The Changing Medical Clinic

BIOMEDICINE IN HISTORICAL AND CULTURAL PERSPECTIVE

Lecture "Roadmap"

- The Medical Gaze (main concept for today)
- History of clinic/biomedicine – intro to Michel Foucault's work
    > Biopower

    > **Medical gaze** Rosenberg – history of diagnosis – ex. of the medical gaze
- Learning the medical gaze (med school)
    > Holmes and Ponte: "en-case-ing"
- What gets lost in the medical gaze
- Attempts to mitigate via "cultural competency" (success? failure?)
- Subverting the medical gaze?

# Biomedicine – self-representations, and public expectations

- Scientific
- Objective + acultural
- Detached and distanced - personality/status irrelevant
- Technological-driven, based on expanding empirical knowledge
- Positive and beneficial
- (a right?)
- Dependent on high-level training and advanced intellect
- Skill + competence + creativity
- Dedicated and noble practitioners, with privileged insight

- Michel Foucault
- 1963: *Naissance de la clinique: une archéologie du regard médical*
- In English (1973): *The Birth of the Clinic: An Archaeology of Medical Perception:*
  - clinic as site of bio-power
  - 'medical gaze'
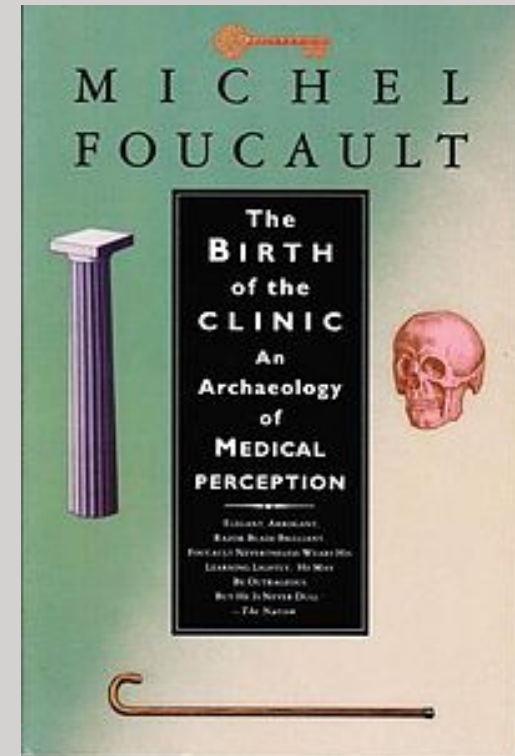
clinic as site of bio-power

- Bio-power – operates through the body
- Power/knowledge (psychiatry, etc.)
- Self-regulation, 'technologies of the self' (pedagogy)

- "Institutions such as the medical clinic are not coercive in the violent or authoritarian sense because they are readily accepted as legitimate and normative at the everyday level. These institutions of normative coercion exercise a moral authority over the individual by explaining individual 'problems' and providing solutions for them." (Turner 1997: xiv)

- Power as PRODUCTIVE, not just repressive

Introduction of the 'medical gaze'

19th C., Western Europe: epistemic shift in views of the body and illness + thus treatments

> Dev of 'modern medicine': focus on pathological anatomy, disease seen as located **inside** the body

> Body as overlapping systems (digestive system, pulmonary system, etc):

   * mapped

   * studied

   * seen as regularized, ideal-typical models, as distinguished from atypical cases
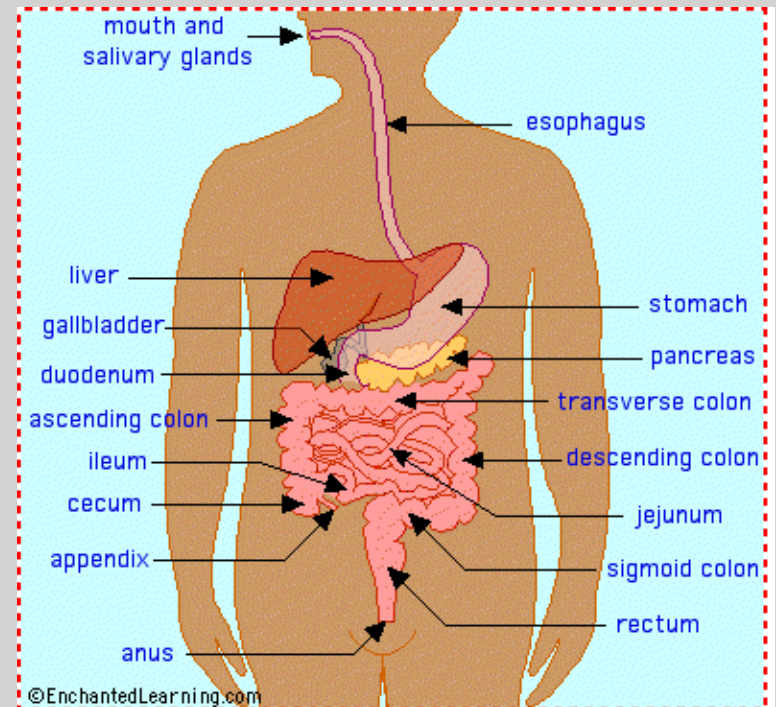
18th vs 19th C perspectives

Huge shift:

19th C. Disease as an entity, with a trajectory, revealed by tell-tale signs (symptoms)

vs.

18th C. generalized conditions identified by the total composite of symptoms

>> from 'what is wrong with you?' to 'where does it hurt?'

"The power of the anatomical-pathological model… lay in its capacity to strip away individual differences, affective and material, so as to perceive the essence of health of disease in organ tissues. The autopsy, not the interview, was the moment of truth" (Lacquer 1990: 188)
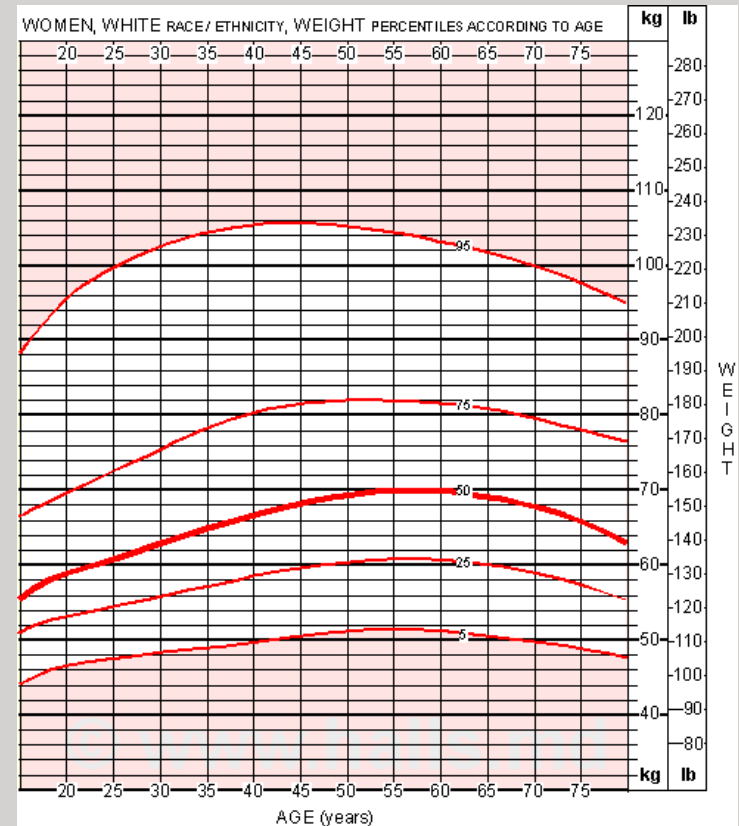
"the language of medical science has sought to be voice of the body without interference from the patient" (Shaw 2012: 111)

Medical Gaze, cont

Notions of normal vs pathological:

- Focus not just on the patient, but the pop. (what is the norm?)

- Normal ultimately as def. by the dr >> the state

- Morality and power are implicit, but hidden

The 'culture' of biomedicine

- Nature as a separable entity (from the supernatural, from culture, from morality)
- Disease separable from social context
- Biological separable from psychosocial
- Social person vs physical body

- Biomed is premised on "the notion that diseases can and should be thought of as entities existing outside the unique manifestations of illness in particular [persons]" (Rosenberg 2002)

- Diseases categories became increasingly standardized, as did the vocab describing them

This used to be a matter of dispute>>
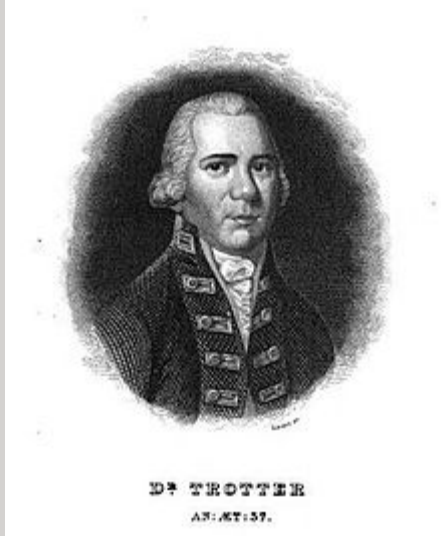
Dr TROTTER
Æt. 57.

- 1804, British physician, Thomas Trotter: "The name and definition of a disease are perhaps of more importance than is generally thought. They are like a central point to which converging rays tend: they direct future inquirers how to compare facts, and become, as it were, the base on which accumulating knowledge is to be heaped."

vs.

- 1827, physician John Robertson : "Whether a nosological arrangement [classification system of diseases], the fruit of modern pathology, is a hopeless expectation remains yet to be seen. The degree to which diseases are modified by constitution, season, climate, and an infinite of accidental circumstances, renders it at least doubtful."

- Strengthened in late 19th C with use of what were called "instruments of precision": thermometer, blood and urine chemistry, and in early 20th C, blood pressure cuff, x-ray, etc.
- Forms for recording disease > computer technology

Historical perspectives on pregnancy

- 18th C. 'like a tree bearing fruit', estab. with mother feeling quickening
- 19th C.: you are/aren't; like a sickness in need of treatment
- Ideas of normal progression, even 'natural childbirth' becomes a prod.
- 20th/21st C. : visualization of the fetus – pregnant body as in need of interpretation/viewing by prof.

Drawings of the stages of pregnancy to guide clinical examination, 1822

Infant mortality

- England, 1836, official mortality statistics begin to be collected by the Registrar-General
- Initially no focus on children, but by 1870s - 'infant mortality rate'
  - 150+ deaths per 1000 live births
- Soon a shift from 'natural causes' to listing of diseases that caused death: diarrhoea, pneumonia, measles, etc.
- Interventions, esp w/ premature births (20th C), dev of 'neonatology' + incubator

"Coupled with a declining birth rate, a persistently high rate of infant mortality raised the spectre of a shrinking supply of young men fit for Europe's imperial armies. The newborn baby assumed a social value and began to attract medical interest." (Weaver 2006, *The Lancet*)

When you see the patient, what do you see?

- Transforming the individual and his/her unique experience into a 'textbook' clinical case

  > Skill taught in medical school (Holmes + Ponte 2011)

- Problem-oriented focus, strips away psycho-social and economic/structural aspects

"You're a professional and you're trained in interpreting phenomenological descriptions of behaviour into physiological and pathophysiological processes…. basically what you're supposed to do is take a walking, talking, confusing, disorganized human being, with an array of symptoms that are experienced, not diagnosed, and take it all in, put it in the Cuisinart and puree it into this sort of form that everyone can quickly extrapolate from. They don't want to hear the story of the person. They just want to hear the edited version…."

   (med student to Delvecchio Good 1994)

Learning the skills of "patient presentation"

- Efficient communication btw medical profs
- Large amounts of information in a recognizable, easy to follow structure
- Other formats cannot be 'heard' by the physician

3rd year med student:

I just met Mrs. Jones and she's really nice, but going through a difficult situation. At first, I couldn't interview her because she was pretty upset about the strange 'chalky' diet of the hospital food she is getting. I helped her talk with the nurse about it and she became much more cooperative. It turns out she is 70 years old, live son her own just down the road a few blocks, and is going through significant financial hardship and stress. Her daughter got married in late July in NJ. It was very expensive, and she had to take out loans to help pay. She also did a lot of work to prepare for the weeding. This was stressful for her, and she thinks the stress led to pain in her right foot. Her foot became red and puffy and then a sore opened up. When I pry for more information, she says that she was wearing tight high-heeled shoes....... She also has diabetes and worries about being able to afford her insulin. In summary, I'm not sure if her ankle ulcer was cause by trauma during the wedding preparations, by welling and poor blood flow, by a spider bit and then subsequent swelling, or...."

Attending Physician:

"I'm sorry but it's hard to follow what you're saying…"

To 4th year med student: "Could *you* please present the patient in an organized manner?"

4ᵗʰ year med student:

"Mrs. Jones is a 70 year old woman with a past medical history of insulin-dependent diabetes who is here due to pain and ulceration of her right foot. She states that she first developed pain, erythema, and edema in her right foot 2 months ago while lifting heavy objects at her daughter's wedding. A few days later, an ulceration appeared at the site of her pain.... Her social history is significant for smoking, though she denies alcohol or drug use, and she lives in a hotel and has difficulty affording her supplies. Her vital signs are: temperature 98.4, Pulse 85, ... [etc]. In summary, we have a 70 year old woman with insulin-dependent diabetes and poor pedal circulation with an infected diabetic foot ulcer. ....

Plan: *Problem #1:* infected foot ulcer..... [etc]. *Problem #2:* Insulin-dependent-diabetes..... [etc]. *Problem 3:* Non-compliance: we have talked to her about her diet..... [etc]. "

- 3rd year student: followed patient's own narrative, hesitant to make conclusions, included all manner of 'extraneous detail'

- 4th year student: 'put the nickel down' on what the situation was, built an argument supporting this assessment, simplified and excised unnecc detail > turned it into a textbook case

- Holmes and Ponte: "en-case-ing"

- Loss of structural issues (poverty etc) because they cannot be addressed by the physician

"As the attending physician can do little to ameliorate their patient's financial problems, they shift the focus of attention to problems that medicine can help. This filters down to the medical student, who is encouraged to focus on the proximal biological or behavioural causes of medical problems and address these factors rather than distal social and financial factors" (Holmes + Ponte 2011: 172)

How do we acquire the medical gaze? socialization of medical students

- First years char by immersion in uncertainty + responsibility, leading to attitudinal and value change, following nearest available model (Hafferty 1991)

- Anatomy lab as ritual staging ground, the cadaver as the "ideal patient" (Hafferty 1991)

- Reductionism

- Detachment and prof. concern

- No place for lay emotions

The values adopted by med students (Good + D. Good; Beagan, Fox, etc.)

- Illness defined by biology, not experience

- Strip away all social, emotional, and biographical details to focus on patient as biological being

- Shared morality is implicit but hidden, i.e. agreement that Health is an ultimate moral good (goals of: extension of life, lessening of pain)

- Formal 'depoliticization' as part of taking on a prof. outlook

What about diversity among physicians?

Beagan (2000) argues that this becomes irrelevant

1) **Total immersion into the group:**

- "I'm not myself; I can't be. The rigorous training forces all 120 of us, regardless of age, ethnicity or other factors, to become essentially identical people. So much of our time is spent in medicine that we don't' have a lot of time to explore other interests." (med student)

- Boot camp

- Martin Shapiro, *Getting Doctored* (1987): long hours, hard work, pressure to study competition, means no other activities or involvements – creates a tight-knit culture

2) **Trained to think along the same models, i.e. clinical diagnostic thinking**

- "medical training trains you to think in a certain way. I mean, every doctor should think clinically and follow the same path." (med student)

- 100 students given the same case should produce 100 identical diagnoses, following the same thought processes (dr)

3) Must on occasion **behave outside of the 'usual norm'** with patients, and have this reinforced: "They share some of the stories but they share them in a kind of way that the behaviour is reinforced… People who question the natural attitude or the assumptions are actually *#$%^ disturbers and are not liked." (Dr)

4) **re-constitution of the self into the NEUTRAL physician:** "professional face"; clothing; haircut

"I think the training tends to streamline and produce sort of a cookie cutter as you come out the end and basically you could be a lesbian feminist and come out as sort of a heterosexual white male in your attitudes.... You are being fit into a mould.' (Dr)
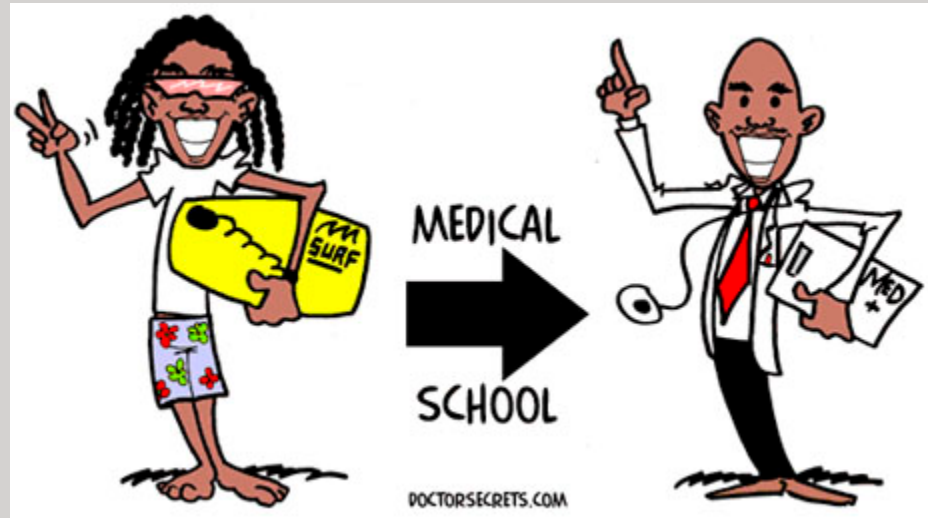
What does the medical gaze look like in Practice?

Cultural Miscommunications in the Clinic

Briggite Jordan and Susan Irwin (1987)

In 1984, Jordan asked take part in Medical Ethics Case Conference, as part of Obstetrics and Gynecology Grand Rounds at local hosp.

Case summary: West African woman refused Cesarean section after physician told her baby was in danger. Judge declared himself willing to order C-section but baby born (healthy) prior to paperwork being completed

Grand Rounds announcement:

"African patient, wife of foreign student, had difficulty progressing through labor. C/section was recommended but patient, + husband, refused. It was their view that upon their return to Africa, facilities for repeat c/sections would not be available and above all else, they wanted to maintain the patient's fertility. If necessary, they were willing to sacrifice the life of this infant to insure future vaginal deliveries. Hosp. admin contacted the Judge who indicated willingness to order c/section. Patient suddenly progressed rapidly and delivered vaginally."

more facts emerge

- Second pregnancy, first normal, delivery stalled + c/section recommended, but 1st baby born ok

- Debate over whether signs of fetal distress were evident: one physician pressured couple for c/section – other staff tell him to back off, couple became distressed

- Confusion over would the surgeons have operated on a non-cooperating mother? How? Would nurses assist?

Judge, defending his decision:

1) woman in care of medical team – like a patient undergoing surgery, needs to be ready for the unexpected + for surgeon to act on her behalf

If the patient retains the right to dictate his or her own care, including the method or procedure of care, what happens when it conflicts with the judgment of the health care professional? …. To avoid malpractice, prof must be allowed to act

2) US Supreme court: state has right in last trimester of pregnancy to protect a viable fetus – rights of mother need to be weighed up against the rights of the fetus

3) Cultural standards are a 'non-issue' – law applies equally to citizens and 'aliens', so do medical decisions: in this case the concern for the preservation of life outweighed other factors

Jordan interprets:

1) birth assumed to be a medical problem, with mother like a patient on the operating table, but this mother was not unconscious

2) is the woman "giving birth" or is the baby "being delivered">> WHO is ultimately resp. for delivery (mother/med personnel)?

3) no definitive sense among the medical personnel that fetus was in imminent danger > judge driving for certainty (as do many med prof)

4) NO evidence of what the couple thought, but:

- many W. Africans view fetus as choosing whether or not to arrive (i.e. not a **sacrifice**, but a **choice** on the part of the fetus' spirit)?

- What is at stake for the mother for having a c-section? (shame? divorce?)

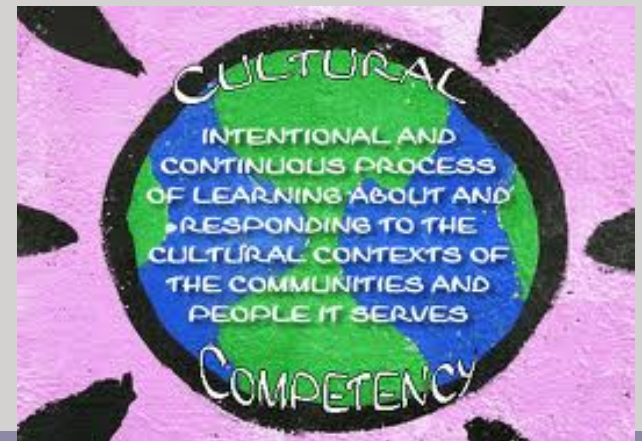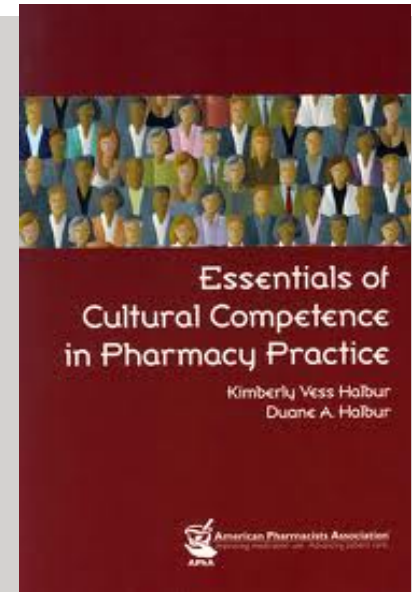- Was she afraid of death in childbirth via c-section?

> Could better communication have resulted in a better outcome?

'Cultural Competency'

Developed as a response to med anthro critiques since the 1980s

- 1990/91: 13% of med schools in CA offer training in CC >> by 2000: 100% in CA

- Focus tends to be in culture of the patient, NOT the physician, and NOT the culture of biomedicine

- Traits list (Chinese think this way, Indians that way...)

  vs. 'open-mindedness' approach (Kleinman + Benson 2006)

Essentials of Cultural Competence in Pharmacy Practice

Kimberly Vess Halbur
Duane A. Halbur

American Pharmacists Association

CULTURAL

INTENTIONAL AND CONTINUOUS PROCESS OF LEARNING ABOUT AND RESPONDING TO THE CULTURAL CONTEXTS OF THE COMMUNITIES AND PEOPLE IT SERVES

COMPETENCY

- Kleinman + Benson, 2006, "Anthropology in the Clinic" in PLoS Medicine:
- Culture often made synonymous with ethnicity, nationality and language
- Focus should be on asking, not assuming
- Outline series of open-ended questions for drs: "What do you call this problem? What do you believe caused it? How does it affect your body and mind? What do you fear most about the treatment?"

New Approach of 'Open-mindedness':

"You don't need to be aware of every single culture out there, and what each culture believes….. [rather] each patient has their own beliefs, and you can't jump to any conclusions about what you think that patient will or will not believe just because they're from a certain background….. Every single person's situation is different." (first year med student, in Jenks 2011)

Jenks (2011) found:

1) tensions btw traits list and open-mindedness

– everyone has culture, except for biomed

- cultural practices are things OUTSIDE of the norm, do NOT include: "I go to the dr and ask for a prescription for an antibiotic'

2) loss of awareness of p-e and structural factors:

"Providers learn to recognize – and to some extent uncritically accept – individual differences without developing an understanding of the social and historical conditions in which these differences have been produced or currently operate. " (Jenks 2011: 212)

Where can cultural competency go wrong?

Kleinman's case study:

- Mexican man in CA is HIV+. Wife died a few years ago, 4 year old son is also HIV+, but is not receiving sustained care. Physician believes cultural miscommunication to be the prob.

- Anthrop investigates: man well educated as to how HIV/AIDS progresses and care that is needed

- Very low paid bus driver, working night shifts, had no time to take son to clinics

>> Not cultural diff, but socio-economic conditions

Seth Holmes (2012), "The Clinical Gaze in the Practice of ◯ Migrant Health"

working with undocumented Mexican farm workers in CA finds the same thing: many health probs tend to be structural: rushed appointments, lack of adequate translators, poor working conditions, stress

Holmes concludes (2012: 879-80):

"the lenses of individual biology and individual risk behavior remain limited, excluding the political economic structures and institutional prejudices that shape much of sickness and health. Thus, well-meaning and well-trained clinicians may inadvertently blame the patient – their biology or behaviour – for their suffering. ... biomedicine thus functions as a subtle and effective 'anti-politics machine' (c.f. Ferguson)"

- 'Clinical gaze' determines what is and isn't seen
- Focus on biology hides the structural conditions that determine health and illness
- Even when steps are taken to ameliorate this (i.e. cultural competency training)

Counter-perspectives: medical practice in Malawi

- Southeastern Africa, formerly British colony, one medical college

Student experience has parallels with other accounts:

After the first year, students "blended in" in terms of clothes, and demeanour: girls got louder, boys quieter, 'gangsta' and missionary clothing give way to common Western-professional look

- Multiple motivations: no scholarship for accounting, no space in the military, father insists, etc.
- By the 2nd year, 1/3 drop out, others settled in:

"It's a great feeling to be here. The concept in Malawi is if you're a doctor you've got a lot of power. ... I've already got most of that power.... We are known as having more brains."

- Learn to 'see through' folk healers, even if using their services
- Look forward to 'fighting disease' just like Northern counterparts (same textbks, same curriculum, same experiments)

"It did not last, however… as their textbook and classroom concept of technological medicine crashed headlong into a clinical world in which thousands of patients queued for care in understaffed, underequipped hospitals that frequently lacked such basic supplies as pain medications and antibiotics, not to mention radiation therapy, fluoroscopy, and mechanical ventilator support for newborns, [antiseptics for surgery] or other technologies of 'global' biomedicine" (Wendland 2012: 763)

- Lack of basic medical staples
- See 60-100 patients per day, often at 2 min intervals
- No privacy for examinations
- While 12% pop is HIV+, in hosp est @80-90% of patient pop.
- Fear of contracting HIV/AIDS – not *if*, but *when*
- Feelings of 'uselessness' or 'paralysis' for patients for whom they could do nothing

Coping strategies

- Emigrate
- Dissuade others from studying medicine
- Be creative in terms of resourcing
- Become politically active

"What I have learned is that many times at the hosp we deal with probs that are not clinical. Some of them are due to poor governance, or financial mismanagement, illiteracy, personal problems, stress."

- Students blamed larger structural factors:
  - Trauma > corruption, terrible road and public transit
  - HIV/AIDS > poverty-related survival strategies including unsafe sex

- Adoption and then breakdown of the 'clinical gaze':

  "Malawi's new drs did not shift the major locus of moral responsibility for disease and disability to the individual sufferer, as biomedicine has long been understood to do, but to broader social areas – an in particular to the state." (Wendland 2012: 769)

Anthropologies of "biomedicines"

Plurality of biomedicines, locally-grounded but also transnational in character (Delvecchio Good 1995)

- Trans-national system/s of knowledge and practice (global initiatives, standards, spread of knowledge, training, etc.)
- Local knowledges, values and cultures
- Local biologies + conditions
- Specific structural opportunities and constraints
- Operating within a nexus of power relations