion of issues as deemed important to the interviewees, and some chose to provide a more lengthy and/or enriched narrative of their experiences and concerns than others. All interviews were audio-taped. During and after the completion of each interview, notes were made by the researcher concerning general demographic variables of the participant and their family (e.g. living arrangements, employment status, age) as well as note-worthy and/or important aspects of their discussion.

The interview protocol included questions pertaining to participants'
background, present living circumstances and unintrusive demographic variables. The main discussion was broached with broad, open-ended questions regarding a number of broad subject matters related to their experiences with the healthcare system. They included the pattern of health service use; opinions of the health system in general; experiences with their physicians; opinions and (if applicable) experiences with midwives; opinions and (if applicable) experiences of alternative medicine and alternative practitioners; experiences with public health nursing services; general experiences of support; experiences during the prenatal, birthing process and postnatal periods; experiences of choice in dealings with the system and their practitioners; level of anxiety experienced; level of satisfaction with clinicians and health institutions; perceptions of any power differentials; perceptions of agency/independence and their ideas for improving their interaction with the health system and their clinicians. (See Appendix A for the full open-ended interview protocol).

All participants' audio-taped interviews were coded to protect the anonymity of the participants. In addition, interviewees were appraised that all references to other people mentioned during the course of discussions would not be mentioned in any report. Other than the researcher, no other person would listen to the audio-tape. Each participant was advised that the taped interviews would be kept until the analyses are completed and then destroyed.

The protocol was semi-structured interviews allowing considerable participant control over the discussion of subject matters of interest to themselves as well as the order and depth of discussions. However, certain key
areas of opinion were sought and in some cases the interviewer elicited opinions on these critical areas when the subject matter was not addressed by participants. In other words, interviewer prompting of participants' discussions occurred in cases where critical areas of interest were omitted or hastily sketched out during the naturally polymorphous flow of the conversation. The interviewer noted such occurrences in order that these subjects might be broached at a convenient juncture during the interview process. The areas for discussion and the open-ended questions functioned in many cases as a checklist rather than a formal question and answer session. Questions at the beginning concerned inquiries into demographic information, a summary of important aspects of their life and their understanding of “independence” in the context of their experiences in general. These questions were asked of every patient participant. However, when approaching the substantial areas concerning health experiences, many participants freely discussed most of the areas of interest with little further formal question presentation by the interviewer. Only those areas not discussed were noted for introduction at a convenient time. Thus, participants had considerable control over the order of presentation of their experiences and opinions.

The question concerning “independence” for the patient/client section was introduced at an early stage of the interview so that information could be obtained regarding how participants understood this concept in general. Introduction at a later date was found in pilots to be too contextualized by their already expressed opinions on health. While patients knew ahead of time that
health experiences were the main area of the discussion, when introduced near the beginning, participants' discussion of independence was far more general. In pilot interviews it was discovered that concepts such as “agency”, “self-efficacy” or “locus of control” were poorly understood and resulted in very halting and poor descriptions. Independence was the nearest concept to agency that elicited a more general discussion of their experiences in acting in their own interests.

A qualitative thematic content analysis was completed on the recorded discussions of experiences and opinions of the participants. Although some broad critical areas of concern were identified beforehand by the protocol, the bulk of the analytical process (including the identification of major themes and patterns) was dependent on and directly generated by the participants' concerns and experiences as freely discussed and recorded.
Chapter 8

Results (Patient / client interviews)

The results presented in this section represent the main patterns in opinions and experiences as communicated by the participants. As mentioned previously the volunteers were divided into four groups depending on their self-report of how they accessed prenatal and maternity care. The themes that emerged from the analysis of the interviews are presented along with representative quotes. The participant associated with each quote is denoted by the following abbreviations: midwifery clients are identified by “MID”, clients of female doctors paid through fee for service are identified by “FF”, those accessing services through male fee for service are identified by “MF” and those who normally receive care by salaried physicians are identified by “JB”. It should be noted that the only place in Capital Health Region where salaried physicians were practicing at the time of this research was at the James Bay Community Centre.

The new mothers who volunteered came from a broad cross-section of the community in the Capital Health Region. The sample included married and single mothers, encompassed the whole spectrum of educational attainment and socio-economic conditions. Some were working, others were stay at home mums, a couple reported being under-employed and two others were students. Each of the four samples from the previously mentioned models of clinical care was also generally very heterogeneous. There were only 3 important demographic differences found between these groups of new mothers.
Volunteers who reported normally seeing a salaried general practitioner tended to be from the James Bay area of town because at the time of this study, this was the only project of its type. In this group, the social-economic status tended to be on average, slightly lower relative to the other three groups. Whereas the other groups included a few people who were quite wealthy, the participants from the James Bay Centre were working or lower middle class mothers. The volunteers who chose midwifery services tended to have a higher educational attainment level than the other three groups, who reported similarly heterogeneous educational levels.

Table 1: Participants demographic profile

<table>
<thead>
<tr>
<th>Type of Clinician Chosen</th>
<th>Participants Mean Age</th>
<th>Participants’ Mean Post-secondary Schooling (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Physician (fee for service)</td>
<td>25.8</td>
<td>2.0</td>
</tr>
<tr>
<td>Female Physician (fee for service)</td>
<td>26.1</td>
<td>1.75</td>
</tr>
<tr>
<td>Salaried Physician</td>
<td>24.7</td>
<td>2.2</td>
</tr>
<tr>
<td>Midwife</td>
<td>28.3</td>
<td>4.1</td>
</tr>
</tbody>
</table>
Less educated and economically poorer new mothers and those who were also younger had a harder time in giving their opinions in general. They found it relatively more difficult to freely discuss the issues, preferring the interviewer to be more interventionary in asking more specific, “closed” questions. Less educated and poorer participants tended to answer questions with less elaboration.

Participants initially tended to indicate that they were relatively satisfied with healthcare in general unless they had experienced an extraordinary difficult relationship with a clinician and/or a medical institution, or had experienced difficulty in receiving appropriate treatment for chronic illness. However, while initial statements sometimes indicated a reasonable level of satisfaction, further elaboration tended to gradually explore issues with which participants were more dissatisfied. New mothers who preferred the interviewer to be more interventionary and to reframe questions as less open-ended, and were less elaborate in their discussions tended to discuss problematic aspects much later in the interview process.

Most interviewees reported that they didn’t really spend much time thinking about their health before they became pregnant. Many new mothers found they became more interested in general health, preventative health or nutrition once they either became pregnant or after their baby was born.

*We're a really healthy family – I never really thought about it – well, not until I had my first child did I think about it (MID 12)*
Umm - when I was younger I didn't go to the doctor much — there's this feeling that I am wasting everybody's time. Since I had children its changed a bit — it's forced me to realize when I need help (MF7)

Health didn't kick in till I was pregnant with (baby's name) — now its extremely important, you know (FF1)

Ahh — it's the kind of thing I don't think about until you get sick — but I've always been healthy — I'd rather not think about it — I tend to keep it in the background. Now. of course it's different (MF9)

Participants who either experienced a major health concern, or were closely related to somebody experiencing a major health concern, indicated a greater interest in health previous to becoming pregnant

My father died when I was 20 — he was 58 — of a heart attack - and before that I never thought about it — then I started thinking about heart attacks and skin cancer — 'cause I'm so pale (MID 10)

Not important — I didn't think very much about it until I ran into some problems in my mid 20's. I've been more focused on my health — one of my pap tests came back a bit funny (JB1)

I was surrounded by people with disabilities all my life and I married a guy who's a paraplegic so it's been on my mind since the beginning (MF8)

Because of my experience with cancer I think more about than other people in their 20's (FF2)
Some participants made an explicit connection that their understanding of health is linked to nutrition and exercise

*I had an ovarian cyst when I was 16 and I was horrified with that – the example I was given growing up is that you’re in charge of your health in that what you choose to eat will have a result* (MID6)

*When I got sick it was because I was stressed – or I’m not eating properly* (MF2)

*It started with healthy eating and that’s how health became important. I was the oldest one and I was responsible for making dinner* (FF3)

**Independence**

Participants who were relatively economically disadvantaged and who had lower educational attainment tended to have more difficulty in communicating how they understand the concept of independence. However, when further encouraged to give examples of the types of things that would either augment or impede their sense of independent action in their everyday life, these participants tended to provide reasonable descriptions.

The overwhelming majority of patient/client participants discussed the meaning of independence as linked to an ability to make choices in their lives.

*Having the freedom to make choices that feel right* (MID6)
Being able to stand on your own feet – make choices for yourself (MF9)

Choice – the ability to make choices – I guess without a time frame (JB5)

Being able to choose (MID11)

In addition, when discussing how they understood independence a very strong theme was that patient/client participants described how they understand independence in terms of economic issues. In other words, they described how having more money and greater financial security would increase a sense of their ability to make more choices. Greater financial security was mentioned by interviewees regardless of their reported social-economic status.

Financial independence? My husband and I are just scraping by – not needing financial support (JB7)

Looking after my own financial business (MID12)

Love to win the lottery – wouldn’t have to work (JB4)

Financially secure – having a job. Money – being able to rely on yourself financially (JB3)

Business allows us a lot more freedom – it would be nice to have the financial (MF3)

Other participants (primarily those who were more educated or expressed an interest in attending institutions of higher education) also described how having
knowledge and education also gives a greater sense of independence in attaining their goals and making informed choices.

*Being able to choose – having all sorts of information so I can choose what I want to do (MID11)*

*Being at Uvic – getting an education and being able to make choices (MID12)*

*Knowledge – it depends on what I'm doing but the more you know - you can come to your own conclusions (FF9)*

*It doesn't mean I have to know everything – but knowing the steps to take to get the information about how to access things (FF3)*

In addition, greater educational attainment and/or expressed interest in returning to a higher educational establishment was highest in the group of mothers who chose midwifery services. The average years of post-secondary schooling for the midwifery group of mothers was 4.1 as compared to 1.75 for mothers who consulted female physicians for their last pregnancy, 2.0 for mothers who consulted male physicians and 2.2 for mothers who consulted salaried physicians.

Only 5 out of 40 interviewees discussed independence as “inter-dependence” when asked to define their understanding. These participants were consciously aware of their identity as being independent through their inter-dependence with others and explicitly noted this. Their interconnectedness with others was
described as supporting the ability to providing at least the potential to make their desires and needs a reality. In addition, those who defined independence as linked to inter-dependence also tended to have experienced life in a variety of cultures or are intimately connected to others from another culture. Three of the participants who contextualized independence with inter-dependent and supportive relationships, elsewhere reported cross-cultural experiences as important in their summary of important life experiences. The other participant reported being involved for a considerable time in a religious community that was based on mutual support. In addition one participant’s definition of independence as linked to inter-dependence seems to be at least partially owing to a history of close relationships with disabled people.

Being with my Peruvian family – its different because I see this more linked to relying on each other (MID8)

....but I don’t mean you don’t have that inter-dependence in your life because that’s a very important part of it. It’s not having to have support (MF9)

Its huge – I had a friend who had (a debilitating and progressive chronic illness) and it was a major thing and we talked about it in terms of inter-dependence – and then in my life it seems to apply to me too (MF8)

Being in a relationship where we can rely on one another (JB5)

Probably being able to do things on your own but also being able to get help – depend on somebody when you need to (FF7)
A much greater proportion of participants reported that their sense of independence was supported through an inter-dependent relation with their clinician. Whereas (as reported above) only 5 interviewees reported their sense independence as supported by inter-dependence when asked specifically about this at the beginning of the interview, many more described a clinical inter-dependent basis of independence, given their definition as linked to "choices" and "informational needs linked to choices". These statements were made later in the discussion of their clinical relationships. In every case their clinical relationships were characterized by a feeling of personal control in making decisions regarding clinical options or "choice" or in having the information to make clinical choices. 4 out of 30 of the interviewees who consulted a physician discussed their sense of independence as supported by the clinician/patient relationship. However, 7 out of the 10 mothers who consulted midwives reported that that their needs for independence (as choice and information) were augmented by their clinical relationship with their midwife. In other words, fully 70% of midwifery clients freely discussed how their interactions with their clinician made them feel better equipped and more confident in their abilities to negotiate the psychological and physical aspects of pregnancy and childbirth. In addition, they reported that the relationship gave them resources for making informed choices in relation to healthcare services, in general. Supporting quotes for these findings can be found in the midwife section, included later.
While the majority of new mothers expressed their understanding of independence as the ability to make choices, a small minority of new mothers expressed another version of independence that was defined as escaping feelings of restriction, or as “freedom from”. In some of these cases, the description of independence was at first a negative version and later elaborated to be concerned with a freedom to choose, or “freedom to”.

It’s a big concern – especially as a teenager and about conflict with parents – having the freedom to do what feels right (MID6)

Relying on yourself – not depending on anyone for anything – you can then do what you want (MF2)

Being independent from anyone else (JB1)

Getting out of my parents place and getting my own family – independence from them (MID2)

Clinical Relationships

There was not a noticeable effect of clinician gender on reports of satisfaction or dissatisfaction from patients. Satisfaction was linked to certain specific clinician behaviours and attitudes. These new mothers had experienced problematic as well as highly satisfactory treatment from both male and female physicians. Overall, one of the most surprising findings was that many new mothers interviewed experienced problematic relationships with physicians of both genders. The great majority of these problem relationships were reported as
being due to a general feeling that many physicians lack care and respect for patients.

The types of occurrences that communicated an uncaring attitude to these interviewed patients were generally linked to problematic communication. Many of these aspects are very closely related. They were (in order of importance):

1. physicians adopting an aloof, overly authoritative or judgmental stance during consultations

   *He was a little bastard who thinks he knows everything – when I go to the clinic I refuse to see him. He told my daughter “Be quiet – this doesn’t hurt”. Don’t tell her that if she thinks it does! This isn’t about you, mister (MF7)*

   *Cold people – you know – real dooms-dayists. Asking would be nice but I’ve never had that. When she wrote that letter – I just wanted another doctor. She’s to the point and I’m not asked (MID1)*

   *He’s fine if you want to be told what to do (MID4)*

   *There was no discussion about it – he never touched me (MF9)*

   *He brings people in to look at you – it’s done in such a way that you can’t say no – I don’t want it (JB9)*

   *She was giving me shit for having a short fat baby, like it was my fault rather than she had done the calculations wrong (MF2)*

2. physicians not listening to patients’ concerns and not considering patients’ knowledge of their own bodies or ideas concerning their illness
She wasn’t taking me seriously – I just remember - she wasn’t treating my condition and what I know, with respect. She wouldn’t even examine (JB8)

I went to the hospital because I was in pain but they just gave me Tylenol and sent me home - It turned out later that I had a gall bladder problem – they weren’t listening (MID5)

I thought she pushed her opinions a lot – I think she must have had shares in IUDs or something – trying to get me on to that. I told her three times that I wasn’t interested but she kept going (FF9)

He just says “no, no, no – don’t even think about it – its my job to read all these scientific things” – basically saying I’m an idiot and what information can I add?(MF7)

....and she’s gotten funny too. Before she’s in the door, she’s saying “well, I hope you’re not in here for a cold”. She doesn’t even know me from a hole in the ground and she wouldn’t even look at her. She was incompetent – she wouldn’t even listen to me. Two days later I went to the clinic and the doctor there says she has bronchitis (FF7)

3 Physicians not answering patients' questions

He just came in and said “we’ll be putting tubes in his ears” – he didn’t even look at him. He said you won’t have any questions – all the answers are on this sheet
— but all there was, was a list of penalties if you don’t do this or that — and how you would be billed for any long distance phone calls to the office (FF2)

I asked him what the affects of the birth control pill were and he just said “a lot less than the affects of becoming pregnant”. He wouldn’t answer my questions. He was really gruff — and wasn’t impressed — and I said, bloody hell! — I’m taking control of it! (FF8)

She answered my question vaguely — like who cares? I thought she was condescending (MID6)

I always had to ask and his answers were always too short. I never felt entirely comfortable asking (MF9)

4 Physicians and/or medical institutions that make patients feel demeaned or dehumanized. (These are more extreme variants of previous categories and the majority of really awful treatment reported by patients concerned male doctors)

He had the bedside manner of Idi Amin. They put you in a shimmy with no slippers. He didn’t ask me anything and didn’t care I felt uncomfortable. Nobody says “hi” and then he just examines you (MF5)

A lot of doctors see people as just “fat” (FF9)

I would go in for a PAP test and he would be making jokes about me the whole time — and another time he grabbed me and said “well, you’re putting on a bit of meat”. You can’t say things like that to a young woman (FF5)
He had a horrible bedside manner – he just looked at (baby's name) and said
"Yeah, he's got it" (serious disability) – it's like he was talking to a pound of ham
or something (FF3)

They treat me like – because I'm part native – I must be a drunk or something –
or a drug addict. This doctor tried to lecture me about taking care of myself better
and not drinking while I'm pregnant (MID5)

I had an abortion because the father was violent and she didn't treat me right
after that – I could tell – she looked at me different. Wouldn't talk to me – just
cold – so I felt even worse (MF7)

5 physicians who implicitly or explicitly communicate their antipathy to
various alternative healing practices

Home birth, when it was mentioned was some crazy thing that nobody would
want to do. The lack of information was a hindrance – she wasn't approving of
midwives (MID6)

He's generally a nice doctor – he does listen sometimes, you know – but there is
one thing I don't like is when he says this (alternative medicine) is just bunk
(MF7)

I left her because she didn't believe in a lot of things – including physiotherapy
(MF8)
She said going to a chiropractor is just another way of getting people to pay attention to me.....She obviously doesn't agree with chiropractors and doesn't want me to go (FF7)

6 appointments that are too short to adequately discuss patient concerns

I'm in there basically ten minutes – sometimes three – she doesn't facilitate exploring anything (MID 2)

It's - lets have a blood pressure measurement and out in under ten minutes – bye (MID6)

I felt very pressured – his answers were quick. Long enough to pee and measure (MF1)

She was a little short – a real stickler and you'd be outa there in seven minutes. You know – how they finish with you – here's a prescription and goodbye (MF4)

You had to wait thirty minutes and then its ten minutes - tops (FF9)

It seemed like he was in a rush – weren't listening to you. He took a history and if I wanted to discuss the problem I came in for, I had to get another appointment and come back – so I never went back (FF10)

7 the overuse of standard surgical interventions and prescriptions when other alternatives might be effective
A lot of money goes into spending money on drugs — it just maintains people in states of ill health (JB5)

I'm afraid of the side-effects of the medicines they use. Some articles claim that there are far more deaths due to drugs rather than herbs (MID9)

He's fine if you want to be told to take drugs — there must be something less toxic (MID2)

Whenever (baby’s name) or I need anything they give a prescription. I always ask “are you sure this is the only way we can do it?” (FF3)

Sometimes people are better off waiting six months for surgery — because its an extreme intervention and maybe they will find other ways to get better (MID6)

8 too much time spent waiting before seeing their doctors

This is one of those things I really hate with doctors — it’s as if they think its O.K. to keep you waiting — as if their time is more important. (MID3)

I had to wait maybe half an hour or more and then I’m only in there for, ahh, ten minutes (MF2)

My time is valuable too — I don’t think its very organized to make patients wait an hour every time (MID4)

I didn’t like her – she didn’t seem terribly compassionate and I didn’t like waiting up to an hour (JB3)
finding out that the physician doesn't really know very much about their health concern and having to depend on their own personal research

I’m kinda wish – wishing with him. I’m wondering why I’m here – I’ve asked him questions and he doesn’t know the answer and he says “well you’d better find out for yourself” (MID8)

I think it was basically – well you’re going to have a baby – some people have birthing plans but you’re on your own here – its not important to me (FF9)

We need more information with a (serious birth disability) child and you expect them to find out if they don’t know. So they don’t know and unless you give them the gears they’re not interested to put some effort in (FF3)

Before I would go to the doctor not knowing an awful lot – I figured he would have all the answers – but this isn’t true. You have to wait months for a ten minute appointment to find out they don’t know much about it – it turns out I already have everything that’s out there (MID4)

We went to old Doctor ___________ he was so out of it – he was a joke (MID9)

physicians’ use of scare tactics. This is often used to gain patient compliance to treatments. The use of scare tactics by physicians were reported to be used especially with expecting mothers who were patients of midwives or were thinking about having a midwife
When I said I was getting a midwife — a lot of doctors didn’t want to deal with me and a couple really tried hard to make me feel that this was dangerous (MID2)

That’s a problem I have — doctors telling me — going too far with what could happen. Same with jaundice — so it goes along and so and then the baby dies. What is that! (MF9)

There was one doctor — he pretty much said I was going to stay home (meaning being ill throughout the pregnancy) till I gave birth — I don’t like it when they try to scare you (MID5)

She made the assumption that I would want all these tests — and if I was a responsible woman I would just go along with it (JB2)

He (the obstetrician) was saying things — to scare me — I think (MID6)

11 communicating that patients have “failed” if standard diagnostic procedures or standard treatments don’t have a great effect and/or blaming patients’ psychological faculties for chronic illness that eludes current standardized tests

They make you feel like you’re doing something wrong — I’m nervous about everything I say - like I’m some kind of hypochondriac (MF7)

The medical profession completely let me down. I was going to (name of prestigious university in Europe) on a scholarship and I was full of energy. I was basically an over-achiever — and then suddenly I didn’t have any energy and I couldn’t remember anything — it was like a total bum-out — it was really scary.
They completely let me down – they told me I was a write-off and told me to see a psychiatrist. Eventually I went to alternative people – they helped me change my diet and nutrition – it completely turned my life around (MID8)

This one doctor wouldn’t help – he said I was a hypochondriac but we made him do the tests and that’s when we found out I had cancer (JB4)

My mum – we found out later she had a cancerous tumour in her stomach - she was going to the doctor for thirteen years complaining that something was wrong – she’d had that for thirteen years but the doctor kept saying “its all in your head” (MID2)

Many patients commented that if they were dissatisfied with a physician the only strategy found to be effective was to leave and try to find another. Often they relied upon friend’s recommendations in this endeavour. However, a much weaker theme concerning this subject was that participants commented that there is little that can be done if they have a physician that they feel does not meet their needs. These participants believed that there are structural impediments against retaining a different physician.

There’s not much you can do – they don’t like you bringing anyone with you and so the only thing that is going to improve the situation is to get somebody else – but how do you know?
I will not stay with a doctor I don't like again — I will leave but it's really tough to change doctors here — you can't change — they won't let us do it if we're already with someone (JB3)

We ended up changing doctors — we felt so guilty (MID3)

The only way that you can change doctors is if you move or pretend that you're new in town otherwise they say they won't let you be a patient (MF2)

I asked friends of mine who they thought was good — it worked out really well — she was taking patients - because now I have somebody I feel I can trust (FF6)

I had a good friend who was in Victoria and she said he (the doctor) was taking patients. I had it in my head that I would interview for a doctor - but you feel intimidated and so I just went with him anyway (MID1)

Many interviewees reported that they had experienced caring and supportive female and male physicians. This was also true for a minority of participants regarding their clinical care during pregnancies. Similarly to the finding that indicators of patient dissatisfaction with clinicians were linked to communicative interaction (regardless of clinician gender), aspects related to patient satisfaction were also linked to communication and a democratic style of interaction. Again, certain physicians (both male and female) were reported to have qualities that patients found appealing. The important finding here is that female patients, including those experiencing care during pregnancy seem equally satisfied with caring male as with caring female physicians. The behaviours and attitudes most linked to satisfaction with a physician are listed below. The categories have
substantial inter-connections and according to participants' reports, tend to accompany one another. They were (in order of importance)

1. physicians who listen to patients' concerns

   A certain openness and sensitivity and a level of humility (FF2)
   It's a real comfort thing with me - taking the time and letting you know that no questions are stupid questions – reflective listening skills (MF5)
   It's mostly the ones who have been able to be present rather than the ones who are too busy and not getting involved – just listening to your concerns – actually taking an interest (MID6)
   Somebody who will listen to you in a non-judgmental way (MF7)
   He was great – he was patient and quiet and really took the time to talk to you – mind you, you waited a long time. I thought maybe a female physician would help with some chronic infections so I left and went to several female doctors. It didn't help – so I realized it's a personality thing. (MF8)
   It's someone who listens to you. He seems to know his stuff and he listens – you need to have this to have a rapport (FF9)
   A good bedside manner is nice – smiling – telling me what you are going to do (MID1)

2. physicians who make patients feel comfortable, treat them respectfully and have a more democratic attitude
He was very relaxed and laid back – not like the other one. I could ask him a lot of questions which was much better than the other one who just told me what to do (MF9)

A good sense of humour – 'caus I tend to thrive on it (JB5)

Taking a personal approach – treating you as an equal person and taking care of your feelings – not just the physical ailment (FF10)

Ones that don’t look at you like you’re a stupid idiot that they’re not so much an authority – that they’re trying to help you (MF7)

Good health outcomes are developed through a trusting relationship and you can’t have that if your doctor is always distant (MID8)

3 being included in decisions regarding treatment and given choices if possible

Whatever choice you made he made sure you felt comfortable with it – made you feel good about it – even if he disagreed (JB6)

That they don’t pretend to know everything – I like to have all the information and be part of the decision-making process (MID6)

I've always known that I can say “no, I don't want to do this”. We discuss it first. She gives me pros and cons and she wouldn’t tell me what to do – it was up to us (FF10)

It’s important that I be involved in it – not just the care receiver (MF3)
Asking me would be nice but I've never had that. I want to be in charge of my own health (MID 8)

She never once said – well this is what I should be doing. She would present options and I would listen to her because she presented choices in a nice way. I appreciated her professional advice (FF5)

4 physicians who are knowledgeable and if not up to speed on particular issues will research patients’ questions

Who will actually say “I don’t know” rather than pretending and will say “I’ll get back to you” (MF)

Somebody who knows what they are talking about and if they don’t know will look it up (FF9)

I like it that my doctor will be a resource for information for me – if he doesn’t know he will research it for me and even phones me when he has something – he’s really good (MID4)

I felt I could tell him everything – and what he didn’t know he would look up in books (JB6)

She isn’t going to bullshit if she doesn’t know the answer – she will consult with somebody else (FF10)

5 physicians who are open to and encourage patient belief in alternative healing practices and who don’t over-rely on prescriptions
I've been very selective - I'm very careful who I go see - who are going to react to alternative medicine (MID6)

She takes a more holistic approach - not just prescriptions (FF10)

Yes she actually recommended that I go to see a chiropractor (FF1)

It's important that doctors take the time and not be against alternative medicine - otherwise I have to find another doctor (MID2)

Yes I'm pretty straight-forward about it - I tell him that I've gone to this person and say what happened. He seems to think that if it helps me then it's O.K. (MF4)

I don't say anything about it - I don't think she would be very impressed - it would be nice that they don't react this way (FF4)

I'm into it and I like my doctor to be open to it (JB6)

It is important to patients that they have the time they need when they do eventually see the doctor

He listens to me, you know and I would be there half an hour. He would sit down somewhere comfortable and we would just talk. So I would wait to see him but I really don't mind that much (JB3)

I really like my doctor now - he will take a lot of time (MF8)
She's not there to get you in and out as fast as she can. I never felt hurried – it's not a rush (FF10)

Not just fobbing you off – they can actually take the time to sit down and talk to you (FF7)

I have to travel all the way across town to see her – and since the operation I can't drive – so I take the bus with the kids and it's worth it because she will spend the time you need (FF3)

He's like a dad really – he knows you and we are able to talk about what's happening and I never feel hurried – that I have to finish up quickly. He always asks if I have any more questions (MF6)

A small minority (2) of participants discussed times when they would prefer their physician to be MORE authoritative and/or interventionary

I had this whole anxiety about what was happening with the baby. He said "you have to tell us – you – your own instincts will tell us if something is wrong" And yes, I can see that but I was feeling weird that all this responsibility was put on me (MF9)

Options yeah - but I need some directions – that would be best. I don't want a choice. I don't know, if something's prescribed to me – I just take it. I don't have much to say(FF8)
Maternity and prenatal care was generally seen to be very unsatisfactory according to participants who were patients of physicians. The same aspects that were linked to dissatisfaction with physicians in general, were reported here. There were 2 physicians who received very good appraisals, one male and one female. The 3 patients who reported satisfaction with their care from a physician for maternity and birthing linked satisfaction with being personal, taking time, not being pushy and in two of the cases, being present for the whole labour. In addition, all the satisfied patients had previous births and so the need for information was much less.

You'd get weighed, a blood pressure check – about fifteen minutes. She was more distant – and rough too. All the visits were short (FF8)
Not very long. She just came in and did my blood pressure – maybe five minutes. The doctor isn't really there. I always felt rushed and she would ask if I had any questions as she went out the door (FF7)
I was seeing her once a month then every two weeks and they would last maybe fifteen minutes. She would measure, check the heartbeat and stuff (FF5)
In at 9.00 – out at 9.10. She wasn't incompetent or anything but there was no relationship – she was horrible, horrible (FF1)
We were in and out in ten minutes (MF3)
That's all they do when you're pregnant is ask you how you feel – it takes about ten minutes. She was very cold (JB3)
I was in maybe five or ten minutes – I didn't like that. I needed longer (MF8)
Usually blood pressure, weigh – it was maybe fifteen minutes (JB4)
Really good – there at least three quarters of an hour. He would ask if I had
questions and ask if I was comfortable going now (JB1)

Physician care at the hospital was generally reported to be unsatisfactory. In
most cases the physicians arrived at the hospital very close to the baby being
born or afterwards. As mentioned previously, in two cases the doctors were
present for the majority of the labour at the hospital and this was reported to be a
highly satisfactory experience for the patient.

I did like her – she had a good bedside manner but she wasn’t going to advocate
for me. She arrived only just in time for the birth anyway (FF1)
The doctor arrived fifteen minutes before the birth (FF9)
She didn’t make it to the birth (FF8)
He got there five minutes too late (JB1)
He gets called at 3 in the morning and arrives at 6 – and they are there to catch
the baby, cut the cord and tell you what you have. That’s about it. It’s fine – it
really didn’t bother me (MF8)
The doctor doesn’t do much really - it’s you and the support – if you have it. I
don’t know anybody who’s had it (MF7)
She was there the whole time – she was an amazing labour coach. She was
wiping my face, rubbing my back – doing all those things that are very intimate.
It’s an amazing thing that your doctor is there the whole time (FF2)
He was fabulous during the delivery – he was there the whole day (MF2)

Patients of salaried physicians

Patients who are generally under the care of salaried physicians are very satisfied with the care they receive. The examples that patients used to support their comments are very similar to the atmosphere and types of behaviours that were associated with patient satisfaction in the immediately preceding section.

It’s more open and less businesslike. The community centre is way more laid back – being friendly and personal – not just getting down to what your medical needs are (JB2)

I must say I’m pretty impressed with the way he interacts with patients (JB1)

So I went to the James Bay Project. I like the doctor I have now – he’s wonderful. They are very kind and caring. They remember your name (JB3)

Very understanding – very down to earth very laid back. Everyone has time for you – even the receptionists (JB7)

I think he’s great (the doctor) – he never fobs you off with “take an aspirin and come back next week”. He gives you lots of options. He’s very personable – makes you feel comfortable (JB6)

They are all nice down there – even the people at reception – it all goes towards the experience. They all seem to remember my name (JB5)
Patients whose physicians are paid by way of salary often see the nurse practitioner. She decides if any particular health concern should be brought to the physician’s attention. Patients generally expressed a high level of satisfaction with this system and with their relationship with the nurse practitioner. The aspects that were spoken about as exemplifying the experience as satisfactory were similar to the aspects highlighted in the section discussing satisfaction with physicians.

I felt there was always lots of time – it’s nice. Its pretty personalized (JB3) 
_______ (the nurse practitioner) is very easy to talk to – a great sense of humour (JB9) 
_______ (the nurse practitioner) does the baby checks and I think that’s a good way to do it. I asked to read the report from the pediatrician and she didn’t care – I’ve never had that happen before (JB6) 
_______ (the nurse practitioner) is great – you can say anything. You phone her up – she knows who you are (JB5) 

You never feel like you’re being rushed out the door – not like that other doctor. She gives you suggestions. She gave me lots of information – she didn’t push me either way (JB2) 

There was only one negative comment concerning treatment from the nurse practitioner.
I'm not 100% comfortable with it because I would prefer just one person. I found her (the nurse practitioner) quite rough with me. She's done (baby's name) baby check-ups and I'm very impressed with how she handles her gently (JB7)

All the patients who ordinarily see a physician paid by way of a salary were forced to find another physician who caters to expecting mothers because their family physician has ceased caring for maternity and delivery. These other physicians they were referred to were paid by traditional fee-for-service. Although some patients were reasonably well satisfied with the maternity doctors (because they will be going back to their original physician after the baby is born), in general, patients were not as well satisfied with the treatment they received from the physician who took care of their pregnancy-related concerns.

I had to go to somebody else. I don't think she liked babies. No words of encouragement – very cold (JB3)

Since my doctor doesn't do pregnancies we had to go with somebody else – the first time I went with another doctor - it was O. K. – but it wasn't a good experience (JB2)

It was kind of impersonal really – the other one doesn't know me and he kept getting me confused with somebody else. I ended up getting somebody else's tests done (JB5)
Patients who chose midwifery services

In general this group of new mothers expressed the greatest satisfaction with prenatal, delivery and post-natal services. The difference between the level of satisfaction with midwives as compared to the much lower level of satisfaction with physicians and obstetricians was overwhelming.

She was incredibly thorough — and gentle too — and she's got a really cool office. It's very comfortable — it's like an artsy home. There was certainly a human touch element (MID11)

It was great (MID5)

This time we went with a midwife — it was a million times better. It's great — especially getting away from all the testing. Much more personal — you build up a relationship and when you're having a baby, that's important (MID8)

I had all the information I needed to make choices. I didn't feel like I was a patient or that I had a medical problem. It's not like when you are at the hospital and they stick things into you all the time and you don't know what's going on (MID5)

I got eight to ten times more time and attention with the midwife (MID9)

There was one major and two minor negative reports concerning the experience with midwives. However, even in these cases the general level of satisfaction was reported as reasonably high.
Major

It was all really a huge mess – we wanted a home birth because of all the material and videos we had seen – it seemed that, well they portray home births and midwifery in very idealistic terms. We went to Vic General and it was all very noisy and the staff were quite rude – they all seemed unfriendly. Right away it became obvious we’re going to have to go to the hospital. There was this managed atmosphere of panic but they (the midwives) tried to manage it – keep it fairly relaxed. It was noisy at the hospital but when the obstetrician came in – he just freaked out on the midwives not knowing the baby was breech. He told them if they can’t tell a head from a bum – they shouldn’t be in the business. He organized an emergency cesarean. The baby was in a strange position by now and this led to her having a hip displacement. We were really angry with the midwives not only for screwing the birth up and nor knowing the baby was in the wrong position but even more for the way they tried to pretend it didn’t happen. They never apologized. Also they didn’t want to make extra visits to the house afterwards because we had so many more questions because of the hip displacement problem (MID4)

Minor

More emphasis is needed on afterwards (afterbirth) – I would have liked the midwives to have focused more on this (MID2)

In some areas I researched areas to find out what the best thing was – well because these are things I’ve never experienced first hand – and I couldn’t make
a firm decision about what I should do – but ________ (the midwife) didn’t want
to give me much direction – you know, help me out of the dilemma – and
sometimes you need somebody who has the knowledge to give you advice – not
just keep turning it around, so I have all the responsibility. When you actually
don’t know what to do (MID4)

In general, the majority of midwifery clients chose this service because they
knew somebody who had a really good experience with a midwife and who made
a personal recommendation. Another, much less common reason for choosing
was owing to previous media exposure. There was an expressed dissatisfaction
with medical clinicians as being an element in decisions, although in the majority
of cases this was not the primary reason. In other words dissatisfaction with
standard medicine may have played a part but the decision was primarily a
positive move towards something rather than an avoidance of standard
alternatives. There was one exception to this pattern.

The medical profession completely let me down and that’s why I thought that if I
ever get pregnant I will have a midwife (MID8)

I just know I wanted somebody with me. I didn’t want Demarol and I’m afraid of
an epidural. I knew I needed continuous labour support. (MID11)

It was my husband who said let’s get a midwife – he knew somebody who’d had
that and they thought it was really good. (MID12)
One of my cousins went with a midwife – it sounded really beautiful – a real reverend way to deal with pregnancy (MID3)

An old family friend has been a midwife forever and so I always knew I would have one too if I ever became pregnant. I wanted the experience to be personal – not just a number (MID1)

I saw a movie on a home birth when I was younger and it seemed to be an easy birth – so I thought it would be a great way to go (MID4)

I heard the midwives were legitimized in B. C. and found the midwives association (MID2)

The reasons given for choosing a particular midwife concerned a general comfort level with particular personalities. However, the vast majority of clients interviewed stated that they felt comfortable with the first midwife they went to and felt they didn't need to investigate other possibilities.

I got on with one better than the other – it's a personality thing – you just click and that was the person I wanted to deliver (MID6)

By the end of the first interview with the midwife I knew that's what I wanted and so I went with her (MID2)

We went to see ________ (midwife) and we talked with her for an hour or so and it just felt right (MID8)
None of the participants mentioned that one of the deciding factors was that midwifery was now covered under Medicare. (This does not necessarily mean that this was not a concern)

All the clients of midwives were satisfied with the time they were given in their appointments

*When you went to see the midwife it was an hour or so and when you see the doctor it’s rush in, jump on the bed, rush out.* (MID5)

*The appointments lasted an hour* (MID1)

*The appointments are an hour – once a month, then every two weeks and then every week – and sometimes they lasted even longer* (MID2)

*It was a very personal service – it just wasn’t fifteen minutes and out the door* (MID6)

All midwifery clients reported that their needs for information were met and this was very often linked to the ability to make choices. (As mentioned previously in the negative comment section, one client would have preferred a particular midwife to have been more authoritative. However, this participant had a need for both choice and information and found that this aspect was mostly satisfactory)
She (the midwife) gave me every bit of information I needed along with all the books she lent me (MID8)

A great reference library too – that was cool (MID1)

Suddenly I was opened up to this whole world – from going from believing that doctors know everything – to questioning everything. I learned from the midwives all this stuff I didn’t know before (MID2)

All this information and education – it made me feel really empowered (MID8)

It was nice to talk to someone who was really supportive of our choices – and she was really into education and I could support that (MID6)

It was nice having the information the midwife gave us – to make it more of a plan because when you’re there (the hospital) it’s hard to make decisions (MID10)

Knowing more means you can say no (MID9)

A very strong theme for midwifery clients was that they made the connection between choice and the ability to make their needs known and to either act on them or to make the necessary arrangements to have them met by others. Their experiences with their midwife tended to give them a feeling of being able to exert some semblance of control over the process both at home and at the hospital.

I say she (the midwife) pretty largely increased my independence – she informed me on all sorts of things – tests that I would decide on taking or not (MID4)
I felt really empowered and excited — I found I could ask questions and make choices. I loved it — it was more like talking about what your worries are. If it wasn’t for them (the midwives) I would have done what I was told. I felt I could say no to things I didn’t want (MID5)

I felt that I was very self-confident about what I wanted and what I was doing during the labour — and felt that ________ (the midwife) supported me in this. I was able to make choices for the most part (MID8)

We had a very personal relationship with ________ (the midwife) and she made the journey of the pregnancy interesting rather than raising fears. When I had the baby — it was my triumph — not the doctors (MID1)

Well ________ (the midwife) just spoke up — I deflected it to her - and she said these are the decisions I had made. If it was up to me — I was so out of it — I would have said yes to anything (at the hospital) (MID3)

It was totally up to us whether we had the tests done. They (the midwives) gave us the information and from that we figured out what we wanted (MID2)

I had much more input and choice with ________ (the midwife) and I felt much more in control of what was happening (MID9)

Many clients of midwives found greater support for the use of alternative therapies than patients of fee for service or salaried physicians.

She (the midwife) was open to alternative health — which I liked (MID1)
Doctors are skilled and should be paid appropriately – they would do well to realize there are lots to be learned from the success of the alternative sphere and ______ (the midwife) was into this as well as _____ at the prenatal classes (MID8) Since being with _____ (the midwife) through the pregnancy I’ve looked into more alternative ways of dealing with my health concerns quite a lot more (MID1) I like it that they also have some working knowledge of alternatives – because when I was younger the side-effects of the prescriptions my doctor wanted to give me seemed to multiply. The only way I got out of it and got better was a friend of mine who knew about natural anti-fungals (MID4)

Many clients of midwives experienced some problems with their usual family physician when they decided to choose a midwife for care during their pregnancy She (the doctor) wrote a letter saying I was not a candidate – she was really put out by my choice to have a midwife (MID1) He (the doctor) refused to send on the files unless I paid him for it. He told me I was being irresponsible. He said I couldn’t see him again at all – for any medical problem (MID3) I remember having a knot in my stomach when I told him – he just said urhh – he wasn’t very happy and quite unfriendly (MID2)
She (the doctor) said “This is it – it’s either me or the midwife. I didn’t go to school all these years – so I’m not going to share this”. She was —aargh — its me or the midwife. It was just one more reason to leave her (MID6)

I told him I was going to see a midwife and he got really angry and said I couldn’t see him anymore – its like — kinda — he sensed that I was making decisions – and he didn’t like that. When you see the doctor, he has all the power — and you know that — you’re forced to put up with it — and me saying “I want this” — it must have been threatening to the whole basis of what he’s about. He can’t tell me what to do and so he basically fired me as his patient. I wasn’t allowed to see him (MID10)

Clients of midwives thought that the "one on one" support they received while in labour from their midwife, to be valuable.

She’s (the midwife) is with you the whole time — even takes you to the hospital. If it’s with a doctor maybe he comes in at the last minute. You’re not in so much of a panic (MID8)

She (the midwife) was there in attendance throughout the whole labour rather than popping in when the baby is due (MID4)

The midwife was with me the whole time — 48 hours through labour (MID3)

She (the midwife) was very calm which was relaxing for me. She encouraged me to be in any position that was comfortable for me. She helped me — to try different things — guiding — but listening — and very encouraging (MID1)
Clients of midwives were able to choose whether they wanted a hospital or a home birth. The participants who wanted a home birth gave reasons that were linked to comfort, privacy and to the ability to have greater control over the process. Those who opted for a hospital birth tended to be more conservative and thought that they could have the best of both worlds if they went to the hospital with the midwife in attendance. However, several participants who opted for a home birth were eventually transported to the hospital as a precaution.

*The advantage being that unless there is a real medical problem — it's so much more comfortable — and I can walk around if I want to — I'm not stuck in a bed. I think we thought there were lots of advantages — there are not all those germs!* (MID6)

*Now I see why people have home births — not having to stay at the hospital. It was just us — there weren't nurses I didn't know, coming and going. Nobody intervened — not having doctors and nurses making decisions for us* (MID2)

*I really appreciated the privacy — it's nice to have control over who is there — not just having people you don't know walking in and out* (MID1)

*I needed quiet — and I don't think I would have had that at the hospital* (MID9)

*I could do what I needed to do and move around if I felt I wanted to. I liked the privacy — only the people I wanted to be there were there* (MID4)

*I didn't want to have a home birth because I could never forgive myself if I needed to have a medical back-up* (MID8)
At the start I was concerned about having a home birth — you know, what if - and so we planned on a hospital birth — but as things went along I had more information and I felt more confident about a home birth — but eventually we decided to go to the hospital anyway — and that was good (MID10)

Many participants who chose midwifery services liked the inclusion of their partners in the appointments. The presence of partners increased comfort and this aspect was also mentioned as supporting their intentions to discuss issues that they may have otherwise forgotten, if they had attended alone.

She (the midwife) wasn't a rampant feminist or anything — she didn't have an exclusionary anti-male agenda and encouraged my husband to be there when we went to see her. One of them I met was and I didn't like that (MID9)

Both of us went to see ________ (the midwife). If we both went to the doctor — you could tell they were strained. It was good because sometimes I would forget to ask something and ________ was there to remind me (MID1)

_______ (husband's name) was included in the meetings — that was nice (MID8)

It was good that both of us could go to the meetings with the midwife — 'cause sometimes you can forget to ask something — or when we get home it would help that both of us were there — so there's less chance of forgetting what she'd said (MID10)
Several clients of midwives thought that home visits during their pregnancy made them feel comfortable in comparison to making visits to their physician's office. However, most midwifery clients interviewed traveled to a midwife's office for appointments.

*She comes to your house to see you – and goes to the hospital with you* (MID10)

*They came to my home – which was great especially if you’re having a home birth – so they know what’s around. It was very comforting.* (MID2)

2 out of 10 clients thought that the system whereby they consulted with two midwives over the course of their pregnancy was not preferable to having only one relationship.

*Well, the problem was that we liked one better than the other and so there was this anxiety about which one would be on duty that week when the birth was happening* (MID4)

*They were both very different personalities and the tendency is that you really like going to one - and the other is good – it’s just that we didn’t click with the other one as much* (MID10)

**Experiences and Opinions of all Participants who went to the Hospital**

Only one patient encountered problems with administration when coming into the hospital. It seems the policy of pre-registration is working
There was a bit of a mix-up when we got to the hospital – it seems that they had lost the file or something so (husband) had to sort that out with them (MF4)

Everyone who chose to have their baby at the Saanich Peninsula Hospital was very satisfied. The staff were caring, it was a relaxed atmosphere conducive to labour and communication between staff, clinicians and patients was experienced to be good. 4 out of the 5 who went here were clients of midwives. After being encouraged to look at both hospitals by their respective midwives during the prenatal period, they decided to go here and they were happy with their choice. All the clients of midwives who were opting for a hospital delivery chose to go to Saanich Peninsula. However, because this hospital does not have the requisite facilities for more serious interventions that require anesthetist services, some labouring mothers were transported to Victoria General instead, where satisfaction was greatly reduced. In addition, other mothers who went to Victoria General had heard how nice Saanich Peninsula is

I went for a tour of Vic General and I said "This is a baby farm – I don't want to be here" and then we went to Saanich Peninsula and I said "This is where I want to be". I just loved it (MID3)

I found it wonderful. The nurses introduced themselves – the nurses were fantastic (MID5)
So nice — so small — beautiful facility. Beautiful calm atmosphere. The nurses were great and we were so impressed that the baby wouldn’t get anything without our consent (MID4)

I heard that Saanich Peninsula was the Club Med of childbirth – because a lot of women who went to Vic General had a horrible time, like me (JB3)

It was really nice at Saanich – all the staff were great and they worked really well with the midwife. The obstetrician was nice too. It was such a beautiful quiet atmosphere (MID10)

Experiences of new mothers at the General Hospital were, in general, much more problematic. Opinions and experiences varied in large measure depending on a number of variables. This included the difficulty of the birth, the age and education level of the patient, whether the patient had a midwife or doula as support, how busy the unit was at the time, the distance the new mother was from the nursing station, and the personality and training of the staff on shift at any particular time. Most dissatisfaction concerned the post-partum ward “Mother and Babes”. Ante-partum was generally reported not to be very good either, though the number of participants who had experienced time in this ward was very small (2). Younger, lower SES, and less educated women tended to have a more difficult time in all wards. The problems they encountered concerned a feeling they were not being taken seriously, the inability to get attention from staff, a general lack of information, not having their questions answered, conflicting information, a feeling that everything was beyond their control and
rude treatment by staff. Participants tended to have a better time in the delivery ward but even here there were a number of problems reported.

Patients were less dissatisfied with the delivery room nurses and staff than either ante-partum (before delivery) or "Mother and Babies" (after the delivery).

I thought that this was the one place where our anxieties were addressed (MF3)

A nurse would pop in every once in a while – it was a busy time. When they moved me into one of the delivery rooms a nurse was with me the whole time. I had wonderful care – couldn’t ask for better care (FF8)

It was worse than I ever could have imagined. I had a Nazi nurse – we had a terrible time even looking for the nurses. There was not a lot of compassion. Nobody explains anything to you. I hated it. I’m not doing it again (JB3)

In the delivery room the nurses were really great – it’s much better than the other side (Mother and Babes) (FF7)

The nurse should have stayed with me during the labour. There was _______ (her husband) – but he doesn’t know a lot. The nurse was reading a Harlequin in the hall (JB7)

The staff were great – commenting all the time how great I was doing this (MF5)

The nurses in the delivery suite were fine – but there were so many who were bitches, afterwards (i.e. in Mother and Babes)(JB6)
Many labouring mothers reported that they tended to experience that labour was happening TO them. In some cases (again, usually young or less educated new mothers) interventions were happening without them being asked or knowing what was happening.

*I had a horrible time – my membranes were stripped without my permission – he (the obstetrician) didn’t even tell me about it. I thought he was doing an internal – he did this – he didn’t even tell me. And then he just took off! (FF1)*

*When I was in labour, I was sufficiently out of it – I couldn’t really agree to anything. Things were being done to me without my permission. I had no information (MID7)*

*I wish they had sorta said “How do you think about doing this?”. I wish they had conferences with me. This is my one piece of advice to everyone – stay at home as long as possible. Because once you get to the hospital – that’s where all the interventions begin – and you have no control over it (FF6)*

*I didn’t know who was going to do the delivery……. I didn’t know – we hadn’t had these conversations (MF9)*

*When you are giving birth you really don’t have control - your body is doing it and they’re (the hospital staff) not helping – they’re trying to freak you out further (MF7)*

For many labouring mothers the nursing staff were perceived as interested in gaining patient compliance to various forms of pain relief. Most of the major
problems with this strategy tended to be with Demerol. It seems that younger and less well educated women tended to comply and some felt badly about this afterwards. This is very much connected to the perception that labour was something that was happening TO labouring mothers. Not only is this just one aspect of control being transferred from patient to staff – it also makes future patient compliance more likely, because of the effect of the medication.

My doctor said “Would you like some Demerol?” – and, well – I didn’t know anything about it. This was out of my control. I think many mothers feel this (FF3) This nurse was so horrible to me. She gave me a double shot of Demerol. She didn’t ask me – she told me “You need this”. I’d never had this stuff before and I was having a hard time breathing. I was terrified (MF7)
They gave me Demerol – I didn’t want it because I’ve never had it before – but the nurses said it would be good for me. It made me sick and I was sweating (JB3)
When I went to the hospital, I told her (the doctor) that my mother was given something like this and passed out – but she basically ignored this information and gave me Demerol and I slept through the whole labour (FF5)

Labouring mothers felt restricted because they were made to feel that they should be on or very near the bed assigned to them. In many cases labouring mothers reported needing to be freed from electronic devises (mostly fetal heart monitors) allowing them to be more mobile facilitating their coping strategies in
dealing with contractions and especially, “back labour”. Nursing staff tended to try to keep them on the bed as much as possible. Those patients who had midwives accompanying to the hospital reported that if the nursing staff wanted them on the bed, the midwife would intervene on their behalf, to allow greater comfort.

It was not what I expected. I definitely had ideas of walking the halls and having a shower – but I was flat on my back with a fetal monitor on. I asked – but they said “no, we need it on”. It was very uncomfortable and restrictive. (MF9)
She (the nurse) wouldn’t let me do what I wanted to do. I wanted to be up but she kept saying “Lie down, lie down”. I got so mad at her. Squatting – it’s way more comfortable (MF7)
When I went into labour they (the hospital staff) wanted me to lay flat on my back and it wasn’t comfortable – they bullied me into laying flat – but it was too painful. I wanted to squat and walk up and down (FF3)
At midnight I wanted to walk around and she (the nurse) wanted me to sleep and gave me a huge dose of Demerol. Why didn’t they stay with me – but I know they have to rely on their printouts (MF3)
They (the nurses) wanted me to lie down. It was uncomfortable and the midwives intervened (MID7)
At Victoria General Hospital, some delivery nurses were impatient with patients and were not paying enough attention to labouring mothers' communication of their needs and especially self-reports of their labour progression.

I went into pushing as soon as they arrived – but they wouldn't believe me (FF9)

She didn't really believe me when I said that the labour is intense – why didn't they stay with me for ten minutes to check out what was happening (FF2)

It's the same with all my labours. I know what's going to work – but they won't listen. They're saying "No, no, no, it's not coming yet" – and within minutes I've had the baby (MF7)

One nurse was horrible – I needed to grunt – and she kept telling me that this (the pain) is not a problem – and so I should just be quiet. She kept telling me I was doing everything wrong (FF3)

The nurse was prepping me for a cesarean – and I was trying to tell them the baby's coming – but they didn't believe me. She just wouldn't listen to me (FF1)

The whole way along I'm saying "Big babies, big babies are in my history" I know that all I need is a little more intervention – more intervention will help – but they wouldn't listen (MF8)

At midnight I wanted to walk around and she (the nurse wanted me to sleep and gave me a huge dose of Demerol.............. but in the morning she wanted me to walk around but I was more comfortable sitting. She didn't care at all and wasn't reading my signals (MF3)
Experiences with specialist obstetricians were mixed. Again, satisfaction was related to good communication and a caring attitude. Dissatisfaction related to a more authoritarian approach to intervention.

*He was very nice* (MID10)

The obstetrician came in and he wanted to do an internal exam - he (her husband who is a physician) had to take him aside - whoa! That's not what we want. He (the obstetrician) was very blunt - he wasn't comforting (MID7)

*I really liked the obstetrician – he was very sincere – he was willing to share as much information with you as you wanted. He was very competent* (FF10)

*I felt he was competent – and I liked the fact that he was cautious – but on the other hand I missed any sense of compassion or relationship. It was quick and he was gone* (FF2)

*He came in, introduced himself and started doing a procedure. He didn't tell me anything – I had no idea what he was going to do. He could have said “This is going to be painful and you're going to need gas”* (FF9)

*He was O.K. with it –he presented the information in a fair way - I think he wanted me to try it (experimental medication) because it would have helped him out – but I couldn’t do it and he was fine with that* (MF9)

Unless specifically prompted by the patient, hospital staff did not appraise the new mothers of any choices they had with regard to immediate after-birth interventions and procedures. Generally, patients of physicians did not know that
certain aspects of care for themselves and their new infant were choices. In many cases the staff did not even appraise the parents that these interventions were being carried out. Clients of midwives were all aware of the choices they could make and had plans that were communicated to the staff by their midwife or another support person.

We chose what to do with the eye thing – we didn’t have to say anything – the midwife had it in hand. It’s a bit disturbing seeing the baby being jabbed and they aren’t telling you (MID6)

After the delivery they wanted to put drops in his eyes and bathe him – and we had to intervene – Oh no you don’t! There’s a way it’s done and if you have other ideas there’s a clash, you know (MID10)

I remember them telling me they put drops – I didn’t know I had a choice (JB4)

No – I was told that was being done. They took him away – I wasn’t very happy about that. I don’t think I had all my faculties there to protest anything (MF9)

No – they just did it (FF9)

No – I think because (her baby) was early. There was no discussion. I would have made a decision but nobody asked – they just did it (FF8)

No – I know (her husband) was a bit put off that they were doing all these things and they weren’t telling him what they were doing (FF10)

Most of the problems experienced by new mothers at the hospital happened in the Mother and Babies Unit.
I can’t say I enjoyed that very much. The nurses seemed to be really great or really bad. They’re a bit rough around the edges. You want a bit of sympathy but to them you’re just another person who’s just had a baby – and smarten up (JB8)

I remember the first time I needed help bathing the baby – but she (the nurse) made me feel stupid – but I’ve never done this before! (JB5)

There was not a lot of compassion – nobody explains anything to you – I hated it (JB3)

I never saw a nurse for the whole of the day (MF2)

I had even less care in there than I did in ante-natal. They made me feel as if I was a problem if I asked for anything. I’m a first time mum and he’s premature. It felt as if you were really on your own there. I was very upset with the lack of support (MF9).

I would say more of them (nurses) you hoped wouldn’t be working the next day. They didn’t want to do things - also it’s how they wouldn’t listen to you. It was really nice when you got a nice nurse (FF10)

Sometimes they come in and just take the baby – they could ask. It’s a bit disturbing (JB5)

They were always forgetting to give me my medicine. Every time I had to tell them – and remember, I’m allergic to penicillin. They were going to give it to me four times – every time I had to tell them – they didn’t know (FF7)
Many labouring mothers or those who have had their baby and are now in the Mother and Babes, post-partum unit were left to their own devices and informal support networks at Victoria General Hospital. This was especially reported when it was a busy time.

The second night, I can remember it was hellish – I was very grateful for getting out of there (Mother and Babes). It was better when she (another patient in the same room) was there because I actually had help that night to get the baby (FF10)

Patient care is fairly minimal – so unless you have family support – it would have been a really bad experience (FF9)

I was very upset with the lack of support – I had to phone a friend to come and show me how to breast-feed. If it wasn’t for the support of my friend I might have just given up and that’s a shame (MF2)

_____ (her husband) had to go find a nurse - nobody ever came in. There’s not enough staff. Nobody came by to give me any information or anything (FF3)

Nobody told me I wasn’t supposed to get up after a cesarean. Nobody told me anything. NOTHING, NOTHING. Rarely saw nurses – you had to go to the desk and they were standing around talking (JB9)

There seemed to be a particular problem with new mothers getting adequate support for breast-feeding from the staff. Many mothers’ confidence was
undermined by the staff and some (especially younger, lower SES and less educated new mothers) felt bullied by certain nurses

This nurse was a real bitch – I should have complained. She said you have to feed the baby every three hours but you only have twenty minutes to feed him and don't bother me. I'm a new mum – and I don't know how to breast-feed (JB6)

I had an experience where the nurses were quite unwilling to help – they were quite nasty. He hadn't breast-fed – he hadn't fed from a bottle. This nurse came in – no hello or anything – She just barks "I've got three babies coming over from delivery – I don't have time for you. If he isn't feeding we're taking him to the nursery". Well, you're stressed already and then she's threatening to take him away (FF7)

I'm a first-time mum and he's premature and they just brought him to me and went away. He's crying and I don't know how to breast-feed – and I said "Hello – how do I do this?" and she said "Well just make sure his mouth is open". You were on your own up there (Mother and Babes) I didn't think they thought my breast-feeding was important. It's "Well why don't you just give him a bottle" It was really unexpected (MF9)

I had an awful time learning to breast-feed. They took him and bottle-fed him. They didn't seem very interested in getting him onto the breast – they weren't very much help (MF1)
In addition, if information was given concerning breast-feeding it seemed that this confused many of the new mothers because a great deal of it was contradictory. The general feeling among the participants was that the nurses needed to be far more encouraging and to have had some training on breast-feeding. Some explicitly noted that some (or more) training was required.

I remember all the nurses had totally conflicting information. We had all these people saying different things...... It was really confusing and we'd fret over it (MID2)

I was getting information – different information from all these different people and I am left to make sense of it all.. The nurse was saying one thing, the obstetrician another and the doctor another. It was just bizarre.... And nobody was talking to one another (MF9)

Another nurse would come and she'd have different ideas – I felt I had to pick and choose until something worked (MF8)

The person next to me had a hard time breast-feeding and the nurses were horrible to her – the doctor was rude too. She got different instructions from all the nurses and different ones from the doctor (FF5)

Yeah – they told me different things – it made me feel really dumb – inadequate. Especially if you're a first-time mother. They should really have training about this. (FF9)

I felt the nurses needed some better training on lactation (JB10)
Even when new mothers had made certain choices regarding the care and feeding of their new infant, in some cases their choices and requests were ignored by staff at the Mother and Babies Unit at the General Hospital. This was particularly a problem with feeding new infants. Some new mothers were unhappy and others either felt too tired to make sure their concerns were addressed or they assumed that there must be a very good reason for ignoring their requests.

_They just took him and bottle-fed him – that’s really encouraging!_ (MF10)

_I wasn’t able to breast-feed him – they just took him away – I wasn’t at all happy but I was just so tired._ (FF2)

_Everybody knows that if you stick a bottle in their mouth it makes breast-feeding harder – they don’t ask – they just did it. I’ve heard this from other mothers too._ (MF7)

_No they didn’t ask – but if he was full term they might have taken my ideas into account. They gave him formula and I guess they know what they are doing. I just let them get on with it._ (FF8)

_I found out later that they were feeding him formula – and I had specifically asked them not to so that the breast-feeding would go better._ (JB2)

_Suddenly there’s no midwife there and we don’t know how to stand up to the nurses. That was real drag – we felt we couldn’t do anything._ (MID7)

_It was horrendous – it depended on the nurse that was there. I was not sure what I could do – or should be doing._ (FF10)
Communication between midwives, hospital staff and specialists was sometimes poor. There are some indications of power struggles that have effects on patient health and safety. It seems that hospital staff have some difficulty knowing who is in charge when a specialist becomes involved and especially when the patient has a midwife.

"and the nurse — well some of them have their nose out of joint with the midwives. The nurse was always trying to take control of the situation." (MID6)

"Yeah, they (the midwives) didn't have the support of all the staff — they were like outsiders." (MID7)

"The doula and the nurse used to disagree a lot." (MF8)

"The obstetrician was really arrogant and, yeah — yeah, he wouldn't listen to the nurse about the varicose vein in my birth canal — and he wouldn't listen and went and broke it — then it was critical!" (FF7)

"They don’t work well together either — there was a huge file on me in the hospital — nobody was reading it and everyone I saw was treating me like I just came in off the street." (MF2)

"Communication between this doctor and the specialist is really lousy. They were also supposed to page my doctor — but she didn't get any message — they just forgot." (FF5)

"People didn't seem to know what to do — there was a level of unsureness regarding information about anything. This may have been due to us having a"
midwife and then having a cesarean – but the midwives seemed to work well with the nurses during the delivery, though (MID4)

............... It was just bizarre.... And nobody was talking to one another (MF9)

Disjointed – it didn’t flow very well. The nurses say “Well, why don’t you do this?” – but nobody seems to know and they don’t tell you anything (JB5)

There were very few favourable comments concerning experiences at the Mother and Babes unit at Victoria General Hospital, and even these were modified by comments about problems, elsewhere during the interview

The nurses were very good – apart from this one – they came in and helped me (JB4)

Mothers, you know are a bit paranoid – and they did a lot to encourage me – that I knew it would work out in the long run with breast-feeding (FF8)

There were very few mothers who had an experience with the ante-partum ward but those who spent some time here did not have a great experience. Mostly this was because their hospitalization was worrying for them as this was obviously interpreted as a precaution against major problems. The other aspect was that there seems to be such a turn-over in staff that patients not only do not get stability of care, they also do not get to know many of the staff and have to keep repeating their case history to every new staff member. This last problem could have consequences for patient health and safety.
I ate so well, exercised – I read everything I could and then I was eating hospital food which was awful. I was doing everything I didn’t want to do it was very difficult. There was a lot of turn-over – you’d see someone once and then never again. So there was no continuity of care - I would have to explain my condition over and over again. (MF9)

The nurses were really busy – you would never hardly see them a lot. I was on ante-partum for four weeks and every time they (the nursing staff) came in they asked me the same questions time after time (FF7)

In general, patients who were cared for by a midwife and/or hired a doula had an easier time at the hospital. They had continuous support during labour, the advantage of an advocate in interacting with the hospital staff to get choices translated into action, and had somebody to help them with the care of their new infant.

I had expressed that I didn’t want drugs – they were well versed in it by the midwife (MID1)

They (the nurses) wanted me to lie down and I didn’t want to lie down – it was uncomfortable – and the midwives intervened. If it wasn’t for them I would have had to do as they said. I wouldn’t have the education – I wouldn’t have the guts to say no (MID7)
Yeah – that was the doula – we had a birth plan – we had a checklist of what we wanted. No Vitamin K or silver nitrate (MF8)

Knowing more means you can say no (MID9)

The feeling of being out of control – I didn’t expect that. All the decisions are made for you. That didn’t happen the second time because I had a plan

with________ (the midwife). If you don’t – you end up being agreeable – so you just do it even though you don’t want to (MID5)

__________ (the midwife) arranged it so I could move around (MID7)

Some patients encountered problems at Victoria General Hospital with security for their newborn.

They lost _______ (baby’s name) twice – they had taken her to another unit and nobody knew. It really concerned me (FF1)

The security bracelet – it just came right off – nobody seemed concerned about it (MF2)

They just didn’t bother to put the bracelets on – they were just in the crib with her (MID4)

Post-natal care at home

A very strong theme was that new mothers found the CRD home visitors to be very helpful. Only two thought that the visitors were a bad idea.
Wonderful – the mums are so lucky to have what they have (MF7)  
Good, yeah – they’re always nice. You have to ask questions though – so you 
have to be informed MF9)  
Yeah – they were really great – they helped me with the feeding and bathing.  
She came to my home and answered all my questions thoroughly (FF9)  
She was wonderful – very supportive and we made lots of acquaintances 
through the mothers’ group (FF8)  
She didn’t tell me anything I didn’t already know (FF10)  
......... But the public health nurse was great (MID1)  
I’ve started using the CRD more, for that (phoning to get information) they’re 
wonderful – especially with breast-feeding (MID2)

A very small number of interviewees were not sure if their home visit was done 
by hospital staff or CRD public health nurses. Two new mothers were expecting 
somebody from the hospital who didn’t show up. One participant was not 
satisfied with the home visitor from the hospital.

The hospital was supposed to send a nurse to take my staples out but she didn’t 
show. My doctor was really surprised – she had to take them out. They didn’t 
have their shit together (FF1)  
The one from the hospital was not very good – but the public health nurse was 
great (JB8)
Clients of midwives found the frequent home visits by their midwife to be supportive. One client found the visit not to be supportive.

*She (the midwife) came the day after the birth and the day after that and the day after that. She is not a terribly panicky person – but she is on the lookout for things going wrong – you can tell (MID1)*

*Afterwards she looks out for the baby and she comes to the house several times – and the doctors don’t do that (MID6)*

*The thing I really liked is that they came to my home lots of times to see we were coping and breast-feeding was going O.K. – With the doctor the first appointment after the baby is born is six weeks (MID8)*

*I thought it was great she came over so much after the birth. It’s better than waiting 2 weeks to see the doctor (MID9)*

**General Health System**

Participants who compared the health system in British Columbia to any other system either in Canada or elsewhere in the world, reported that they prefer the system in B.C.

*It’s much better here than in Ontario – you’re less of a number. You get much better service (MID4)*

*Here is better. In Quebec you go to clinics so there’s a two hour wait and then sometimes a language problem (FF3)*
I think we have a really good system compared to the States – but the hospitals I don't think there is much support. Patient care is fairly minimal (MF4)

Much better than in England. In England I had some old guy who was a million miles from what I could relate to (JB5)

We're lucky we have the facilities. In England a friend of mine just had a baby and five hours later you're out the door. At least you have the option to stay in here (MID2)

Health is much better than in New Zealand. My sister had a baby two years before me and she had to pay $2000 – and I said "Wow – good old Canada. Every time you see a doctor there you have to pay (JB5)

It's way better than in Alberta (MID2)

Many participants reported that there appears to be a funding crisis for healthcare. However, the majority also said that there is also a problem with where the money is spent and this is more serious.

We're paying too much for all the machines that go ping. They won't pay for a chiropractor – but they'll pay all that money for a surgical procedure (MID5)

Most things aren't under-funded – it's how they use the money (JB9)

The system may be under-funded but the main problem concerns how the money is allocated – there is too much money spent on technological intervention and big machines and not enough money spent on the right staffing levels and enough beds in hospitals (MID7)
I want to say more money – but we have to use the money we have much better (FF8)

Mismanagement – shortage of funds, sure – but mismanagement (MF8)

I think its under-funded – it's a government thing - so there is money going places it shouldn't (MF2)

It would be easy to say lack of money – but its what they do with the money (FF3)

Many interviewees stated that any funding shortfall was the fault of “the NDP” rather than referring to the Provincial government in a generic sense. Many fewer put the blame on the Federal government.

I think it's under-funded – it's the government – the NDP (MF7)

Well, it's the NDP (MF8)

Firstly I blame the nurses – then the government (FF1)

You can change the government – that might help. It's the NDP (JB3)

The government – the one in power the Liberals. I think it's both – they both make cuts, right? (FF6)

The majority of participants said that they did not support the policy of physicians to close their offices for Reduced Activity Days (RAD days), though some were at least partially supportive. Of those who supported the physicians, even most of these thought that a strike was the wrong way to get their message across. The
overwhelming majority felt that it was an attempt to turn the population against
the government in order to increase the pressure to give physicians more money.

I think it's horrible that people have to be used (FF1)

It was just an awful scene – I honestly don't know that much about it but I
suspect that they (the doctors) just want more power. They always want
whatever they want – and they want more money. I don't think they are that
interested in quality health – if they did – they'd give us more choices (MID1)

I think it's absolutely fine – I'm not going to work if I'm not paid – well I don't know
what they are trying to accomplish except make people mad – I think it's the
wrong way (FF4).

I don't think they should get any more money – I think they're doing really well
(JB2)

O. K. I'm not sure about that – doctors are paid well enough for what they do and
I think they can find better ways to get that message across. It's pretty
irresponsible (FF8)

Many doctors are finding they can't cure people so that major reinforcer isn't
there any more so they're now working for the money (MID6)

If they have higher wages then you just get people doing it for the wrong reasons
(MF7)

Even those who supported the doctors in their attempt to get more money were
against them closing for nine days in a row over a statutory holiday
I think I'm opposed – they took off the spring break week when kids would be coming in with broken arms and things (MF8)

I don't like that nine days in a row – that's too much (FF9)

The most reported "best" sources of information concerning general health matters were (in order of expressed importance) books, friends, and the Internet. Physicians were not mentioned as a "best" source.

Articles – whether it be magazines or the paper (FF9)

All the things I should be aware of I got from books – I didn't rely on the doctors for anything (JB8)

All through friends mainly – family. It's nice having an R.N. around the corner (FF8)

The Internet is the best (MID5)

Books, magazines – there you go – oh, friends too (MID1)

Books it's not the doctor, that's for sure MID2)

The best sources of information on birth and prenatal matters were reported to be (in order of expressed importance) books, friends and/or family members, prenatal classes and the Internet. For those who were clients of midwives their clinician was the most important choice for best source of information.
We got all the information from the midwives (MID2)

Midwife, I think - oh I did reading as well. I think the class was really good – we went through stuff pretty well (MID6)

Books, books, books (MF7)

I think it was a book – it was a really big one. I think it had to be the things I’d read – it sure wasn’t the doctor ‘cause we never talked about it (MF9)

I like to read – so I was reading everything I could get my hands on. Prenatal classes would be another one and friends (FF8)

______________ (the midwife) was really good – and books – I’m a big reader (Mid1)

Books, prenatal classes and the doula was a great help (MF8)

I read books – and my sister-in-law (FF10)

All clients of midwives reported that the midwife was a good source of information on pregnancy related matters. 7 out of 10 (70%) reported that the midwife was “the best” or “one of the best” sources of information whereas only 2 out of 30 (6%) patients of doctors reported their clinicians as “one of the best” sources of information. No patient of a physician rated their doctor as “the best” source of information

The best reported sources of information on parenting were (in order of expressed emphasis) other mums and baby group meetings, friends and family and books
Friends – just getting as many opinions as possible. Books – it’s not the doctor (MID8)

Well – the class (baby group at James Bay) is good – and some of the reading I did (MID6)

I think the best information comes from friends and other parents at the baby group. I think it’s really important to normalize the experience of bringing a baby home. Labour is not the hardest thing – it’s when you get home (FF2)

Friends and family - reading what to expect (FF8)

Talk to other mums at the new mums’ programme I went to - it’s good to see how other mums are doing and how other babies are developing (FF10)

Miscellaneous Themes

Beliefs concerning midwifery by those who were patients of physicians

Many interviewees that were cared for by a physician during their pregnancy stated that they assumed having a midwife meant having a home birth and/or not having any pain relief. Many did not feel confident about the safety of home births.

I didn’t get a midwife because I wasn’t going to have a home birth (MF8)

I would never have a midwife – never. I would feel a lot safer with a doctor.

Being at home? If I had been at home – I wouldn’t have made it (FF9)
No, the thought of having a child at home didn’t appeal to me. I think I like the comfort of a big building and lots of gadgets. I’m totally ignorant about midwifery – it’s a bit too touchy-feely (FF8)

I didn’t know you could have a midwife and have your baby at the hospital. If I had known that, then maybe I would have had them – yeah – for sure – I think I would’ve got better care (FF7)

No, never thought about it. It’s very interactive – one on one – but they don’t allow you to use drugs (FF1)

Never thought about it because I wasn’t going to have _______ (baby’s name) at home (JB6)

Some participants were not interested in having a midwife because they had heard rumours regarding serious negative consequences of midwives and home births.

No I didn’t. I think it is something too scary. I have a pretty healthy fear of the kind of things that go wrong (MF3)

The terrible stories you hear about things going wrong – in the newspaper and that – and personal stories from friends who heard about it. It’s too scary (JB1)

I don’t know – just what you hear from people. I’ve never met anyone who had one (a midwife)
Some participants had heard of the availability of midwifery, were supportive of it in principle but felt that it was not for them. None of these participants had talked to a midwife or looked into the possibility seriously.

I know that they are pretty useful and that they provide a lot of care I missed out on. They provide a very important service – but I would still want a doctor. It’s just that doctors have seven years of training (MF9)

No, I found out about it – what they did. I was happy with my physician. I had a couple of friends who did but it’s not for me (FF10)

I didn’t feel I needed anything extra. Another friend had a midwife and gave birth at home and she said it was a great experience. Yeah – they’re great – but I was fine (FF1)

No I was happy with my doctor. They (the midwives) are not second to doctors. I’ve heard really good things. It just wasn’t an issue – so I didn’t consider it. There would’ve been definite advantages (FF5)

Prenatal programmes

Opinions regarding prenatal classes were very mixed. Some were reported to be very good (for instance the classes organized for clients of midwives) while most others received very mixed reviews. The Best Babies programme in Fernwood didn’t receive any positive ratings. It seems that many instructors have certain beliefs and this may clash with the needs of the expecting parents. Also, from a position of after the birth of the baby, many new
mothers criticized particular classes as not having been relevant to their experience. Most of the negative comments concerned the mismatch between the view a particular instructor presented and how the actual birth happened for the mothers. There is particular anger and guilt associated with the general prenatal philosophy that pain management is "bad" whereas in actuality, many labouring mothers found that they wanted to avail themselves of some form of intervention for pain.

The instructor could have been better – she didn't say anything about cesareans but three out of ten in our class did (have cesarean sections) (FF10)

It was excellent – it was a weekend thing (MID9)

I still feel a little angry with the prenatal instructor about the pain.....how pain relief is bad for the baby. So it was like you weren't given permission to have pain relief. I am very angry about this guilt - you know – bad mother. I thought that they were very misleading (JB1)

We really liked it – we found it was great.... It would have been hard to go to a conventional prenatal class – we'd have thought it was complete crap (MID6)

It was very biased against pain management – it was biased from her own philosophy – there is nothing there to suggest that this is what some people would do (MF2)

I didn't like the prenatal group at Femwood – it was very disorganized – it was really more of a gossip session (MID2)

She's a doula – and she really talked that up (MF9)
One important finding is that one of the aspects that expecting mothers and couples are attracted to, and reported as very important, is the possibility for forming connections to a peer group of new parents. Keeping this in mind, it would seem that placement in a class needs to be considered in terms of social variables and the “fit” of the class (both in terms of difficulty of material and SES) for a particular expecting mother.

"I would have liked longer because you got to meet these other couples going through it" (MID8)

"It was great being there with all these other couples – and if you didn’t go there you’d probably never meet them" (MF4)

"Yeah it was O.K. - we got to know some people though - and that was good" (FF10)

Many new mothers reported that mother and babies groups were very helpful. They tended to overcome what may have otherwise been an isolating experience as a new mother. New mothers reported attendance as helpful in gaining knowledge and confidence in their abilities to be mothers. In particular the one at James Bay received positive reviews.

"But it’s when you come home – so maybe they need to focus on this more" (MF8)

"Well – the class is good (baby group at James Bay)" (MID6)
I think the best information comes from the friends and other parents at the baby group. I think it's really important to normalize the experience of bringing a baby home. Labour is not the hardest thing — it's when you get home (FF2)

Talk to other mums and the new mums programme I went to. It's good to see how other mums are doing and how other babies are developing (FF10)

Many participants who reported using alternative health practices said they are aware they need to be careful in choosing which methods and which practitioners are safe.

I'm interested in reflexology — I think there's a ton to learn about it — but as a mum I worry about it. I wouldn't take echinacea when I'm pregnant (MF8)

I think it might be beneficial in certain areas — but it's basically buyer beware because you never know (FF7)

The only problem is trying to judge who is good and who is a quack — because anyone can advertise — but the longer I look at it the more I learn. I have to rely on my own research (MID2)

They go to these people and they always come back with these allergies they didn't have before — they tend to overdo it — they blame everything on allergies (MID1)

I think it kinda goes through fashions — they come out with so many things — I get confused (MID8)
Some participants would like to see less animosity between allopathic and alternative practitioners. Also, some reported that health clinics that have a variety of health-related professionals under one roof are a good idea.

I’d love to see more of that – like that clinic up at Fort and Foul Bay – where they are all together. That’s good – that should be paid for too (MF7)

They should find a way to work together – the doctors and different alternative methods (MID5)

I think the health system would benefit from integrating more alternative and less interventionist forms such as homeopathy and naturopathic medicine (MID7)

Maybe there should be a choice to have services that are more holistic (FF2)

Being able to fill your prescription – have a choice – take it to an alternative place if you wanted. Herbs are far less dangerous (MID1)

Some participants stated that they had never used alternative therapies or had been to see an alternative therapist but during the interview talked about the times they had used chiropractors, herbs, mega-vitamin regimes, etc. It seems that the definition of “alternative” is both fluid and individual

No, I’ve never gone to an alternative physician – or acupuncture – or anything like that – though I did go to a massage therapist. If I had a problem I would go to a standard medical authority (FF8)
No – my mother-in-law is good for those remedies – that’s why I wouldn’t go probably. We had echinacea at home. Perhaps I would try acupuncture - but then I wouldn’t need to (FF10)

No, no, we’ve never – umm, I guess I’ve always been leery – but I go to a chiropractor – I guess that’s alternative

I wouldn’t go to any alternative people – you don’t know if they really know anything – anyway you always come back being allergic to something, don’t you. But I go to the health food store and get those herbs for prenatal – they were good. (MF10)

In addition to a harmonization of allopathic and alternative medicine some of the participants discussed other items that they would like to see more emphasis on and integrated into the mainstream of paid services. They are (in order of expressed emphasis to these participants):

More mother and baby groups
Free-standing birthing centres
Dental coverage
Phone in contact with doctors
Doula services
Chapter 9
Discussion

As mentioned previously, this study was expecting that the concept of patient agency would be found as one of the important themes that participants would discuss in relation to experiences and opinions regarding accessing healthcare. This expectation led to the inclusion of a section at the beginning of the open-ended interview protocol that asked participants' understanding of the concept before the exploration of their experiences with healthcare. In the pilot interviews, the word “agency” as well as “self-efficacy”, “locus of control” and “autonomy” were all poorly understood by participants. These terms were ones that were perceived as too specialized and abstract to make much sense. The best term that seemed to spark participant discussion of their ability to make choices and act in their own interests was “independence”.

The results regarding how these participants understood the term “independence” show a number of culturally contextualized patterns. At a meta-level the great majority of the participants' subsequent, detailed open-ended discussions were concerning how they were generally dissatisfied with medical encounters that limited their sense of agency and that any encounter that gave them a greater sense of personal control was preferable. However, there was a marked difference in the understanding of aspects that were linked to this ability to choose and act on these choices, depending on whether the context of everyday practical experience was included or not. When the discussion moved
from the abstract discussion of this concept to a discussion of actual experiences of medical encounters, many more participants explicitly made connections between choosing and acting and concepts such as information, power, relationships and communication.

In the section where we asked for participants' uncontextualized understanding of "independence", most understood this concept as the ability to make choices for themselves and many also linked this to the ability to be financially independent. In other words, the constraints of limited monetary resources were seen as an impediment to the widening of their horizons of possibility and it can be extrapolated that these participants viewed increased financial clout as connected to an increased sense of personal agency. This concurs with reasonable expectations of the perceptions of members of an industrial consumer-oriented culture where the ability to choose is generally connected to the ability to purchase various commodities. This connection of agency and choice to money is one that is reflected in many societal institutions especially western media. Most members of industrial-consumer societies are bombarded by messages that tend to promote the ethic that equates an upper middle class lifestyle with greater consuming power and greater happiness. Regarding the aftermath of the incidents of September 11th citizens of the industrialized west (and particularly Americans) were reminded that it was imperative to thwart the thrust of terrorism as a threat to western hegemony by remembering to continue consuming. The corporate and government sectors were reinforcing the notion of agency in the "free democracies" as linked to
consumerism. Social-psychological research regarding this connection appears to demonstrate that happiness is tenuously linked to increased opportunities for consuming. As incomes and buying power have increased over the past 50 years, general life-satisfaction has decreased (DeGraaf & Boe, 1997).

Regardless of any measure of happiness, many of the new mothers interviewed felt that their sense of control would be augmented if they were able to make more money or have greater disposable income.

In the context-free, “independence” section of the interviews some participants (generally those with a higher educational level) perceived their ability to widen the possibilities of their life horizons as connected to having the requisite information or the ability to access information in this endeavour. As the interviews progressed many more of the participants (including all educational levels) discussed how their general medical and specifically birthing needs were met by having as much information as possible. Thus, while only some well-educated participants were able to discuss how information is linked to their sense of control in an abstract form, in a discussion of practical medical matters informational power was seen as highly desirable by a great many more. In the majority of cases this connection between information and the augmentation of their ability to choose and to act on choices was explicit. However, this explicit connection was not necessarily made with an abstract concept of independence in all cases.

While midwives were overwhelmingly reported as the best source of information regarding prenatal, birthing and parenting information by those who
accessed their clinical services in this fashion, those who chose physicians reported that the best sources of information were books, friends, family and the Internet (in descending order of importance). In addition, with regards to general health related matters participants (regardless of how they accessed maternity care) overwhelmingly chose mediated and personal informational sources as the best and most reliable sources of information about health. Physicians were hardly ever mentioned in the context of being even adequate sources of information on health matters even though many participants expressed a desire that they should be. It is interesting to note that the handful of participants who were highly satisfied with their physician also reported books and friends as their most trusted source of health information.

Regarding understanding of the concept of independence in its more decontextualized form, a few participants also made the explicit connection between independence as the ability to make choices in their own interest and inter-dependence with members of their family or community. There appeared to be no particular link between this understanding of independence and a choice of any particular model of clinical practice in accessing prenatal and birthing care. These participants tended to have considerable experience with other cultures and/or were brought up in various cultural or sub-cultural meaning systems that valued communitarianism.

In the context of actual experiences of care during the maternity period the findings demonstrated a definite pattern with regard to inter-dependence. Clients of midwives freely chose to discuss that their experiences of the clinical
relationship with their midwife provided the best source of prenatal and birthing information in the overwhelming majority of cases. Further, they also explicitly reported that the inter-dependent relationship augmented their sense of their ability to make decisions in their own interest. Thus, agency was definitely supported through this model of the patient-clinician relationship. This experience was extremely rare for those who chose traditional physician services. It should be noted that participants who chose midwifery as opposed to physician services while pregnant, tended to be better educated and perhaps because of their understanding of the importance of seeking as much information as possible, tended to seek out a clinical relationship that would satisfy this need. It would appear from these interviews that many of the midwife group are highly conscious of their agency as being improved by their clinical relationships (which is a sense of agency formed through inter-dependent means) but they tend to be less conscious of this connection when the subject is broached via a more general and context-free form of inquiry. This provides support for the notion that research that investigates decontextualized abstracted concepts in questionnaire form tends to collect relatively impoverished or even misleading data as compared to research that assumes a concrete connection between perceptions and everyday activities.

A small minority of participants expressed that their understanding of independence was connected to a “freedom from” the restrictions and censure of others in the context-independent section. Some of this minority also added a further but secondary, more proactive version that was related to the ability to
make and act on their choices. Again, in the general discussion of their experience with health institutions and personnel, their discussions (which were contextualized by everyday experience) seemed to be connected to the more proactive version, whereas this was discussed only as a secondary aspect when this concept was removed from health contexts and actual experiences. Taken as a whole these results demonstrate that in general people's understanding of abstracted concepts is much poorer as compared to if their everyday experiences are explored. This finding suggests the great importance and utility of in-depth qualitative exploration to discover their thoughts as contextualized by concrete experience. In addition, these findings also suggest that the study of perceptions of such concepts as agency not only need to take into account everyday understanding of such terms and to find terms that match with ordinary people's usage but need to take into account the specific practical contexts in which they are explored.

**Agency, communication and satisfaction with physicians**

The results presented findings regarding two intricately linked phenomena. Data were gathered on the experiences of this group of younger female participants regarding their experiences with physicians and medical institutions in general as well as their experiences with personnel and structures during a recent pregnancy. The aspects that were found to be important in general medical encounters were also found to be important during pregnancy and birthing care. The concept of agency was found to be deeply implicated in general patient satisfaction or dissatisfaction with communication in physician-
patient diagnostic interactions. In general, participants found that doctors who did not listen to their concerns, were overly authoritative and judgmental, dismissing of patients' knowledge of their condition, openly antagonistic to patient beliefs in alternative medicine, and did not allow enough time for discussion, were not really interested in engaging with patients' in a manner consistent with their wishes. All of these aspects linked with dissatisfaction tend to tilt the power balance in favour of the clinician and to limit patient choice and information sharing. Antagonism to alternative therapy and the over-reliance on standard pharmaceutical intervention (both reported as linked to patient dissatisfaction) are yet other ways that the medical agenda limits patient discussion and choice in dealing with their health problems. As mentioned earlier, there is research that demonstrates that taking patients' concerns and beliefs into consideration tends to bolster patient agency and has been linked to improved health outcomes (Koenig, 1999; Sloan, Bagiella & Powell, 1999). Many physicians feel that the claims of many alternative paradigms cannot be supported by their understanding of the requirements of scientific evidence and tend to steer patients way from such treatments, in an effort to save them from quackery. However, while many of the patients interviewed here were supportive of alternative medicine in general, many also discussed that they were not overly naïve in believing every claim made by alternative practitioners or systems. This may be interpreted as evidence demonstrating the tendency for physicians to be overly paternalistic in relation to their patients (which the majority of patients do not feel comfortable with) and provides further support to the results reported in
British Columbian health investigation (Mullett & Coughlan, 1998) that physicians often have a distorted or erroneous understanding of regarding patients' opinions or needs.

Many patients were upset that physicians are sometimes not very conversant with specific health problems and were either not very forthcoming with information or were not interested enough to research the problem and pass the information onto the patient. Many patients either chose or were forced to research the problem on their own. Thus, patient agency as linked to informational power was not always supported by the physician-patient relationship in many cases.

Another group of complaints made by these participants concerned what could be referred to as an abuse of power. It seems that the use of scare tactics by allopathic medical personnel in order to encourage patient compliance to an imposed treatment regimen was a fairly commonly reported phenomenon. Patients were upset by the use of scare-mongering by their physicians and many realized that such means were being employed specifically to augment physician power and to reduce the perceptions of agency of the patient as linked to having a legitimated voice in discussion and choice of treatments. Such instances were reported in many aspects of physician-patient interaction but specifically reported in the context of when patients' were discussing the possibility of choosing to consult with a midwife during pregnancy. Some doctors were reported to be obviously upset at this disclosure and attempted to make the transition as worrisome as possible for the patient. Tactics employed included general scare-
mongering concerning the safety of midwifery, the withholding of files from midwives until monetary arrangements were agreed to, and not allowing patients future access to their normal physician. It should also be mentioned that while patients who were “fired” by their allopathic family physician were upset by their petulant behaviour, the perception of the doctors’ bad attitude was enough reason for these patients not to continue the relationship, in any case. It may be considered sometimes acceptable by physicians to try to use all methods in an attempt to gain compliance to treatment regimens. After all it is in the patient’s best interests that the professional clinical advice is followed. However, the results from this current investigation seem to demonstrate that the actual compliance to treatment tends to occur when the patient feels that their issues are fully discussed and their opinions are taken into account. A more paternalistic strategy which may include bullying or scare-mongering actually fails to deliver because any increase in the power differential decreases the physician credibility in the eyes of the patient.

While it is understandable for physicians to be upset at the change in the structure of maternity care which requires them to be in competition with midwives, such behaviour is not only unnecessarily petulant and unprofessional, but actually further undermines their credibility in the eyes of their patients. Many patients rely on family and friends in an effort to locate physician services that are more congruent with patient satisfaction thus such behaviour will tend to diminish their maternity practice even further, as these experiences with unethical behaviours are communicated throughout the local patient population.
Another form of abuse of power that was reported by some participants concerned the shifting of blame onto the patient when standard diagnostic tests were unable to uncover reasons for experiences of poor health. Rather than admit the limitations of allopathic diagnostic capabilities or the limitations of physician knowledge, the physician sometimes avoided the dissonance associated with illness that is unable to be labeled by the usual methods, by making the patient believe that such an occurrence was their fault. Through strategically employed discursive means physicians sometimes attempted to convince the patient that they had "failed" the tests rather than the reality of the situation: that is the tests and interventions (and perhaps the physician) had "failed" the patient. A further and more extreme example of this avoidance of admitting the limitations of present allopathic strategies employed by clinical personnel concerns the communication by physicians that health experiences that allude standard diagnostics must therefore be owing to patients' psychological imbalances. This finding was relatively rare but nevertheless such an abrogation of responsibility is perceived as abusive by patients. Instances such as those detailed here (in addition to other instances of blaming the patient) really deserve censure from governing medical ethical bodies.

The problem is that very few occurrences are ever reported to medical councils for review. Certainly none of the occurrences mentioned in this study were reported to be brought to the attention of any governing body or review committee. While medical bodies can report the overall rates of satisfaction with physician care as being high because of the low overall numbers of substantiated
complaints, they are probably drastically underestimating the number of
occurrences of abuse of power and instances of dissatisfaction with treatment.
Patients consistently reported that when they receive care that is either
unsatisfactory, inadequate or abusive, they feel that their only recourse is to find
another physician and to hope that they will be taken more seriously or treated
with more respect, elsewhere. These participants noted no other means of
redress. In addition, some participants felt that even attempting to find another
physician constituted a problem as they believed that physicians are very mindful
in not accepting patients of other physicians in the local area. Thus, these
participants felt that this practice and the structure of inter-physician relations
severely restrict their ability to choose physicians that will give them the type of
relationship they need.

In the same way that patient agency was heavily implicated in the aspects
that participants linked to dissatisfaction with their clinical practitioner, this was
also true of the kind of treatment that contributed to their perceptions of
satisfaction. Again, choice, the ability to have some input into treatment options,
and informational power are all linked to agency and were all mentioned by these
participants. The top two aspects of clinical care connected to satisfaction were
that patients should feel included in any decisional process regarding treatment
and feel comfortable in conversation with a doctor who takes the time and energy
to listen to patients’ stories. Both of these reduce the power differential between
clinician and patient, allowing patients to feel comfortable communicating on a
more democratic and co-operative basis. These participants reported that they
need to be included in the process of deciding diagnostic and interventionary actions. There is much support in the literature to suggest that patients who feel they have a stake in the planning process will tend to be more mindful and committed to treatment regimens and that patient choice in treatment is linked to improved health outcomes (Greenfield, Kaplan & Ware, 1985; Kreps, O'Hare & Clowers, 1989; 1994; Mintz, 1992; Pettigrew, 1988; Stewart & Roter, 1989; Winefield & Murrel, 1991). Patients reinforced this finding by explicitly expressing that they want a more democratic relation. In addition, patients expressed a desire that their physician should be better prepared to offer the information they need to help them in their research regarding the best possible course of action in treatment, and to be willing to act as mentors in the search for such information.

Patients prefer that their doctor not be inimical to alternative healing and to have the information base to describe treatment choices other than standard pharmacological or surgical interventions. Patients tend to prefer less invasive interventions and for some this may require the doctor to be conversant with a more holistic paradigm, if at all applicable to the problem. Many of these participants would like their physician to have a broader informational base that may include at least a cursory knowledge of alternatives and preventative outlook on health management. Patients want to feel comfortable discussing their thoughts concerning possible alternative therapies and to be able to discuss the treatments they might be receiving from alternative practitioners with their allopathic physician. However, general physicians already have their hands full in
being up to date on medicalized knowledge and procedures so it would seem rather impractical for them to be expected to become authorities on a whole host of alternative, complimentary or holistic areas. It would seem that while patients would ideally prefer their physician to be conversant in these areas, they would be happy to seek such information elsewhere as long as their family physician was not openly hostile to alternative and complimentary knowledge and techniques.

It should be noted that the overwhelming majority of participants had an experience of a physician who had at least some of the qualities that led to satisfaction and some were very happy with the physician they now see. The majority of those who reported being very satisfied were those that receive medical care through the James Bay Community Project which provides physician services through a salary method of reimbursement (the discussion of results from this group of participants will discussed at length presently). In addition, two “fee for service” physicians were reported to have provided a very high level of care in general and in particular, to have been very attentive to the needs of labouring mothers. These particular physicians (one male and one female) were reported to have been available for one on one care throughout the labour and to have been extremely supportive, caring and attentive.

One of the most surprising findings of this in-depth qualitative interview protocol was that dissatisfaction occurred with a great number of physicians regardless of gender or age. The same problems were reported with equally as many male as female physicians and with older and younger practitioners alike.
Alternatively, many physicians were singled out for their satisfactory care and this too seemed not to be related to gender or age. It would seem that previous research that appears to show that female physicians may be more willing than males to treat their patients with respect and to allow a more democratic style of relationship in consultation (e.g. Weijts, 1994; Korsgaard, 1991) were not supported by this study. In addition, the changes to medical education that are heralded as providing greater emphasis on communication and what is commonly referred to as “bedside manner technique” are not showing a great effect if these participants are representative of the population in the Capital Health Region. These participants’ comments demonstrate that the ability to be skilled in communicative interaction that fosters greater patient involvement may be unrelated to recency of graduation from medical school. Thus, although one should be careful in drawing any hard and fast conclusions based solely on qualitative data, it appears that a much greater emphasis still needs to be placed on physician-patient communication technique in medical school education if we are to improve level of satisfaction as perceived by patients in diagnostic encounters.

Agency, communication and satisfaction with salaried physicians

As mentioned previously, the greatest overall level of satisfaction with physicians was experienced primarily by participants who accessed physician services at the James Bay Community Project. The aspects that were linked to satisfaction seem to be reported in greater abundance describing this group of physicians who are paid by way of salary. Patients reported that they feel they
always have enough time to discuss issues that are important to them and that they feel included in the diagnostic and planning for intervention processes. They felt they were treated respectfully and that their physicians were listening to their concerns. In addition, the overwhelming majority of patients at the clinic are highly satisfied with seeing the nurse practitioner for many of their appointments. None of the participants mentioned that they would have preferred seeing their doctor instead. Another aspect linked to this group's overwhelming level of satisfaction with the project involved the reception and office staff. Patients reported that they were always welcome and they really appreciated that everyone involved in care at the project was friendly and personal with them. It should be noted in contrast that problems with office, reception and nursing staff at regular physician offices were mentioned by a few patients of fee for service physicians as being a problem and in some cases a barrier to care. Care must be taken in evaluating whether the effect of greater satisfaction with the different approach to clinical care at the project is caused by the differential remunerative policies. Certainly physicians who are paid a salary will not have the same encouragement to increase the rate of patient throughput but it should be kept in mind that physicians who chose to practice and be paid a salary are probably very different that those who chose not to. In other words, much of the effect may well be owing to the level of respect these physicians have towards their patients and their practices would be linked to greater satisfaction regardless of the structure of remuneration.
The only negative aspect of note mentioned by patients at the project was that they felt they would have preferred their maternity care to have been provided by the staff at the project, rather than having to find another physician. Recently, physicians have stopped doing maternity care at the project because of funding limitations and patients were appraised that they needed to find an alternative physician during the maternity period. In these cases, patients had to see physicians who were paid through normal fee for service and they found the relations with these physicians to be in general, much less satisfactory.

Agency, communication and midwives

The participants who chose midwifery services, as mentioned earlier had on average, a much higher education level and this may be linked for a desire for greater agency through informational means. The reasons that these participants gave for seeking out a midwife were varied and considering this study was done during the first 18 months of its inclusion in paid clinical services through the Medical Services Plan, surprisingly none of the participants reported that their choice was linked to this change. The socio-economic demographics of this group of participants were not significantly different (except for the higher average educational level) from any of the other groups (except that the patients at James Bay had a slightly lower SES than the others). Some of these participants chose midwifery because they had experienced poor care from medical personnel in the past, and two of these participants had experienced previous births with a doctor where they considered their care to be less than satisfactory. Others reported their main reason as a greater need for information.
and choice and felt that midwives would be able to provide an augmented level of support. The majority of midwifery clients had known a family member or a close friend who had experienced birthing with a midwife and these personal connections were reported as being very important in their decision. Very few of the participants who chose physicians had a friend or a family member deliver a baby with a midwife.

The reports of their experiences and the aspects linked to their extremely high level of satisfaction were intimately connected to their perception of greater agency supported by a more personal and democratic relationship with their clinician. All the participants met with their clinician on a similar schedule to those who were patients of physicians but the appointments lasted on average approximately one hour and in some cases even longer. In contrast, patients of physicians reported appointments that were generally in the 10-15 minute range. Partners of the patients were encouraged to attend the appointments and this was reported as not only adding to the comfort level of expecting mothers but had practical purposes, in addition. The attendance of partners worked for these participants in improving the communication between patient and clinician as an additional person facilitated reminding the patient of issues they wanted to discuss. The attendance of two people also enhances patient retention of information during appointments. Again the results seem to point to an augmented perception of agency as linked to an increased level of sociality and inter-dependence in diagnostic interactions with clinicians as well as partners.
Clients of midwives consistently discussed that the appointments fostered open discussion and created the conditions for a necessary learning process surrounding prenatal health and birthing. Communication with their clinicians prepared them not only for decisions they would be making during their labour and immediately after the birth but choices they needed to make with regards to their general health and diagnostic intervention during the prenatal period. Whereas patients of midwives were given access to information that enabled them to decide which tests and the level of intervention they wanted, patients of physicians were rarely if ever appraised that they were in a position to make decisions and had the power to decline interventions they felt were not appropriate. In addition, many patients of midwives discussed that they were happy that their midwife was very supportive of their choices and in particular that clinicians respected patients' beliefs in alternative medical practices.

Patients were able to decide if they preferred a home birth or for the midwife to be in attendance at the hospital during their labour. Some participants decided that they would prefer a home birth and once again the issue of agency was front and centre in this decision. Those who expressed a preference for a home birth reported that their reasons were linked to feeling more in control of and comfortable with their environment. In particular they felt that having a baby at home gave them increased power to access anything they might need and to choose whom they wanted to attend as support. In some cases, while the labour progressed to a certain point at home, the attending midwives recommended
transport to a hospital and these labouring mothers resumed labour with the midwife in attendance at this facility.

Others preferred to be at the hospital for their birth and the prime reasons reflected a need to be conservative and to have medical intervention at hand should this become necessary. This can be seen as reflecting a preference to have the best of both worlds. They discussed their need to be supported and educated about the processes of pregnancy, labour and birth but wanted an additional level of comfort derived from being in proximity to access to medical interventions, should they become necessary. Regardless of where they chose to give birth all were highly satisfied with the continuous one on one support they received during the labour, which is something many patients of physicians did not experience.

Patients of physicians were generally much more dependent on their own informal support network during the early stages of labour with occasional attendance by hospital nurses. In some cases participants reported that it was very difficult to get attention from nurses until the critical period shortly before the birth of their baby. Other patients of physicians reported that they found themselves getting intervention they did not want (including pain medication that had serious side-effects) and they were often not appraised of these interventions, let alone asked if they agreed. Many patients of physicians viewed that labour was happening to them and that they had very little power to arrange the situation so that they were getting the level and kind of support they needed. At some point in the birthing process the feeling that the birth of their baby is out
of their direct control is something that is quite normal as the biological systems are working of their own accord. However, many of the participants who decided to be cared for under the usual allopathic system found that, to the extent their agency could have been supported by the medical arrangements at the hospital, they were not helped in this regard for the most part. For example, many patients reported that they felt constrained by nursing staff to labour in positions that were extremely uncomfortable. In general, one of the standard procedures that nursing staff tended to insist on required labouring mothers to be on a bed and often on their back with a fetal monitor attached. The use of fetal monitors is an added insurance to protect against fetal distress during the labour process and can be a valuable tool. However, much research has demonstrated that they tend to be over-employed and the diagnosis of fetal distress is often made in error (O'Connor, 1993, Hanvey, Levitt & Chance, 1996). Such a diagnosis then leads to increasing strategies of intervention, perhaps even cesarean section when in fact such interventions would not otherwise be necessary (O'Connor, 1993). More often than not, the result of the utilization of a fetal monitor makes the labour not only more uncomfortable for the mother (resulting in greater exhaustion) but contributes to a more difficult birth process. The longer, more exhausting process that results from the mother's position of being flat on her back will more than likely result in further interventions as the result of or leading to, an increased probability of fetal distress. In other words, the over-reliance on fetal monitors as an insurance can often have the effect of producing exactly the
problems that their use purports to protect against (LoCicero, 1993; Peterson, 1983).

For midwifery clients who either chose a hospital delivery or were transported from home, the midwife was reported to have functioned as a advocate for the patient, working to improve the patient’s agency. As a result, the experiences of midwifery clients at the hospital were reported to be more satisfactory. In large measure, this increased sense of satisfaction was owing to their midwives intervening in normal hospital routines and working as advocates to arrange labouring situations, allowing the maximum amount of choice for the comfort of patients. Whereas nurses generally tended to want the labouring mother on or next to their assigned bed (often with diagnostic technology attached) patients of midwives were able to make many more decisions regarding how, where and in what position they would labour. Midwives also tended to function as a mediator regarding what, if any pain management techniques their clients had stated they wished to take advantage of.

In addition, midwives advocated on behalf of their patients concerning patient choices made regarding post-natal treatments and interventions. Whereas patients of physicians were hardly if ever appraised of medical intervention, let alone given choices regarding treatment to the newborn baby (e.g. the application of silver nitrate and injection with vitamin K), midwifery clients were able to rely on their midwife to ensure that their prior choices were adhered to.
Another aspect that was discussed as improving patient satisfaction by midwifery patients were the frequent home visits by clinicians after the birth. It's at this point that many mothers (regardless of how they accessed care during prenatal and maternity) realized that they have put much of their energy into prenatal care and birthing and they now have a whole new set of challenges for which they have much less preparation. Caring for a new infant can be fraught with difficulty. One of the main problems reported by all mothers was becoming comfortable and competent with breast-feeding. Whereas many patients of physicians (especially those who are first-time mothers) depended heavily on nurses in the postnatal ward, patients of midwives had more and more usable advice both in the hospital and at home. In general, midwives visited their clients for the first three days after birth (in the case of home births) and the first three days at home after being discharged from the hospital. Additional visits were also scheduled during the first two weeks. In comparison, patients of physicians usually have their first postnatal appointment with their doctor two weeks after birth. Midwifery clients were very satisfied with these visits and found that they increased their ability to feel more competent in various aspects of infant care.

There were only three complaints made about the care patients of midwives received and two involved the concept of agency in different ways. One of these could be considered a major problem that should require the College of Midwives to address problems of this type with a fuller discussion of policy. In the case of one scheduled home birth, the patient after labouring at home needed to be transported to the hospital. Once admitted, the attending obstetrician
recommended an emergency cesarean because the baby was in a breech position. The attending midwives had missed the signs and the resulting surgical intervention was reported to have led to hip displacement in the infant. This birth-related trauma required considerable ongoing care and intervention to rectify the problem. The parents were rather upset that the midwives did not communicate with them about how they misinterpreted the signs and did not appear to admit to or accept responsibility for this unfortunate outcome. It may be that the different relationship between patient and clinician that gives greater agency to mothers in deciding the level and type of care they receive, actually works to dissipate personal responsibility on the part of the clinician in the case of unforeseen outcomes. There may be a decreased tendency for clinicians to feel they need to be accountable because they merely provide information and it is the patient that makes most of the decisions regarding care. There is the possibility for clinicians to erroneously view that this more democratic relation absolves the clinician of responsibility to some degree. No doubt, such issues are difficult for clinical staff to deal with and a greater effort should have been made to communicate with the parents about this outcome. However, such incidents really test the adequacy of this model of care and it would behoove the College of Midwives to work to define a code of ethics with respect to accepting responsibility for accidents and bad as well as good outcomes.

The other two issues that were broached were minor (in terms of medical outcome) but one represents a case that provides concrete contextualization allowing a fuller discussion of the practical meaning of agency. In this case the
mother was very motivated to find a great deal of information concerning
decisions she would make with respect to immediate postnatal interventions on
her baby. She found that sometimes the amount of agency experienced in her
relation with her midwife to be problematic. In other words, she had amassed a
whole host of information but found the midwife was very reticent to give advice
concerning her decision and subsequent course of action in this regard. This
participant expressed the opinion that in certain circumstances clinicians should
provide their point of view and greater guidance because the clinician’s greater
experience can be a valuable resource where considerable doubt and indecision
exist. Not everything can be automatically deflected in the interest of the highly
laudable goal of empowering the patient. An expanded and more sophisticated
account of informed choice should include a co-operative effort to find the correct
balance between freedom and necessity in healthcare. Providing direction may
sometimes be appropriate in efforts to improve probabilities of good outcomes
and to reduce patient anxiety.

Both of these issues show that there needs to be a balancing of patient
agency with clinical expertise. It would be an important consideration to keep in
mind that if we accept that the promotion of agency in physician-patient
relationships leads to better health outcomes (which a whole host of literature
presented earlier would support), then the attempts to promote patient agency
should not be reduced to applying a formula allowing clinicians to conveniently
take a back seat to patient wishes in all cases. The promotion of agency requires
an ongoing gauging, balancing and the re-assessment of both situations and
patient reactions in order to insure patient comfort and safety. Patients who are asked to shoulder more responsibility for decisional power than they feel able or willing to accept will tend to actually decrease their perceptions of agency (Haney & Long, 1995; Bandura, 1986; Litt, 1988). The ensuing anxiety and feelings of lack of actual agency following from their predicament may then have a tendency to compromise health outcomes (McCaul, Sangren, King & O’Donnell, 1999; Schnoll, Harlow, Stolbach & Brandt, 1998; Gray, Fitch, Davis & Phillips 1997).

The third negative comment (also minor) consisted of the perception of one midwifery patient that there was insufficient attention to parenting issues by this participant’s midwife. The preparation for the prenatal and birth experience was found to be satisfactory but this participant found that she felt much less prepared once the baby was born. It should be kept in mind that although these three problems were encountered, the overall rate of satisfaction with midwifery was extremely high. Even the three negative comments made with respect to experiences with midwives are contextualized by a high degree of satisfaction with the overall level of clinical care in each case. Most of the midwifery patients interviewed had nothing but glowing reports of their experiences, primarily because they felt their clinical relationships supported their needs to organize their health care in accord with their requirements for personal control.

Agency and communication at the hospital

The experiences reported by these participants at the hospital were mixed. Satisfaction was high when there was a perception by patients that the staff were communicating with them concerning medical interventions and when there was
a perception by the new mothers that their needs were taken seriously. Unfortunately, the majority of participants reported at least one incident where their needs were not met. Younger, less well-educated, first-time mothers who were patients of physicians and who laboured at Victoria General Hospital tended to experience more problems. This was especially true when the hospital was busy. Patients of midwives, when they were either transported or chose to deliver at a hospital reported the best experiences. This was primarily because they experienced continuous one on one care from their midwife and they had an advocate who interceded with hospital staff to extend their agency. They also tended to be better informed concerning labour and likely interventions because of their increased contact with their clinician and the more empowering form of interaction. They were better prepared to meet most labouring eventualities and the more democratic style of clinical relationship during the prenatal period had either changed or reinforced a generalized expectation for greater control over processes and interventions.

In addition, those who chose to have their baby at the Saanich Peninsula Hospital reported a highly satisfactory experience. Patients reported that the staff were very attentive and caring, seemed to have time for patient care, allowed the patient greater choice in dealing with the pain of contractions and communication between staff, doctors and midwives was reported to be excellent. The quiet rural setting and the relaxed atmosphere in labour and delivery added to the experience for participants. It should be noted that (without taking anything away from the caring attitude of the hospital staff) that four out of the five participants
who elected to deliver at Saanich Peninsula were patients of midwives, and this might account for at least some of their high level of satisfaction. It is interesting to note that even hospital selection by patients was something that was actively encouraged by midwives. Whereas many patients of physicians did not know that there were alternatives open to them, patients of midwives were encouraged to tour all the available facilities and to make a choice. Some of the midwifery clients stated that they chose Saanich Peninsula because the staff were very welcoming and the quieter atmosphere seemed more conducive to labour and birthing. In addition, some reported that their initial reaction to the tour through Victoria General left them feeling that they would not feel comfortable in such a large and busy facility. As one mother put it "I'm not staying here – this is a baby factory...."

As mentioned above, the experiences of participants who went to Victoria General Hospital was extremely uneven. The delivery ward was reported to be better than both the ante-partum and post-partum wards and again dissatisfaction was connected to problems with patients feeling that they did not have a sense of control. Hospitals, owing to their institutional regulation tend by general medical and administrative policies to organize interactions with an unsymmetrical power differentiation between medical personnel and patients (Rothman, 1983). There are also problems in their organization because modern health and hospital administrations are often concerned with efficiency and the top level administrative positions are generally staffed by professional administrators and healthcare efficiency experts (Saul, 2000). The efficiency
models and "just in time" economic models of industrial production applied by professional management are often incongruent at a fundamental level with the medical interventionary needs of medical personnel. In addition, the "top-down" hierarchical communication channels mean that the needs of management are often applied without sufficient consultation with medical personnel that have to both answer to management and serve the healthcare needs of patients. In recent conversations with many nursing personnel I have been appraised that there is some bitter resentment to management practices with respect to hiring and staffing policies as well as priorities in duties. Some nurses have complained in interviews concerning the increasing pressure on their time that is not only owing to insufficient staffing levels but to the proliferation of management-generated policies. Some of these changes in policy emanating from management appear to be aimed primarily at improving the system's ability to maintain adequate records in an effort to protect against litigation in the event of accidents or improper treatment. Such priorities combined with inadequate staffing levels, and staff burn-out actually serve to increase the probability that critical situations will not be appropriately addressed. There is already a severely limited time for personal contact with the patient and the needs of the organization in terms of record-keeping exacerbates an already problematic situation with regard to appropriate patient care.

According to Saul (2000) many of the problems with healthcare in general and hospitals in particular stem from professional management techniques. Administrators are applying methods of management erroneously conflating the
latest efficiency models with the goals of the organization. Management is derived from the French word meaning "housekeeping" and while housekeeping is a laudable activity, it should not be confused with the goals of organizations that require careful consideration of valued outcomes and ethics. Medical personnel need to reassert control over these health organizations, set the medical goals in accordance with the best clinical outcomes in mind and within the parameters of specific health targets, allow the professional managers to devise plans that meet these health goals, rather than set them. According to Saul, management protocols entail no particular valued outcome and therefore without adequate steering from those with a vision to meet society's needs in healthcare, only disaster can result. While I am supportive of this general view that models of efficiency are not necessarily applicable to health management I believe that Saul has forgotten that the utilization of such methods actually does represent a restatement of certain ideological positions, values and ethics. It is just that the values of industrial production of input-output models that attempt to maximize gains in terms of fiscal efficiency with the minimum input, are hidden and unstated. The logic of market forces and accounting procedures are assumed to be inviolable rules derived from nature and therefore "value-neutral". Accounting procedures are a crystallization of a particular ideology that removes the person and agency from the measurement of abstract economic goals and/or parcels these aspects out as error in, an effort to define care in terms of dollar values and outputs. However, in the context of healthcare they are not only often impractical, they can result in the structuration of immoral and insupportable
shortfalls in care. Their application results not only in patient dissatisfaction but poorer health outcomes. In addition, such a fiscally driven model of management assumes that maximum "efficiency" can be accomplished by closing down smaller hospitals that research shows is connected to both higher patient satisfaction and improved health outcomes (Saul, 2000). Thus, there is an unsymmetrical power differential and incongruence between the aims and methods of management and medical staff, and again between medical staff and patients' need for care.

Policies are designed to augment the power of the institution and its employees and patients are expected to be available for interventions as and when the institution and the medical staff dictate (O'Connor, 1993). In addition, hospitals are institutions where illness is diagnosed, treated and (hopefully) cured whereas labour and delivery (while in some small percentage of cases may require some medical intervention) is not itself an "illness" requiring the sorts of intervention usually associated with disease (LoCicero, 1993; O'Connor, 1993). Thus, the model of care that such an institution embraces (however problematic this may be to patient satisfaction in the case of bona fide illness) is hardly appropriate to the non-congruent case of labouring and birthing.

An example of this mismatch between the policies of hospitals and the needs of patients is illustrated by the fact that many labouring mothers expressed the need to be walking, sitting, squatting, or in the shower and to be free to select any one of these activities as labour progressed. Whereas, apart from some cases, the general needs of the staff were that patients should be on or as near
as possible to their bed. Many patients reported that hospital staff were happiest when they were labouring flat on their back and generally with a fetal monitor attached, which makes surveillance and access to the patient convenient for interventionary reasons but is probably the most difficult and painful situation for the labouring mother.

In the delivery ward some patients reported they were highly satisfied with the attention they received from the nursing staff and medical personnel. However, unless labouring mothers had an advocate to function as a mediator between themselves and the hospital staff and policies, patient agency was often either not generally supported or in some cases, actively circumvented. As mentioned previously, many participants (especially younger, poorer, poorly-educated and first-time mothers) reported that they felt their concerns were not adequately addressed by nurses. In some circumstances when the hospital was busy, it was really difficult to get the attention of any nurse. Unless they had a midwife or a doula, some patients were left to rely primarily on their informal support network. Some participants also reported that the knowledge of their own health and body as well as appraisals and reports of their experience of their labour progression were routinely discounted by staff. There was a general feeling by many participants that the authoritative view concerning actual progression was pronounced by nursing staff, not as the result of an open discussion of patient experience with her own experience of her bodily changes.

Many patients felt that labour was happening to them and in most cases they were rarely asked their opinions or choices of intervention, and a few
reported that they were not even appraised of planned examinations on their own body. Patient concerns regarding the side-effects of medications and pain management interventions were sometimes not adequately addressed. Admittedly, in extreme circumstances a quick response is required and often there are few, if any, alternatives to be considered. However, patients reported that they felt they were sometimes regarded as no more than objects rather than as conscious persons and often felt removed from the information loop. This had a tendency to slow their labour and/or increase their level of anxiety and in some cases made them feel angry. None of these feelings can contribute to best outcomes.

There is a lot of interest in renovating maternity units to make them more modern and comfortable. This can be a very positive exercise but if such planned budgets were switched to funding staff training in maternity units this may have a far greater positive effect on the experience for labouring mothers. Klein (1995) concludes that the main issue for labour and delivery is choice from a reasonable menu of options and finding the best fit between a woman, the particular location and a set of caregivers. Among caregivers there are a large range of beliefs and assumptions about what this experience of childbirth involves. At one end of the spectrum are clinicians who believe that childbirth is only natural in retrospect, that women are unreliable incubators and that clinicians are the best people to decide when intervention should take place rather than if there is a place for it at all (Klein, 1995; LoCicero, 1993). At the other end are clinicians who believe that this is not a medical problem and although vigilance is necessary, in the
overwhelming majority of cases little or no intervention is required. The general professional climate among obstetricians is that birth is dangerous in most cases and that medical timetables based upon norms collected from aggregate data on “average” labour will lead to the best management of this “illness” (LoCicero, 1993). Unfortunately, whereas the midwifery and home birth movements adhere to an understanding that pregnancy, labour and birthing are individual, idiosyncratic events, professional allopathic personnel and structures employ a scripted timetable. The incommensurability of individual labouring events to norms based on the “average” birth (an abstracted “ideal” construct) contributes not only to disagreement between the midwifery and allopathy models of care, but to the abrogation of patient agency and as a consequence, dissatisfaction with care in hospitals. Women need to find the type of maternity and labouring care that best fits with their own set of beliefs and the needs that these engender.

McNiven, Hodnett and O'Brien-Pallas (1992) investigated the effect of continuous one on one care by completing a meta-analysis of the results of 11 randomized controlled trials and found that there was overwhelming evidence that protocols that allowed such care as opposed to usual hospital care where continuous care was not present, had superior outcomes. These measured outcomes included, the satisfaction of the mother, rates of Cesarean sections, amount of pain relief intervention, health outcomes of the baby and post-partum depression rates of mothers. Only about 10% of the time that nurses spend on labour and delivery wards is one on one care. The introduction of technology has meant that nurses are spending increasing time doing record-keeping duties or
tending the machines rather than supporting the mothers (Hodnett, 1995; Hanvey, Levitt & Chance, 1996). Continuous one on one labour care reduced the rate of Cesarean sections by 10%, reduced the use of forceps interventions, epidural anesthetic and reduced the length of labour on average by 2 hours. This same study showed that even having an observer sit quietly in the room for the entire process reduced the need for intervention by 5%.

Technology and Care

There is no research support suggesting that the routine use of ultrasound during pregnancy has any clinical benefits. There are several reasons why patients and their belief in choice may in part be driving the use of ultrasound machines and the first three of these can be generalized to technological interventions in general. Patients are becoming more knowledgeable about medicine and medicalized childbirth in particular. They want as much information as possible and if at all possible they will ask to use facilities that are known to be available. This is closely connected to the second reason which is that patients are also exercising a greater sense of agency in the context of health and will ask for their needs to be met in greater numbers than previously. The third driving force is concerning the general population's love affair with technology and wanting the finest in cutting-edge scientific medicine. However its use often leads to a cascade of more and increasingly invasive tests when there may be no real medical necessity to have started out down this road in the first place. Lastly, ultrasound during pregnancy is often seen as a prenatal photography session by
many parents and this becomes the part of the driving force behind their use (Gorbauld, 1999).

The other part of the puzzle behind the increasing use of expensive technological screening and interventions is linked to physicians and the structure of the health system, particularly the way remuneration is paid to clinical staff. Within a fee for service system the more interventions physicians order the more they are remunerated. Yet, not all of the physicians' willingness to order tests is completely economically driven as they often really want to do the right thing, which may include giving peace of mind to worried mothers. However, in an increasingly litigious society many physicians are adapting to this cultural change by ordering more tests as an insurance against malpractice claims (Johnson, 1995; LoCiciero, 1993).

Technology is often being routinely introduced before there are any scientific studies that show that they have any clinical value. Fetal heartbeat monitoring was introduced and yet there are studies that have shown that their use provides no improvement in outcome (Hanvey Levitt & Chance, 1996; Levitt, 1995). Such scientifically valid studies have made no impact on the increasing purchase and use of this technology. It seems that the culture of medical administration has led to some illogical decisions surrounding the use and purchase of technology. This is especially noteworthy when we contrast the willingness to pay for machines without receiving any measurable benefits and yet refuse to pay for staffing and improved staff training even though it has been.
scientifically demonstrated to be clinically advantageous (Levitt, 1995; Johnson, 1996).

Other aspects that might come into play in this regard are concerned with power. Technology tends to increase the power that the administrative sector of a hospital has over the healthcare process, both by eliminating jobs and by reordering the work that front-line healthcare professionals do. Clinical staff at hospitals are spending a greater proportion of time caring for the needs of various machines, thus not only are they less available for the patient in terms of real interaction and care-giving, they themselves are more tightly monitored in terms of their work efficiency. Patient data collected by technological means and recorded in administrative documents can also service as an monitoring instrument over staff. In addition, the political classes can utilize the funding of machinery in hospitals to greater political advantage as the purchase of a shiny new machine will often garner more press coverage than a promise to better train or hire more front-line staff. Such purchases are politically expedient because the structure of political governance exists within 4-5 year opportunity horizons. A long term plan that might fail to show any measurable difference within a short period (i.e. before the next election) is less likely to be approved for considerable funding commitments.

Many other routine interventions done with labouring women in hospitals are also unnecessary (Hanvey Levitt & Chance, 1996; Anderson, Axcell & Hunsburger, 1994). In 1996 it was found that 16% of hospitals routinely perform shaving with the traditional rationalization that this will protect against infections
when delivering the baby as well as facilitating easier suturing after a tear or episiotomy. Research has demonstrated that neither of these arguments are scientifically supportable (Gorbauld, 1996). The percentage of hospitals using this procedure in Canada has decreased from 50%, ten years earlier but there is no clinical reasoning behind this policy what to speak of the costs in staffing time and materials (Levitt, 1996). Many hospitals routinely use enemas or suppositories in an effort to eliminate the possibility that the newborn will come into contact with fecal matter. However, this is not a major problem and their use often makes things even more messy (Levitt, 1995:1996).

Enabling women to deliver the baby in whatever position they feel the most comfortable is probably the most efficient way to facilitate birth. To design and maintain an environment where this can be facilitated should be viewed as an important aspect of promoting the best clinical outcomes (Klee, 1996). While some hospitals have included some aspects of this philosophy in the design of delivery suites, there is not yet enough attention to the simple changes that can be made to improve clinical outcomes, allow greater agency to the labouring mother and by extension, to promote positive experiences for her and improve clinical outcomes (Levitt, 1995). The problem is that hospitals are primarily places for “the sick” and this philosophy is a very powerful determinant of the policies, procedures and design of maternity units to this day (Hanvey, Levitt & Chance, 1996). The connection is still made between a patient and “a bed”. Whereas the matching of “patients” and beds can be made with those who are actually ill, there is no logical reason to extend this pairing to labouring mothers. Thus
connection is merely a vestige of traditional administrative and clinical models of care that reinforce the power of the institution and the clinical staff over patients. Thirty-seven percent of hospitals in Canada still prefer the lithotomy position, where the labouring mother is in bed with her legs in the air held by stirrups. This is one of the most difficult positions for a labouring mother but it is one that allows the most convenience for surveillance and intervention by medical staff (Levitt, 1995).

Klein (1995) examined the relationship between physician belief and the care that maternity patients received, including the types of interventions that were undertaken with special attention to the rate of episiotomy. If a woman has a physician who is wedded to routinely intervening with an episiotomy, she will naturally be more likely to have one. In addition, she is also likely to experience more intervention and trauma of many sorts. There is a far greater probability of cesarean section, and 10 times the diagnosis of fetal distress that is in error. Patients are less satisfied with their care as compared to those patients cared for by physicians whose views on episiotomies are sceptical. Although those physicians who adhere to the routine utilization of episiotomy believe that this decreases the probability of third and fourth degree tears, the opposite is in fact true. The great majority of serious tears occur because of this intervention (Klein, 1995).

The conclusion to be drawn from this investigation and previous research is that patients need to be able to discuss both physician and patient beliefs in order to negotiate the type of treatment that will be beneficial and comfortable for
the patient. This exercise should require an unencumbered communicative relationship and considerable knowledge and sense of purpose on the part of the patient. In many cases this can be problematic owing to less than adequate communicative expertise by patient and/or physician. In general though many physicians have been socialized to interact with patients in an authoritative style and are uncomfortable with a more co-operative relationship.

Certain beliefs, policies and practices common in hospitals after delivery have been shown to be unrelated to positive outcomes. The majority of Canadian hospitals have a routine observation period for healthy newborns following birth, but there is no evidence that such a policy of removing the baby from the mother for a period of time has any positive effects (Kennell, 1995, Gorbauld, 1996).

Cesarean section rates in the Capital Health Region are very high as compared to the provincial and national average of 19-23%. Over the past fifteen years the rate in Victoria has averaged 24% and has been relatively stable over that time. A recent review by the Capital Health Region by medical personnel was unable to discover why this was the case and says that such matters are difficult to ascertain. According to the report, the reason given approximately 40% of the time a decision is made to do a c-section is noted as "failure to progress" which is viewed to increase the probability of fetal distress. To avoid fetal distress the intervention is made. However Klein's investigation (1995) shows that the largest predictor of various intervention strategies are physician beliefs rather than the actual individual progress of labour. In other words, the orienting ideology of the doctor will greatly affect whether or not the mother will give birth.
normally or not. As mentioned previously, fetal distress has been shown to be erroneously over-diagnosed (Sakala, 1993; LoCicero, 1993)

The most commonly reported problematic experiences were encountered by participants at the post-partum ward (Mothers and Babes) at Victoria General Hospital. While some patients experienced staff to be caring and helpful, many more incidences of problems were reported here as compared to those reported in the delivery suites. Participants who commented favourably on the care and attention they received in any ward in the hospital always felt this experience was linked to nurses who took the time to talk to patients personally and who in some way were encouraging, especially with physical touch. Many new mothers found that staffing levels were inadequate and nurses were either hard to find, were sometimes very short with patients and/or gave conflicting information regarding the care and feeding of their new infant. A few commented that they had to continually remind nurses about their case because it seemed that because of problems with staffing, nurses were not adequately briefed or were not referring to the patient's charts. Patients reported seeing nurses for one shift and then never again. A couple of patients reported that this lack of background in patient casework and lack of continuity of care led to more troubling examples such as patients being given medication in error or medication that they were allergic to. Such care was actually reported to have put the patient at risk.

Post-partum mothers, although somewhat exhilarated by the birth of their baby are tired and in the case of first-time mothers, anxious and unsure about the intricacies of caring for their new baby. Many mothers reported that getting
adequate information from hospital staff at the post-partum ward was often difficult at Victoria General. Reports of conflicting instructions were common and this had a tendency to increase feelings of inadequacy. A couple of new mothers who had endured a cesarean were told not to get out of bed but then they could not get the help of nurses when their babies needed attention. They attempted to deal with the situation on their own only to be reprimanded. In addition their inability to receive assistance from nursing staff put them in a Hobson's choice situation: Should they not attend to their newborn or should they compromise their own medical outcomes by doing so?

Different nurses had divergent ideas on breast-feeding techniques that again made many first-time mothers feel severe cognitive dissonance that had the effect of undermining their confidence in being able to care for their infant. Help regarding breast-feeding was sometimes very difficult to get and some participants felt that staff were not sufficiently committed to establishing breast-feeding over the use of formula. Kennell (1995) found that in comparison to newborns who are left with the mother, newborns put in the care of others (including hospital personnel) experience "separation distress". A series of investigations from Sweden have shown that babies born without the use of pain medication or any other intervention will often orient themselves to move towards the mother's breast and within 30 minutes actually latch successfully to the nipple and attempt to feed. These actions on behalf of the newborn are correlated to more successful and longer breast-feeding routines. Kennell replicated these studies and demonstrated that newborns left with the mother were able to crawl
on their own to the breast whereas those who had been separated for observation could not.

Breast feeding has enormous benefits both for the infant and the mother. For instance, breast-feeding mothers have lower rates of ovarian and premenopausal breast cancer as well as osteoporosis later in life (Gorbauld, 1995). Infants that breast-feed are 10 times less likely to get H-flu meningitis, and half the chance of contracting urinary tract infection and insulin-dependent diabetes. There is even evidence that intellectual performance is improved as compared to those who are not breast-fed. However, 25% of hospitals still distribute free samples of formula to new mothers who have chosen to breast-feed their baby (Gartner, 1995). The power of marketing a product by companies involved in a billion dollar industry is shown in that the medical evidence is firmly opposed to formula and yet hospitals have been cajoled into becoming a mouthpiece for these practices against the interests of the public and the health system.

A couple of new mothers at Victoria General asked to see the breast-feeding specialist and in both cases this person did not make an appearance before the mothers and newborns were discharged. In all these interviews no participant ever reported seeing this "expert". Sometimes, mothers' instructions regarding care of their infant in the nursery were disregarded by staff. In three cases the infant's security bracelets were either so loosely tied that they would slip off or they were just left in the crib next to the infant. Thus, security was so lapse that an opportunity existed for babies to go missing.
The reported experiences of mothers with obstetricians were mixed and satisfaction was again linked to a caring manner, good communication and the patients' ability to openly discuss and make choices in their treatment. Communication between staff at Victoria General was sometimes problematic, especially when midwives were the primary clinician and an obstetrician was consulted. Nurses were sometimes unsure who was in charge and some nurses were reported to openly show hostility to midwives and doulas. The hostility by some nurses towards midwives represents a problem for patient care and safety. It can also be understood in terms of inter-group psychology that midwives who were for so long considered outside and inferior to medical personnel are now making decisions and giving instructions which nurses are duty-bound to follow. This reversal of status is naturally a difficult problem for nurses who see their more central connection to the culture of medicine as being usurped by practitioners who were previously outside and often considered little more than quacks by some sections of medical culture. Before the addition of midwifery to maternity services in hospital, in all practical senses, nurses were in charge of treatment until the patient's family physician arrived or an obstetrician was needed. In many cases, physicians request not be paged until labour is moving into the final stage as they prefer to arrive shortly before the birth. Thus, nurses have become used to considerable power with regard to patient care. This privileged position of proxy control over decisions regarding labour and delivery is eliminated to a great degree in cases where labouring mothers are midwifery clients because the clinician is in attendance throughout labour.
Nurses have commented to me in interviews that many midwives have not demonstrated sufficient expertise in necessary basic nursing skills (for example, suturing, catheterization and fetal heart monitoring) so in their opinion it is hard to feel respect for them. In addition, many nurses now working in delivery wards in the Capital Health Region were trained as midwives under medical training programmes in many European and Oceanic nations and feel equally (if not better) trained to become midwives. However, many have reported that they have been snubbed by the College of Midwives of British Columbia and therefore have been refused the membership necessary in gaining admission to the profession.

Whereas it was reported by labouring mothers that some nurses, midwives and physicians are able to work together well, when it comes to inter-group relations there are numerous problems of communication and philosophical, political and economic interests which can pit each group against the others. For instance, one might have the opinion that nurses would be supportive of the entry of midwives into the mainstream of paid medical services and their ability to consult with birthing mothers in a hospital environment. This is not always true. Many nurses have closed ranks against the midwives because they identify with the medical model. Others are not supportive because they see the midwives as usurping their position within the hospital as labour coach and support which removes the joy of working in a maternity unit for many.

Some nurses have reported that they did not like working with mothers who had secured the services of midwives because the mothers were constantly
asking questions and making decisions about possible treatments that nurses disagreed with. In other words, many nurses did not like the fact that mothers who were educated about the processes of birth and general hospital routines were empowered to intervene to act in accord with their own interests. Some nurses were unused to the level of education about such procedures and were affronted by the fact that mothers would demand increased information and knew their rights to refuse certain treatments.

The investigation of relations within groups and the differences between such relations with relations between groups and between members of different groups has been a major category of research within social psychology (Schopler & Insko, 1992; Colman, 1982; Kelley & Thibaut, 1978; Farringdon, Berkovitz & West, 1982). Although that it is unfortunate that the overwhelming majority of investigations have used abstract laboratory-based games to understand this phenomenon, some of the findings can be cautiously applied to real life situations. In reviewing the research in this area it seems that the discontinuity effect (the phenomenon that inter-group behaviour is more competitive than inter-individual behaviour) is a robust and reliable finding (Schopler & Insko, 1992). The out-group seems to be seen in much more negative terms than is the case if individuals interact on an ongoing basis. When individuals are expected to make decisions on the basis of collective group interests there is a greater expectation of competitive behaviour by others. In addition, when a group displays behaviour that is not competitive, other groups will often exploit this co-operativeness for their own ends. This is seen as explained by the greater influence in-group
members have on each other and the social support within a group for maximizing short-term self-interest for their members. This may explain why the official policies of medical colleges seem to be far more antagonistic to other health interest groups than individual members often report.

Taken together, it can be seen that the normalization of relations and communication between nurses, physicians and midwives will take some time and effort. Some compromise is needed and because midwives will be joining an existing, large and well structured medical culture, as they become accustomed to hospital settings it would seem to be more probable that midwives will move further towards a compromise relationship than the mainstream medical culture. However, it would be a mistake for midwives to agree to any policies that give greater powers to the institution at the expense of patient need for information and choice. Hopefully, such power politics will eventually decrease and that in the meantime this turf war will not interfere with patient treatment or safety.

Physicians are not very pleased with the addition and extension of hospital privileges to midwives. Physicians' organizations vehemently fought this change from the beginning. One of their main publicly reported concerns, apart from the scare-mongering over patient safety, was that midwives would be paid a great deal more money than they are currently receiving for maternity care. However, they fail to mention that physician appointments with pregnant women are generally 25% of the duration of midwives' appointments, midwives are contracted to be in attendance throughout labour and delivery and considerable time is spent on follow-up appointments with their clients. Often, physicians arrive
for the last 15 minutes of labour (if they arrive at all) and do not generally make post-natal house visits. In this investigation, a great many participants reported that their physician didn't make it to the birth. Physicians were so opposed to this change to include midwifery care as a paid service under the Provincial health plan (and that ostensibly opens up a “closed shop” to another model of clinical care) they refused to allow midwives to be admitted to the Department of Maternity at the region's hospitals. Consequently, midwives now have their own department, that in reality gives them increased power, positioning them to be on an equal footing with physicians. Whereas if the physicians had not been totally opposed, midwives would have had relatively little power as a marginalized minority group within the physician's department. It would seem that the depth of animosity towards midwives was so great that the College of Maternity's judgment was coloured to such an extent that they made a fatal mistake in their Machiavellian strategy to undermine midwives position in the medical establishment. Seen from the point of view of the midwives in the Capital Health Region, this petulance seems to have been rather fortuitous.

One of the arrangements that would provide an atmosphere more conducive to patients' needs for agency during labour and birthing are the establishment of birthing centres. Accelerating in 1950's and especially since the 1970's the majority of births took place in hospitals, especially in North America (Gorbauld, 1999). Home births that previously were very common were then portrayed as “scary” in comparison to physician-attended hospital births by the medical establishment. Research in this area does not support this position
(Shumaker & Smith, 1994; Davis-Floyd, 1994). One of the reasons that midwives have been very supportive of the idea of creating birthing centres was to bridge the gap between home and hospital (Klee, 1986). It gave a generation of women brought up with the expectation of hospital birthing procedures, who were leaning towards home birth, a middle way that provides the best aspects of both models. Only low risk pregnancies are catered to at such centres. Birthing centre projects attempt to institutionalize the democratic nature of clinician-patient relationships common in home births facilitated by midwives (Klee, 1986). One of the main differences for clinicians and patients between hospital and home birthing is the power dimension. Whereas in the hospital, labouring mothers are admitted through a medicalized bureaucratic ritual requiring surrender to the types of interventions the clinicians deem as appropriate, in the home the mother is in her natural environment retaining more of her own power and agency. Birth, in the realm of the clinical legitimates and reinforces institutional personnel rights to intervene as they see fit and even demands they do so, in certain cases (Davis-Floyd, 1992; 1994)

It took considerable lobbying in Toronto from 1979 through to 1992 for the health authority to see that a free-standing birth centre was not only something requested by expecting mothers and many clinicians but was a safe and highly economical way of providing birthing services. Research has shown that the great majority of pregnancies and births are uneventful and require little intervention, especially of the medical or surgical variety (Klein, 1995; Levitt, 1995). Thus, if there is no reason to have women attend a hospital maternity
setting not only would the experience be improved for the mothers, the health system can enjoy considerable savings. There are considerable overheads associated with any hospitalization (Gorbauld, 1995).

The Toronto Birth Centre projected it would cost $980 to deliver a baby whereas a similar birth in a hospital would cost approximately $2000, with a projected annual savings to the healthcare system of $1 million per annum. In 1994 the Ontario NDP government approved funding for four such birth centres, but in 1995 the entire programme was cancelled (Gorbauld, 1995). The new Conservative government rationalized the abandonment of this programme (ironically) under the fiscally thrifty, cost-cutting auspices of the so called “common sense revolution”.

After birth services, agency and communication

As mentioned previously in the midwifery section, these participants were very satisfied with the augmented level of patient care given by midwives for the first few days at home. The establishment of good breast-feeding practices is sometimes a very difficult transition for a first-time mother and the convenience of home visits by clinicians over a protracted time frame was greatly appreciated. This augmented level of care in the patient’s home environment should promote greater confidence and will tend to be associated with more successful and longer-term breast-feeding practices. As mentioned previously, research has demonstrated that an extended duration of breast-feeding before moving to formula or solid diet is also connected with better short and long-term child health (Gartner, 1995; Gorbauld, 1995; Kennell, 1995; Hanvey, Levitt & Chance, 1996).
In addition, research has demonstrated the value of several visits from home health visitors as compared to overloading patients with information after the birth and before discharge from the hospital (both sub-optimal circumstances). Home visits lead to greater measured levels of information retention (Korsch, 1994).

Regardless of whether participants accessed care through a physician or midwife the overwhelming majority were impressed by the visits by Capital Health Region, public health home visitors. These mothers reported that they appreciated a caring manner, low power differential and the informational value of visits because they facilitated confidence in their new role. As mentioned above, the transition from pregnancy to motherhood is difficult and any help with the new challenges is greatly appreciated. Home visits are not only convenient, they actually lessen power differentials the home environment will augment the agency of the mother. While satisfaction was high for the public health visitors, visitors from the hospital were rare and not experienced to be very helpful. A few participants were appraised as they left the hospital of a subsequent visit from a hospital nurse and in two out of three cases the hospital visitor did not arrive. Conclusions drawn from experiences of hospital home visitors, should be made with considerable caution owing to the small number of participants who reported any interaction. However, the sketchy knowledge drawn from these few experiences may well serve to highlight an area where a much more in-depth study of the appropriateness of the different models of care internalized by different types of home visitors. Such investigations may also serve to further
highlight communication problems at the hospital that were reported in previous sections.

Participants reported (as mentioned earlier) that the best sources of information on general health matters tended to be from mediated sources, friends and family. In the case of parenting knowledge, a similar result was obtained but with the additional approval by many new mothers of mother and babies groups. Many participants who attended these groups appreciated the knowledge they gained not only from facilitators but especially from other mothers who had infants the same age or slightly older than their own. They appreciated having a peer group whereby they could compare their baby's development with others of the same age as well as ask questions of mothers whose infants had already successfully made transitions from earlier stages of development. Advice from such mothers worked not only to impart practical knowledge but to restore confidence to mothers who may have been worried about certain scenarios or behaviour. In addition, new mothers live a more isolated existence that tends to be governed by the sleeping and feeding patterns of their infants and the addition of a social opportunity is greatly welcomed. Such groups were appreciated because, again, they functioned to improve new mothers' sense of agency as mediated through social peer interaction where relations were not burdened by unsymmetrical power relations.

Miscellaneous Findings

Those participants who chose to compare their medical care in British Columbia with any other jurisdiction (either in another province or country) all
commented that they thought the level of care here was superior. While this augers well for an evaluation of the policies of the present government with regards to replacing Federal government transfer payments for health with new provincial money, care should be taken in interpretation. For instance participants' recollections of health care elsewhere were recollections of the recent past. Although unlikely (especially in the case of those who were in other provinces of Canada), owing to the steady decline in health spending across Canada and throughout the world since 1990, the recency of their experiences may well have affected their perceptions of comparisons.

The majority of participants believe that physicians' claims that the implementation of Reduced Activity Days by the British Columbia Medical Association in 1999, is a strategy to bring attention to health funding for the benefit of patient care is not credible. Most participants were opposed to this policy and many were angry that doctors closed their offices for nine days in a row over a spring break. In addition, most participants realized that this strategy was more about securing augmented remuneration for physicians and many people believe they are not only already well remunerated but their motives are chiefly concerned with demonstrating their power. This finding concurs with aspects of Mullett and Coughlan (1998) that showed that physicians seem to have a very poor understanding of the opinions of their patients. The B.C.M.A. continues to proclaim that physicians enjoy the support of patients on this issue and it should be noted that they generally erroneously understand that patients are highly supportive of their views on a whole host of other issues. This present
investigation supported previous research that found that this was far from the case. For example, previous research has shown that physicians' organizations seriously over-estimated the support by senior patients of their opposition to Reference Based Pricing and Low Cost Alternative policies designed to offset increasing costs to the provincial Pharmacare programme (Brunt, Chappell, McClure & Cassels, 1998; Mullett & Coughlan, 1998). Physicians did not understand that patients prefer their doctors be not only to be more democratic but knowledgeable concerning drug side-effects, drug interactions and public policy issues connected to coverage under Pharmacare. In addition, physicians believe that their patients view physicians' organizations as champions of Medicare when the majority of patients do not. The argument could be made that doctors erroneously interpret what appears to them as patient compliance to the present structure of health interactions as representing satisfaction and tacit approval.

Theoretical and methodological implications

Throughout the themes of this in-depth qualitative interview research the connection of patient satisfaction with patient-physician interactions and both agency and communication have been reinforced continually by the participants. While participants have not used the word “agency” we can readily appreciate that patients want to be able to get the information they need so as to facilitate choice and to be supported to act on these choices in their own interests. As mentioned previously, the pilot studies showed that participant understanding of words such as “agency”, “self-efficacy”, “autonomy” and “locus of control” were
poorly understood. They were not words used in everyday practical life to refer to
the concept of being able to make and act on choices and to feel a sense of
personal control. “Independence” on the other hand was a word that participants
understood as more connected to their expression of this need.

In addition, the understanding of the abstracted concept of independence
as a decontextualized concept removed from everyday practical interests was
shown to be impoverished as compared to the understanding that emerged from
their discussions of practical matters related to obtaining health care services.
Some better educated participants made the explicit connection with education
and the ability to access information to augmenting their ability to make and act
on choices in the non-contextualized section but the overwhelming majority only
discussed the concept of agency when discussing their experiences in relation to
actual health interactions. It is when we ask participants to discuss their concrete
experiences (such as interactions with health institutions and clinicians) that
participants understand independence as the ability to make and act on choices
that is very much interpenetrated with socially mediated relations and
communication. Very few of the patients interviewed explicitly described their
understanding as linked to inter-dependence with others during the de-
contextualized section. However, during the discussion of their health
experiences and desires, the overwhelming majority described how they want to
make choices in relation to clinicians that allows free discussion, co-operative
efforts to find solutions, thus fostering a greater sense of personal control.
These findings suggest the utility of testing for and finding language that is understood by lay persons that fits with the more academic or scientific concepts we may want to investigate. Using poorly understood scientific concepts may well produce results that do not actually capture the phenomenon under study, reducing construct validity. In addition to adequately testing participants' practical understanding of a concept we need to do more than ask their perceptions of the meaning of the concept. While this can produce interesting results and is superior to merely assuming a mainstream cultural understanding, we can see a great deal more can be understood if we allow participants to explore concepts in relation to and contextualized by their own everyday practical experiences. By allowing participants free rein to speak on the issues that are important to them in terms of their experiences and desires, we obtain data concerning the multidimensionality of the issues that they themselves choose to illustrate. Again this highlights the utility of in-depth interview protocols for understanding how people construct meaning in their lived reality. It also underlines the research utility of investigative methods that augment greater research participant agency.

As mentioned previously many participants who were poorer and/or less well educated had a more difficult time discussing their experiences. Such a finding may be linked to their socialized belief that their opinions are not important. Initially, they also seemed to suggest that they were reasonably happy with their interactions with health institutions and clinicians. However, as the interview progressed their expressed level of dissatisfaction seemed to increase as they explored the issues at more length and in more detail. Such findings
would also reinforce the suggestion regarding the practicability of in-depth qualitative interviews as compared with reasonably brief and more superficial questionnaire designs. Researcher generated hypotheses linked to questionnaires that investigate matters that investigators deem as important and especially those that limit participant responses to Likert style answers often do not encourage such participants to reflect on and record the true expansiveness of satisfaction or dissatisfaction. It may seem reasonable to assume that if this study were primarily a relatively more brief questionnaire design, many of the issues related to dissatisfaction may well have failed to have been reported and an erroneously optimistic result may have been produced.

Throughout the results section the overwhelming majority of participants discussed their satisfaction as linked to their ability to gain access to information and to be able to make and act on informed choices regarding their health needs. None of the participants expressed a view that they wanted to be left alone to take care of themselves. None preferred to individually access health information and act alone. Participants consistently expressed that their clinicians should be able to accommodate their needs for agency through the relationship via discursive means. In other words, the types of interactions with clinicians that were satisfying participants' needs for agency were those that could be best described as offering a Zone of Proximal Development (ZPD). This Vygotskian concept, addressed earlier in the theoretical section, describes a relationship whereby one person has more knowledge and experience interacts with another who has less. The interaction often results in the accelerated development of the
neophyte. In general terms, this concept was discussed by Vygotsky regarding children's cognitive development and overturned Piaget's notion of the development of cognitive stages that follows the lead of individual biological development. Through experiments with socially mediated learning, Vygotsky demonstrated that in fact cognitive development contextualized by social interaction may often run ahead of biological development. These participants consistently described satisfactory relations with physicians that were comprised of the physician being able to augment their informational needs and to discuss with them the options so that they felt comfortable with making a decision. They wanted the physician to be able to communicate with them in their own language and to be able to construct an environment whereby patients would feel comfortable working with their physician as a mentor. The object of this communicative interaction is to arrive at a destination whereby patients are learning material related to their health needs and then continuing in a cooperative effort to find a solution. This particular form of the relation between patient and physician is connected to the Latin root of the word “doctor” which means “medical teacher”. There seems to be evidence that demonstrates the usefulness of describing the results as patients’ desire to create a Zone of Proximal development with their physician.

Alternatively, all the themes linked with patient dissatisfaction could be interpreted as ways of interacting that were utilized by medical practitioners to increase their own authority vis-a-vie their patients, to limit the sharing of information and the erection of barriers against creating a ZPD. Allopathic
institutional structures and relations circumvent the creation of such a zone to limit the experience of patient agency. In this study the most widely reported and successful ZPD occurred between midwives and their clients, followed by physicians who were remunerated by salary. While some fee for service physicians were reported as fulfilling satisfaction criteria and creating this zone, the majority owing both to the structure of fee for service time constraints and an overly authoritative medical socialization, were very poor at creating this zone.

Thirty out of the forty participants interviewed were patients of physicians. It is interesting to note their views on midwifery and the reasons given why they did not chose midwives or did not consider the possibility. Many patients of physicians were simply not aware that a choice of clinical model existed whereas others knew of the possibility but chose not to seek a midwife for their prenatal and birthing needs. Some of the participants who were aware of their choice reported that they did not want a midwife because they were not planning to have a home birth and/or they thought they may need interventions for pain relief. Their beliefs were that midwives don’t allow intervention for pain. However, neither belief is true. Others stated that they were aware of the possibility of midwifery but had heard negative stories either through rumour or through the media. In all the above cases we have a scenario where knowledge is objectively available but for various reasons, expecting mothers were not able to access it or they believed erroneous information. Holtzkamp’s concept “ reduced horizons for action possibilities” could help explain these findings that demonstrate how ordinary people are removed from gaining access to
information or who are convinced by powerful authority or social convention to believe flawed information and to remain content with inadequate circumstances. In such cases, action to improve an inadequate status-quo position does not translate into action. Even though some serious dissatisfaction with the status quo of patient-physician relationships is voiced, there seems to be a lack of motivation to discover information that might improve their ability to choose and act in accord with their own interests.

Many people have been socialized to have faith in medical authority and the publicly available opinion of the medical profession is that midwives are not as safe as trained medical doctors. Physicians have considerable power in our society and they are very motivated to publicize their opposition to the alternative system now offered through the Hospital Services Plan of British Columbia. As a powerful and legitimated authority, allopathic medicine also maintains an augmented ability to broadcast their message through public and corporate media. The erroneous message that patients have received (either by political design or accident) is enough for many to self-limit their abilities to search for greater agency in birthing and labour care.

It is interesting to note that a few participants reported that they had some knowledge of midwifery and that they thought it was a viable option that would have provided them many advantages but they decided that “it just wasn’t for them”. These participants, while not contacting a midwife or taking the possibility seriously, have a better understanding of how their ability to make choices for themselves might be augmented by accessing care through a midwife. However,
they chose to stop short and stated that their preference was to go with their physician. A couple of these participants reported elsewhere that they were very satisfied with their present physician because they have at least some of the qualities that were connected to patient satisfaction. No doubt, they already experience a reasonable ZPD with their physician. However, the problem remains to explain why the others did not take that extra step and investigate the possibility, when they are clearly dissatisfied with their physician relationship.

Holzkamp would explain this phenomenon as exemplifying "restricted action potency". These participants were aware of the possibility of the advantages of midwifery, were not particularly happy with their present physician and decided to go with the traditional but inferior model of care. These participants could be described as truly "conservative". Holzkamp would venture that their socialization in and attachment to mainstream traditional values and ideology is deeply ingrained. The attachment to mainstream legitimated values and ideology is so central to their core belief system that even though their personal interests as agents may be improved with breaking from the mainstream they feel a greater need to feel secure in the more constraining paradigm. This need is so great that they willingly choose to turn their back on their own interests in order to keep faith with mainstream traditional values. They do not feel safe in venturing outside of this paradigm and are now policing their own behaviour to maintain the attachment to systems that are objectively working against their own interests and that limit their experience of agency.
Many lower SES, younger and under-educated participants were found to have a much more difficult time interacting with health institutions and personnel. Such participants tend to have relatively little power in society and experience their health relations as more problematic than others because they feel they cannot get the care they desire. In this open-ended interview situation lower SES, younger and under-educated participants tended to have a more difficult time expressing their opinions in an open and fluent manner. They felt uncomfortable with the amount of agency that was afforded them by the investigative protocol and seemed to want the questions to be more closed-ended, providing them with a template to follow. Their life experiences to date have ill prepared them to be able to feel comfortable with more freedom to make their own decisions. The internalization of their relative powerlessness could be seen as an example of restricted action potence while the perceived lowered horizons for agency during the interview process is reflective of their generalized expectations for agency in many aspects of their lives, including health settings. These lowered horizons of possibility for agency may also explain their relative dissatisfaction. They don't expect to be treated well because life has invariably demonstrated this reality. In turn, medical staff who have both internalized the model of unsymmetrical power relations between themselves and patients, coupled with the economic incentives for speedy treatment owing to fee for service provisions, know with whom they can get away with highly unsatisfactory treatment. Patients used to having greater power and agency are more likely to communicate that they are less willing to accept inappropriate treatment. Medical
staff may realize the increased agency of such patients and to some extent, alter their behaviour to provide somewhat more respectful treatment. Power is not only crystallized as legitimate by societal structures, institutions and popular ideological means it is continuously mediated and reinforced by interpersonal transactional relations (Volosinov, 1990). In other words, legitimate power structures exist because of their constant reinforcement in actual relations and actual relations are contextualized by the existing ideology and societal structures, in a dialectic relationship (Harre & Gillett, 1994; Shotter, 1993; Palmer, 1990; Volosinov, 1990; Foucault, 1984).

Possible policy implications

The results from this open-ended qualitative investigation have illustrated the kinds of problems that many women face during the prenatal period during labour and immediately after the birth of their child. They also indicate the types of relations and model of clinical care that many patients found highly satisfactory. The themes discussed here are valuable in and of themselves in understanding some of the problematic health relations and structures in the Capital Health Region. In addition, these findings can be utilized for the creation and distribution a larger, comprehensive and more widely distributed investigation using a mixture of qualitative and quantitative methodologies. In other words, while these findings are indicative of satisfaction with current clinical care they should not be used on their own to make conclusions or predictions concerning actual rates of occurrences generalizable to the population. However,
some of the knowledge gained from this investigation can be utilized to indicate the probable directions for health policy initiatives for the region and beyond.

The power dynamics of interest groups in the health sector are changing. The increased availability of information owing to the Internet and greater media attention to health matters means that patients are increasingly more educated and are increasingly demanding greater and more accurate health information from their clinicians. Physicians and hospital institutions are facing increasing pressure to provide greater agency because the increasing informational power of patients. Patients are increasingly resenting the role of physicians as authorities and gatekeepers to healthcare services. Unless there is considerable change in the attitude of mainstream health institutions and clinicians, they may find themselves becoming perceived by patients as less credible and the lack of willingness for change may actually work against their central position of power. Clinical culture will sooner or later be forced to reinvent itself and adapt to the changing needs of increasingly knowledgeable health users.

These interviews show overwhelming support for the inclusion of midwives as a mainstream clinical provider in terms of patient satisfaction. However, more time and energy needs to be spent by all clinical stakeholders to lessen the animosity between competing clinical providers, in the interest of patient safety and satisfaction. All groups (physicians, nurses, midwives and alternative practitioners) should be reminded that the patient should be the focus rather than (as has been sometimes demonstrated here) a pawn in the power politics of
health provision. The values and beliefs of the patient should be considered by clinicians when assessing interventionary strategies and communicating advice.

It would seem that some mediation is necessary between nurses who are already qualified as midwives abroad or who wish to become qualified as midwives in B. C. and the College of Midwives, to allow maximum access into the College. The College should also work together with other clinical stakeholders to overcome perceptions that midwives are sometimes not competent in minor interventionary skills applicable to labour and birthing. In addition, midwives need to carefully examine their code of ethics and policies regarding clinician responsibilities and communication with patients when outcomes are less than satisfactory. This is especially critical in extreme cases.

More effort and time is needed to improve the communication skills of physicians and specialists before they graduate from medical schools. Some effort has been expended to improve this facet in recent years but this investigation demonstrates that the majority of patients believe communication is still problematic. Simply training doctors in communication skills to gain patient compliance is not sufficient to improve patient satisfaction or patient health outcomes. The findings suggest that patients are more satisfied with their medical care when they are in health relations with physicians who communicate in a democratic fashion, share decision-making roles with patients and who allow sufficient time for discussion. The current structure of power and mainstream fee for service provisions for clinician remuneration in the medical culture tends to work against this desire of patients.
Amelioration of these cultural/structural impediments require a wholesale re-evaluation of training processes in medical school as well as the increase of alternatives to standard fee for service remunerative mechanisms. Patients are increasingly expecting their clinician to be able to help them access information on health matters. Physicians who are paid purely by fee for service provisions are not paid for this aspect of care or for tending to administrative tasks. It would seem that some hybrid alternative form of payment (combining salary, capitation and fee for service) would be beneficial for clinicians, patients and the health of the system in general.

Staffing levels in hospital delivery and post-partum wards need to be improved and maintained above minimum levels. In post-partum especially, many patients reported an inappropriately poor level of nursing help because of inadequate training in critical areas (breast-feeding) combined with inadequate staffing levels. In addition, the finding that nurses are sometimes not paying attention to patient reports of labour progression may at least in part be owing to inadequate number of staff on duty. The remaining nurses may be suffering burn-out and this is reflected in reports by patients that nurses have little time to help first time mothers with the care of their infant. A significant rise in staffing levels should ameliorate the apparent problems reported by patients that nurses have insufficient knowledge of the prescribed care for each case. In some cases insufficient attention to charts and/or communication problems led to some new mothers being given medication in error.
Nurses need to be able to be paid to receive training in issues linked to good prognoses for new mothers and infants especially training in breast-feeding techniques. This will go a considerable distance towards relieving the current level of confusion reported by new mothers who are being given contradictory information that functions to shorten the duration of breast-feeding as well as generally undermining their confidence to take care of their infant. More attention needs to be paid to hospital policies concerning infants' security bracelets and if necessary, different designs piloted to ensure that they fit snugly and cannot be removed by unauthorized persons.

Communication between administrative personnel who set hospital policies and front-line medical staff who are responsible for patient care need to be re-evaluated and democratized. At the moment the top-down management style current in many institutions is working against the needs of both patients and medical staff. Greater emphasis must be placed on clinician and patient input into planning and funding policies at all levels of decision-making.

The culture of care at hospitals and other medical institutions evolved in relation to interventions primarily concerned with the diagnosis and treatment of disease. Pregnancy and birth are not diseases and therefore the culture of the institution is incongruent with the actual process being facilitated by clinical staff in maternity (Hanvey, Levitt & Chance, 1996; Gorbauld, 1995). The types of interventions that may be required in a small percentage of cases could easily be handled by compromise facilities such as "stand alone" birthing centres. The separation in physical proximity from hospitals and the separation of staff in
cultural and psychological terms would foster both increased patient and staff satisfaction. The creation of a different model of clinical care suited to the natural process of birthing would not only be beneficial, according to pilot studies it would save a substantial amount of money. In comparison to the cost of the average hospital birth the savings per birth may be in excess of 50% (Gorbauld, 1995).

Professionally facilitated mothers and babies groups decrease anxiety and improve confidence of new mothers. Such groups also function as a preventative measure promoting infant health and decreasing the probability of the ill effects of isolation and postnatal depression in new mothers. It will also reduce the dependence on the physician and the healthcare budget for unnecessary visits to medical facilities because mothers will have greater information allowing them to distinguish medical from non-medical events.
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Appendix A

Health Services Satisfaction Study

Open-ended Interview Protocol for Patient/Client Qualitative Interviews

1. Introduction
   Introduce topic; get permissions (for taping) explain confidentiality; right to withdraw at any time and right not to answer any particular question

2. Personal Data.
   Perhaps you can tell me a little bit about yourself and your living circumstances at this time. Name (will be coded) age; live alone or shared accommodation; family; pets; friends; belong to any organizations; hobbies; education

3. Life History Data
   So that I can get to know you a little better and so we can understand your experiences in the context of your life, it would be nice if you can give me a thumbnail sketch of life events that have been important to you (e.g. where you were born, where you have lived, travel, work, school, family, hobbies, interests)

   What does INDEPENDENCE mean to you and how have you experienced it in your life

   (Note, and if necessary request elaboration on life-events that seem to be connected to health or any unusual or alternative lifestyle choices)

4. General Views/Activities with regard to health
   (a) Perhaps you would give me a brief idea of how you have seen your health in the context of your life.

   (b) Perhaps you could elaborate on the type of relationships you have had with health professionals and/or the health system

   (c) How often do you see your doctor? (Do you see your doctor regularly or only when you have specific questions or problems).

   (d) Is your doctor part of a community health clinic where you can see nurses/social workers/ nutritionists etc. in the same office?
If yes
(i) Could you tell me about your experience with this clinic
(ii) What, in your opinion are the advantages and disadvantages of this type of clinic
(iii) Have you any views on the differences or similarities to other physicians that you have experience with
(iv) On Average how long do you spend with your physician, when you see him/her
(v) On average how long do you wait to see your physician and what is your opinion regarding your experiences
(vi) How does this compare with other clinicians you have seen (nurse practitioners: midwives: specialists)
(vi) What has been your experience with nurse practitioners (if yes - go to section g)

(e) How have your relationships been with your physicians that you have interacted with (was doctor aloof/friendly-time constraints).

(i) Would you have liked or would you like the relationship, interactions to be different in any way. (authoritative/democratic)

(ii) Were there physicians that you liked better than others? What made this relationship more/less satisfactory?

(iii) Have you had experiences with physicians you didn’t like and if so what didn’t you like

(iv) Again, if so, what were you able to do that remedied the situation

(v) What are the qualities both professional and personal that make you feel confident in your physician and comfortable with the relationship

(vi) Do you feel you are given the care, attention and time to freely discuss all your health concerns

(vii) Do you feel that it is important to be included in the decision making process that leads to a treatment plan and does this happen with the physicians you’ve had experiences with
In your experience, is there anything different about relationships, or interactions with your physicians that have been different than interactions with other people?

(i) equal / unequal  
(ii) democratic / authoritarian  
(iii) freedom to speak openly  
(iv) time to fully understand and to feel you are understood too

Do you feel you have the same ability to share or get information, make decisions and remain an independent person with your physician as you do with

(i) other ordinary people you encounter, such as friends colleagues acquaintances etc.?  
(ii) other professional contacts or experts you normally consult from time to time

How would you best compare the relationship you have with your doctor. Is it more like a business contact? boss at work? an authority figure such as a priest or policeman? an acquaintance? a friend?

(f) Have you at any time had occasion to receive treatment from a nurse practitioner and if so could you tell me about your experience

(i) Did you have any fears or expectations and were these borne out by the experience  
(ii) In comparison to other health clinicians what were the differences and similarities with regard to the treatment and care you received  
(iii) Did you find that you were given enough time and attention to describe your health concerns  
(iv) What is your opinion of the advantages or disadvantages of seeing a nurse practitioner

(g) What is your overall opinion concerning the addition of nurse practitioners to the regular health system

(i) In your opinion are there any advantages or disadvantages

(h) Have your regular physicians referred you to other services?

(i) Which ones?  
(ii) What did you think about these services?

(i) How important is it to you that you be given choices concerning health matters
(i) in the kind of health practitioner you see
(ii) in the treatment plan that is embarked on
(iii) Which practitioners in your experience (if any) gave you the choice of how you were to be treated

5 CARE DURING PREGNANCY

(a) Have you used the services of a physician while you were pregnant and if so what was your experience

(i) What can you tell me about the physician (without mentioning his/her name)
(ii) What has been your experience with these services
(iii) How often did you see your physician, during the pregnancy
(iv) In your experience, what aspects did you particularly like or found particularly helpful about the physician services you encountered
(v) Were there aspects that you didn't like or found particularly unhelpful or problematic
(vi) How did you make the decision to seek out a particular physician
(vii) What aspects seemed important when you made your decision to seek out a physician
(viii) What were your expectations and were these expectations fulfilled
(ix) Did you have any reservations before you sought a physician and were these misgivings born out or not
(x) Were you referred? If so, by whom?
(xi) Do you think your physician increased or decreased your sense of independence?
(xii) Did you think your physician allowed you to make choices or were the choices limited or made by your physician
(xiii) If you were to make a comparison of physicians and midwives you have experienced how would you characterize this

Differences
Similarities

(xiv) If you decided to retain the services of a different physician than your usual general practitioner, what was the effect of this on your relationship with your regular physician

Were you anxious about informing
What was the physician reaction
Did any of this affect your views about the birth or any of the clinicians you were planning to engage
Did this increase or decrease misgivings or anxiety
(xv) What is your opinion concerning how well your physician prepared you for the birth(s)

(xvi) What is your opinion concerning how well your physician prepared you for parenthood

(b) Do you use or have you used any midwifery services

If yes

(i) What has been your experience with these services

(ii) How often do you (or did you) see your midwife

(iii) In your experience, what aspects did you particularly like or found particularly helpful about the midwifery services you encountered

(iv) Were there aspects that you didn’t like or found particularly unhelpful or problematic

(v) What opinions do you have regarding service providers you have had experiences with

(vi) How did you make the decision to seek out a midwife

(vii) What aspects seemed important when you made your decision to seek out a midwife

(viii) What were your expectations regarding the use of midwifery services, and were these expectations fulfilled

(ix) Did you have any reservations about possible problems with seeing a midwife, before you sought midwifery services and were these misgivings born out or not

(x) Were you referred? If so, by whom?

(xi) Do you think midwifery services increased or decreased your sense of independence?

(xii) Did you think your midwife allowed you to make choices or were the choices limited or made by your midwife

(xiii) If you were to make a comparison of physicians and midwives you have experienced how would you characterize this

Differences

Similarities

(xiv) When you decided to retain the services of a midwife, what was the effect of this on your relationship with your physician

Were you anxious about informing

What was the physician reaction

Did any of this affect your views about the birth, your midwife or your physician

Did this increase or decrease misgivings or anxiety

(xv) What is your opinion regarding how well your midwife prepared you for the birth
(xvi) What is your opinion regarding how well your midwife prepared you for parenthood

(xv) From what sources did you hear views concerning midwifery services.
   What were the views expressed
   What is your view concerning the credibility of these sources

If no

(i) What do you know about midwifery services
(ii) Have you ever thought about using them?
(iii) If so, why did you decide not to?
(iv) Do you think that it is a good idea to have such services available for those who wish to use them
(v) If you decided to use such services in the future would you know who to contact?
(vi) How do you think midwifery services might help you?
(vii) Do you think these services might have any affect on your ability to make choices for yourself?
(viii) What, if any, are your misgivings about midwifery services
(ix) From what sources did you hear views concerning midwifery services.
   What were the views expressed
   What is your view concerning the credibility of these sources

(c) What was your opinion on any prenatal classes or programmes you attended
   (i) Where and who gave them
   (ii) Did you feel they prepared you for the birth
   (iii) Did you feel they prepared you for parenthood
   (iv) What is your opinion regarding possible improvements

(d) In your opinion what was your best source of credible and relevant factual and practical information concerning
   (i) the prenatal period
   (ii) the birth experience
   (iii) the experience of parenthood

(e) What were your experiences during the birth of your child or any of your children
   (i) Was it a home, hospital or other place of birth(s)
   (ii) Did you find your physician or midwife helpful during the birth(s)
   (iii) What other support did you have during the birth(s)
(iv) Did your birth go according to your plans and/or pre-conceptions.

(v) If you had a home birth, did you need to see anyone at the hospital after the birth and if so, what was your opinion of the hospital staff.

(vi) Did you need the services of a specialist, consultant or obstetrician and if so, what was the intervention and what was your experience with this intervention and any medical staff connected with it.

(vii) How was the communication between the people who were helping you during and after the birth.

(ix) Did you have any expectations for the birth and were they fulfilled.

(x) Did you have any fears for the birthing process and if so how did the experience compare to your fears.

(xi) If you gave birth in the hospital, what is your opinion of the way the hospital treated you in general. Did you have any dealings with the administration and if so what was your experience.

(xii) What is your opinion of the birthing facilities at the hospital. Was there any lack of equipment that could have made the experience better or safer.

(xii) Is there any aspect of the birth experience that could have been improved in your view.

6. SUPPORT

Could you tell me about your experiences for the first few weeks after the birth of your child/children.

(i) Did any of your medical practitioners visit you after the birth and if so what was your experience?

(ii) Did you receive visits from other medical practitioners and if so what was your experience?

(iii) How frequent were these visits and how long did they last?

(iv) Did you find these visits useful or problematic?

(v) Were you referred to any other medical or non-medical services by any of your medical practitioners at this time?

(vi) If so, what services and how what was your opinion of them?

(vii) What were your sources of information concerning you and your child’s health and which were best?

(viii) Did you have any expectations concerning the period immediately after the birth of your child/children and were they fulfilled?

(ix) Did you have any fears regarding this period immediately after the birth and were these fears warranted?

(x) Concerning the period immediately after the birth(s) was there anything that was unexpected?
Could you tell me a little about the contact you have with others (friends; family; neighbours; acquaintances; )

(i) Are there people you like to keep in touch with?
   Do they visit you or do you visit them or do you take turns?
   Do you meet at a community centre or cafe or any other place?
   Do you belong to any community groups?
   Are you in phone contact with many people?

(ii) Would you prefer more or less contact with others?

(iii) Is there anyone you feel that you can ask for help from or asks for your help?

(iv) Is there anyone you would feel comfortable discussing any medical issues or health preferences/services with?

7 OVERALL OPINIONS ON HEALTH SERVICES

(a) What is your overall opinion of the health services system in B. C.

   (i) What aspects do you find particularly valuable
   (ii) What aspects do you find not to be very valuable
   (iii) Is there any aspect that you think could be improved
   (iv) What, in your view, are the greatest pressures facing the health system at the present time
   (v) What steps should be taken to safeguard the system from these pressures
   (vi) What do you think are the greatest obstacles (if any) to you receiving quality healthcare
   (vii) What is your opinion on what your physician might think the greatest obstacles are to providing quality healthcare
   (viii) If you have seen a midwife and/or nurse practitioner and/or alternative practitioner, what is your opinion on how they might view the main obstacles to providing you with quality healthcare
   (vi) Do you think the health system is underfunded and if so what or whom do you think is responsible for this
   (vii) What is your opinion of the policy of doctors to close offices and refuse treatment on certain days of the month

(b) What do you think about prescriptions and pharmaceutical drugs.
(i) Do you think the prescription medications that your regular doctor prescribes have been effective?

(ii) Have you ever been bothered by any prescription medications (side-effects / interactions with other medications)

(iii) What do you think about over the counter medicines? Do you take any? For what conditions?

(c) When you have been feeling unwell are there any remedies or tricks that you’ve learned that help you (medicines your mother used; tricks nurses or friends taught you; vitamins; herbs; remedies from health food stores; diets)

(d) Where do you get most of your information about your health (doctors; pharmacists; books; friends; internet; TV or other media)

Which sources seem to be the best for you?

(e) What effect (if any) do you think diet has on your health?
   (i) Have you made any changes of diet. If yes. What led you to change your eating habits?
   (ii) Has anyone talked to you about certain foods that you should take or avoid.
   (i) If so, whom. What did you think about this information?
   (ii) Has it or did it make a noticeable difference?

(f) Have you experienced any extended periods of ill health.
   (i) Were you referred to any other practitioners services
   (ii) Were you referred to any alternative practitioners
   (iii) If so, what type
   (iv) Were you happy with their service/explanations.
   (v) Were alternative practitioners contradicting regular doctors
   (vi) What did you think about any differences in their approach or differences in their diagnoses
   (vii) Did you inform your regular physician of your visits? (why or why not)
   (viii) What did your regular physician think?
   (ix) What was your alternative health practitioner’s attitude to standard medical practice provided by physician
(g). Have you ever consulted any alternative medical practitioners
(list if necessary: chiropractor; herbalist; aroma therapy; massage;
homeopath; acupuncture; oriental medicine; traditional native
medicine

If yes,
(i) How did you find out about it.
(ii) What was your experience?
(iii) Did you inform your regular physician?
   If yes, (a) What did s/he think?
   (b) How did you feel about your physician's attitude?
   If no, (a) Any reason for not informing

If no
   (i) What do you think about alternative medicine?
   (ii) If you wanted to consult an alternative medical practitioner do you
        know how you would find one?

(h) Is there anything about alternative medicine that makes you feel uncomfortable?
(i) What (if any) advantages might be found in alternative medicine in your view?

(j) What is your views on the whole idea of preventative medicine?

Do you have anything more to say about any of the issues we’ve discussed today or is there anything at all you would like to add?
Appendix B

Information and Consent Form

Health Services Satisfaction Study

Investigator and Interviewer: Rory Coughlan
Department of Psychology
University of Victoria
Ph: 595 1704

Supervisor
Dr. Charles Tolman
Department of Psychology
University of Victoria
Ph: 721 7525

This research study is designed by a doctoral candidate in psychology at the University of Victoria and is undertaken to investigate your experiences and opinions regarding satisfaction with current health services in British Columbia. The interview will be open-ended and will be tape-recorded.

Before deciding to participate in this study you should know that:

1. Your participation is voluntary and you may withdraw from the study at any time without penalty or loss of benefits to which you are otherwise entitled. Your choice to volunteer will have no affect on your ability to access any services now or in the future. Should you choose to withdraw part-way through the interview all notes and tape-recordings will be destroyed and none of the data will be used in the study.

2. All of the information given by you during the course of the interview will be kept in the strictest confidentiality. All the
tapes and transcripts of your remarks and opinions will be kept in a secured place and no access to them will be granted to any other person not working on this project.

3 All the information you give will remain anonymous. Any tape-recorded information or transcripts of your remarks will be coded and will not have your name connected with them, and you will not be identified in any way.

4 The interview will be tape-recorded and notes will be made by the researcher and the tapes will be destroyed after the final analysis has been completed.

5 No part of your taped interview will be played in public, used as a teaching aid in university classes or played at any scholarly meeting. Only the researcher and the transcriber will hear or play the tapes and there will be no reference to your name or any other identifying remarks (other than the coded number) made on the tape.

Having read this letter of consent and having had an opportunity to receive answers to any of my questions regarding this research project, I willingly agree to participate in this open-ended interview which will investigate my satisfaction with and opinions on healthcare. I agree to have this interview tape-recorded.

__________________________________________  ________________________________
Participant Signature                        Date

__________________________________________
Interviewer Signature