POWER IN THE PHYSICIAN-PATIENT RELATIONSHIP

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DECLARATION

I the undersigned hereby declare that the work contained in this assignment is my own original work and has not previously in its entirety or in part been submitted at any university for a degree

Summary

This paper examines aspects of power within the physician-patient relationship. The historical development of the physician-patient relationship is briefly reviewed and some of the complexities of the relationship highlighted. It is shown that, historically, there is no imperative for the physician to consider only the interests of the patient and it has always been acceptable to consider the interests of a third party, such as the State or an employer - essentially the interests of whoever is paying the physician.

The classical sources of power are then considered. These sources include legitimate power, coercive power, information power, reward power, expert power, referent power, economic power, indirect power, associative power, group power, resource power and gender power. Other approaches to power are also considered such as principle-centred power as described by Covey, power relationships as explained by Foucault, the power experience as described by McClelland and an analysis of power as expounded by Morriss.

The various sources of power are then considered specifically within the physician-patient relationship to determine:

if this particular type of power is operative in the physician-patient relationship, and if so
if it operates primarily to the advantage of the physician or the advantage of the patient.

A simple method of quantifying power is proposed. Each form of power operative in the physician-patient relationship is then considered and graphically depicted in the form of a bar chart. Each form of power is shown as a bar and bars are added to the chart to 'build up' an argument which demonstrates the extent of the power disparity between physician and patient.

It is clearly demonstrated that all forms of power operate to the advantage of the physician and in those rare circumstances where the patient is able to mobilize power to his/her advantage, the physician quickly calls on other sources

of power to re-establish the usual, comfortable, power distance. Forms of abuse of power are mentioned.

Finally, the ethical consequences of the power disparity are briefly considered. Concern is expressed that the power disparity exists at all but this is offset by the apparent need for society to empower physicians.

Conversely, consideration is given to various societal developments which are intended to disempower physicians, particularly at the level of the general practitioner.

Various suggestions are made as to how the power relationships will develop in future with or without conscious effort by the profession to change the relationship.

Hierdie voordrag ondersoek aspekte van mag in die verwantskap tussen pasiënt en geneesheer. Die historiese ontwikkeling van die verwantskap word kortliks hersien en 'n kort beskrywing van die ingewikkeldheid van die verwantskap word uitgelig.

Vanuit 'n historiese oogpunt, word 'n geneesheer nie verplig om alleenlik na die belange van die pasiënt om te sien nie en was dit nog altyd aanvaarbaar om die belange van 'n derde party soos die Staat of 'n werkgewer se belange to oorweeg – hoofsaaklik die belange van wie ookal die geneesheer moet betaal.

Die tradisionele bronne van mag word oorweeg. Hierdie bronne sluit in: wetlike mag of 'gesag', die mag om te kan dwing, inligtingsmag, vergoedingsmag, deskundigheidsmag, verwysingsmag, ekonomiesemag, indirektemag, vereeningingsmag, groepsmag, bronnemag en gelslagsmag. Alternatiewe benaderings word ook voorgelê, naamlik die beginsel van etiese mag soos deur Covey beskryf, krag in menslike verhoudings soos deur Foucault, die ondervinding van krag soos beskryf deur McClelland en 'n ontleding van krag soos deur Morriss verduidelik.

Hierdie verskillende mag/gesagsbronne word spesifiek met betrekking tot die geneesheer-pasiënt verhouding uiteengesit om te besluit:

of hierdie tipe mag aktief is tussen geneesheer en pasiënt, en indien wel, werk dit tot die voordeel van die geneesheer of die pasiënt.

'n Eenvoudige sisteem vir die meting van mag/gesag word voorgestel. Die bronne word individueel oorweeg en gemeet en die resultaat in 'n grafiese voorstelling voorgelê op so 'n wyse dat 'n argument daardeur 'opgebou' word om die verskille van van mag/gesag tussen geneesheer en pasiënt uit te wys.

Dit word duidelik uiteengesit dat alle vorms van mag/gesag ten gunste van die geneesheer werk. Kommer is getoon dat hierdie magsverskil werklik bestaan, asook die snaakse

teenstelling dat die gemeenskap wil eintlik die geneesheer in 'n magsposiesie plaas.

Die etiese gevolge van hierdie ongebalanseerde verwantskap, asook die moontlikheid van wangebruik van hierdie mag word ook genoem.

Verskillende gemeenskaplike ontwikkelinge wat die mag van die geneesheer wil wegneem word geidentifiseer, meestal op die vlak van die algmene praktisyn.

Verskeie voorstelle vir toekomstige ontwikkeling van die verwantskap word voorgelê, met of sonder spesifieke pogings van die professie om die verwantskap te verbeter.

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Introduction

Normal people, under normal conditions, value "life" as one of the most important "goods", if not the most important good. *Disease*, an unhealthy state of body or mind (Microsoft, 1997), is that which threatens life or detracts from it. It is therefore not surprising that any person who claims to be able to eliminate disease or improve life, either in quality or quantity, would be given a hearing. (Of course, people who are mentally unstable, or who are in conditions in which normal judgment cannot be exercised, may value life differently. This does not diminish the import of the assertion that life is generally valued as a fundamental good.) As far as one can go back in recorded history, there have always been those who claimed to be able to heal. At about the time of the Greek enlightenment, schools were developed for the training of physicians. Today we know that they had very little in their therapeutic armamentarium. Nevertheless, they commanded a great deal of respect in society, and generally benefited materially.

An individual who perceives that there is some threat to his or her health presents him- or herself (as the patient) to the healer (the physician) for help. It is not, then, surprising that this relationship is characterized by an imbalance of power. A strong case can be made that this is the most unequal relationship in society. Even the most powerful persons in society cannot guarantee their own health. They too must, from time to time, present themselves to the physician, and be subject to intimate physical examination or to interventional procedures which may carry serious risks.

History has shown that where power differentials exist, there is the potential for abuse. In Western medicine, physicians have used this imbalance to justify extreme wealth, which has caused alienation between patients and physicians. Even in more egalitarian societies, the power distance is unacceptable, and a number of far-reaching social adjustments are being made, for example in the development of managed health care, where the power of the physician is significantly decreased.

The purpose of this paper is to examine the nature of the patient-physician relationship with special reference to power relationships and the ethical implications of the imbalance. The societal consequences of the perception of power imbalance will be

considered under various scenarios, such as active intervention on the part of physicians, as a profession, to address the effects and perceptions of imbalance and the otherwise unmodified natural course of events.

Chapter 1 will sketch the development of the physician-patient relationship from early recorded history to the present.

Chapter 2 will review the nature of power and its sources.

Chapter 3 will draw on the first two chapters in analysing power in the physician-patient relationship. An "intuitive power scale" will be proposed which will graphically depict the power imbalance in the physician-patient relationship.

In Chapter 4, I will consider the ethical implications of the issues highlighted in Chapter 3. This chapter will include a discussion of current trends towards disempowering physicians, as well as trends which propose the allocation of additional power to physicians – for example, physician involvement in patient suicides and voluntary euthanasia.

The paper concludes with a review of issues, and predictions and recommendations.

History of the physician-patient relationship

There are a number of components in the relationship. For the purposes of analysis, the relationship will be disaggregated into the following components:

1. the historical development of the relationship;
2. the role of the patient;
3. the role of the physician;
4. the nature of the communication between patient and physician;
5. the role of the system within which the relationship occurs; and
6. third party interests.

Each component will be briefly reviewed.

Historical development of the physician-patient relationship

The history of medicine can be traced back to about 3200 BC, at which time Egyptian doctors were already producing their medicines, in accordance with text-book methods, from herbal compounds which had proved their worth (Keller, 1956). The Sumerian civilisation, at about the same time, recognised a number of diseases, such as a variety of fevers, apoplexy and plague. Doctors in Assyria and Babylonia were answerable to the priests (who, in turn, were answerable to the gods), while the surgeons were laymen, answerable to the State for the operations they performed (Margotta, 1967). Hammurabi (1948–1905 BC) was the first to define the profession's civil and criminal liability. Some enactments laid down the scale of fees and the penalties for incompetence or negligence. For example, if the patient lost his life, or his eye, during an operation, the doctor had his hands cut off. Herodotus described the early specialisation in medicine as follows: "each physician applies himself to one disease only and not more. All places abound in physicians; some for the eyes, others for the head, others for the teeth, others for the intestines and others for internal disorders". The Greek historian, Siculus, noted "... within Egypt, the sick are all treated free of charge, because doctors are paid by the state and scrupulous observance of the prescriptions drawn up by the great doctors of the past is incumbent on them".

As the centuries passed, little change was noted. Medicine was practised largely for the purpose of freeing the patient from demonic powers.

From the 6th Century BC, Greek medicine developed a professional status. Aspiring doctors (asclepiads) applied for a licence. A Council granted the licence once the standing of the school the student had attended had been taken into account. Practitioners could open a surgery in which they could receive and treat patients for fees.

Pythagoras founded a school which provided the most important basis for scientific medicine. Aristotle named this school the "Italic school".

The first recorded statement concerning the doctor-patient relationship came from Hippocrates, from the Cos school, in the 5th Century BC. The Hippocratic Oath contains the following "... I will go to help the sick and never with the intention of doing harm or injury. I will not abuse my position to indulge in sexual contacts ... and whatever I see or hear, I will keep secret". Writings of the Cos school at this period included works such as "On Honourable Conduct" and "On Precepts". Hippocrates had a profound understanding of human suffering, and put the doctor at the service of the patient, saying that his place was at the bedside of the sick. The maxim "do no harm" appears in "The Epidemics", but the origin of the expression *primum non nocere* (above all, do not harm) is obscure (Jonsen, 1978). Galen later adds the "*primum*" to the expression "to help".

In Rome, doctors played an important part in the military machine of the Roman Empire. "The formation of stationary armies in large garrisons gave rise to the establishment of a medical service, with physicians ranked as non-combatant officers, called principales, who took their orders directly from the camp commander or, in his absence, from the tribune of the legions. At the time of Hadrian, every legion, including the cavalry, had its own medical personnel. Naval units, too, had physicians aboard every trireme; these were called duplicarii, which indicates that they received double pay" (Margotta: 91).

As the Roman Empire declined, physicians became more respectable and respected; physicians were often the most important members of the court and the trusted friends of the ruler.

Galen in about 162 AD is known to have had skill in sorting out malingerers from those with genuine disease. It is not known, unfortunately, what the relationship was between Galen and these patients, that is, who paid for the treatment, and who benefited from Galen's identification of malingering, is obscure.

From the above it can be seen that generally physicians fell into two categories:

(a) those who were employed to do the bidding of their employer (the emperor, the army, and so on); and

(b) those who received payment directly from the patient and looked after the interests of the patient.

Those in category (a) could, in many instances, be considered as serving the interests of a third party, while those in (b) served the patient directly.

Thus it is important to note that, historically, there was no ethical imperative for physicians to look only to the interests of the patient. The care of the patient could be simply for the benefit of the third party or employer. The historical model for the physician-patient relationship involved patient dependence on the physician's professional authority. Believing that the patient would benefit from the physician's actions, a patient's preferences were generally overridden or ignored. For centuries, the concept of physician beneficence allowed this paternalistic model to thrive.

The patient

Patient autonomy

During the second half of the twentieth century, the physician-patient relationship, in the Western world, has evolved towards shared decision-making. This model respects the patient as an autonomous agent with a right to hold views, to make choices, and to take actions based on personal values and beliefs. Patients have been increasingly entitled to weigh the benefits and risks of alternative treatments, including the alternative of no treatment, and to select the alternative that best promotes their own values (Washington School of Medicine, 1998).

The American Medical Association (1994) sees this more as a change of emphasis rather than a change in philosophy or a new model: "From ancient times, physicians have recognized that "the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of the greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance". Although this view may be based more on wishful thinking than on fact, the Association goes on to emphasise that physicians

can best contribute to this alliance by serving as their patients' advocate and by fostering the following rights:

1. The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4. The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5. The patient has the right to continuity of health care. The physician has an obligation to co-operate in the co-ordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

6. The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfilment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate.

The American Medical Association assumes that the patient is competent to share this decision-making role. While this may be true of the average patient in the United States, it is not necessarily true universally.

Hughes (1994) sets out various models of the physician-patient relationship. He shows how Parsons (1951, 1958, 1978) began with the assumption that illness was a form of "dysfunctional deviance" that required "reintegration with the social organism". Illness, or even feigned illness, exempted people from work and other responsibilities, and thus was potentially detrimental to the social order if uncontrolled. Maintaining the social order required the development of a legitimised "sick role" to control this deviance, and make illness a transitional state prior to being returned to the normal role performance.

Parson's norms governing the "sick role"

(a) In Western society, Parsons saw four norms governing the functional sick role: the individual is not responsible for their illness;
(b) exemption of the sick from normal obligations until they are well;
(c) illness is undesirable; and
(d) the ill should seek professional help.

Parsons does not discuss the case where the patient is indeed responsible in some way for his/her illness. For example, the patient who is fully informed of the dangers of smoking but chooses to continue to smoke must be responsible, at least to some degree, for any adverse health consequences that may result. It has been shown that physicians react less positively to patients with conditions "brought on by their own actions" (Hafferty, 1988). Perhaps this is most seriously noted in the case of patients infected with HIV.

Parson's view that the ill should seek professional help is presumably based on the economic necessity, from a societal point of view, to return a patient to a productive capacity as soon as possible. However, this view is being challenged in modern society. The ill are free to consult a wide variety of "healers", and there is currently strong political pressure in this country to permit traditional healers and others to certify that a person is ill and therefore unable to perform their normal work. Generally, such a decision has a financial implication, which the employer in the main has to carry.

Cassell (1978) paints the scenario of a patient who presents to the physician suffering from a completely curable but potentially fatal infection. The physician explains the

situation to the patient but the patient refuses treatment, saying he wants to be allowed to die. At first glance, it would appear that the patient is exercising his right to refuse treatment. But, Cassell states, "I would guess that it would be a rare hospital where such a patient would not be treated against his will. The physicians would ask for a psychiatric consultation to declare the patient to be incompetent and then start therapy".

Cassell explains that when a patient enters the doctor's surgery or hospital seeking help, he enters a relationship with the treating doctor, which although undefined, cannot simply be terminated by the refusal of the patient to accept treatment. The act of coming to the physician or hospital is an implied request for assistance which creates obligations on the attending doctor. Unless the patient and physician had previously agreed on a limitation to the responsibility of the physician, the physician would be expected to act in what he believes to be the interest of the patient.

This is contrasted to the situation in which a Jehovah's Witness refuses a blood transfusion which is deemed by the physician to be life-saving. In this case, the motivation of the patient is clear and his actions are consistent with a well-known set of beliefs. In these two cases, time is also a factor. In the case of the Jehovah's Witness, the decision is a "durable" one, as it has been tested over time. In the first case, there was not sufficient time to assess the patient's motivation, and the motivation was not at all clear. In the case of a patient with a chronic disease which, although incurable, can be managed so as to prevent death, the patient who refuses such treatment is likely to be allowed to do so because he has had sufficient time to assess the effect of the treatment on his lifestyle and general wellbeing. .

Cassell's criteria for autonomy

From the comparison of the above two situations, it can be concluded that the doctor should act in the best interest of the patient *as defined by the patient,* provided that:

(a) that the patient has had sufficient time to make the decision;

(b) is in a fit state to make the decision; and

(c) in the opinion of the doctor, the patient is acting in a truly autonomous manner.

Cassell feels that the recent increase in importance of the concept of "autonomy" is a way of adjusting the physician-patient relationship from a paternalistic one to a partnership arrangement in which the patient fully participates in his or her own care.

Dworkin's modification of Cassell's criteria

Dworkin (1976) adds that autonomy also requires that the decision of the patient must be both:

(a) *authentic* – that is, the beliefs, ideas and actions on which a decision is based are truly those of the patient; and

(b) *independent* – that is, the decision is not being made under duress.

To Dworkin independence, in turn, requires:

(i) sufficient knowledge about the area in which the decision is to be made;

(ii) the ability to reason and think clearly; and

(iii) the ability to act on the decision.

Severe illnesses negatively impact on both authenticity ("... is this really me lying in the bed full of faeces?") and independence.

The physician

Socially we seem to feel a need to allocate to physicians a role of power. While there are many reasons for this, the physician remains an average person, subject to the pressures and temptations experienced by the average person. We dislike thinking of physicians in this way, particularly if we ourselves have experienced exceptionally good service from our own physician or if we have been in a position of critical dependence on the advice of our physician. However, there are sufficient instances of failure of physicians to act in an ethical way to make such analysis imperative. Physicians are influenced by:

(a) *Financial interests*

The physician in private practice is under considerable financial pressure in the early years of practice. There are generally high repayments on study loans, high insurance premiums, and the costs of setting up a practice. It is not surprising that physicians might make decisions that are intended mainly to increase their revenue rather than the patient's health. In these cases it is usually very easy for the physician to justify the decision. Having just purchased a new electro-cardiograph, for example, the indications to perform an ECG on a patient may be very much less stringent than previously. A totally unnecessary ECG could be taken "for the purpose of determining a baseline" for the patient.

(b) *Personal discomfort*

There are many situations in which the physician would prefer not to fully inform the patient, either because of the nature of the illness, the characteristics of the patient (or family), or the time and effort that such communication may necessitate. Even in situations where physicians are discussing matters as serious as "advance directives" (instructions to the doctor in the event of critical illness or injury), the average consultation took only five to six minutes. The physician spoke for two-thirds of this time (Tulsky, 1998). In very few serious discussions did the physician attempt to determine the patient's own values or their attitudes towards uncertainty (Johanson, 1998).

(c) *Political or religious ideologies*

Physicians may refuse to treat certain classes or groups of people based on their own beliefs. While this is generally frowned upon and regarded as unethical, it nevertheless occurs. Some white physicians will not treat black patients, some Muslim female doctors will not treat male patients. Nazi doctors took the biological model so far that they ceased to feel the necessity of moral action in respect of certain groups of people. Our own "Doctor Death" (Dr. Wouter Basson) served the interests of the apartheid regime by developing biological weapons and testing them on political opponents.

(d) *Personal risk*

In my experience, physicians decline to carry out some treatment or action because of considerations of personal risk. Some instances have been refusal to do an air evacuation from a neighbouring country during times of hostility; refusal to accompany a patient with Congo Fever in an ambulance or to treat such a patient; and refusal to operate on patients infected with HIV on the basis that it constitutes too great a personal risk.

On the more positive side, the physician is also influenced by the needs of patients and the requirements of the profession. For Parsons, the physician's role is to represent and communicate current norms to the patient and to control deviations from the norms. Physicians exemplify, for Parsons, the shift to "affect-neutral" relationships in modern society, with physician and patient being protected by emotional distance. Parsons believes that medical education and social role expectations generally result in "normative socialisation" which ensures that physicians act in the interests of the patient rather than their own material interests. Because physicians have mastered a body of technical

knowledge, it is "functional for the social order" to allow physicians professional autonomy and authority, controlled by their socialisation and role expectations.

Parsons has also been accused of having been overly optimistic about the success of physician socialisation to universalism and affective-neutrality. Physicians often react negatively to dying patients, patients they do not like, and patients they believe are complainers (Hafferty, 1988). Physicians also are subject to personal financial and personal interests in patient care.

Szasz and Hollender's (1956) work refined Parsons by elaborating different physician-patient models arising around different types of illness. Szasz and Hollender proposed that patient passivity and physician assertiveness are the most common reactions to acute illness; less acute illness is characterised by physician guidance and patient co-operation; and chronic illness is characterised by physicians participating in a treatment plan where patients had the bulk of the responsibility to help themselves.

Professional Power and Autonomy

The study of physician-patient relationships in one society may not indicate how much the particular structures and norms of the provider-patient relationship are simply the result of historical chance, rather than necessitated by the nature of illness and healing in an industrialised society. Secondly, such a study may not indicate whether the particular practices and norms are leading in a dysfunctional direction. The question can be asked, does "the aura of omnipotence with which the medical establishment has surrounded itself deter you from inspecting your doctor closely enough to discover that he really has feet of clay"? (Mendelsohn, 1982: 21).

It appears that contemporary social scientists are inspired by growing resistance to unjustified claims to power by physicians. Physicians' defence of professional power and autonomy appears to be merely self-interested authoritarianism. Physicians' high incomes and defence of autonomy appeared to result in both bad medicine and bad health policy, and physicians' perceived high levels of power appeared all the more sinister because of medicine's intimate invasion of the body. Physicians have relied on the "sacred" or intimate nature of the physician-patient relationship to maintain the social status quo. They have nevertheless not succeeded in preventing the development of power-decreasing universal health insurance schemes and managed care.

In this context, Eliot Freidson's work (1961, 1970, 1975, 1986), crystallised the notion that professional power was more "self-interested" than "collectivity-oriented". Freidson saw the physician-patient relationship as a bargained interface between a professional system and a lay system, each with its own interests.

Professionalisation grants physicians a monopoly on the definition of health and illness, and they use this power over diagnosis to extend their control. This control extends beyond the claim to technical proficiency in medicine, to claims of authority over the organisation and financing of health care, areas which have little to do with their training.

There are now many studies of the way that professional power has been institutionalised in the structure and language of the physician-patient relationship. For instance, a recent study of medical students' presentation of cases demonstrated that physicians were being trained to talk about their patients in a way that portrayed the physician as merely the vehicle of an impersonal medicine acting on malfunctioning organs, rather than a potentially fallible human being interacting with another potentially fallible human being. The more highly regarded presenters were found to:

(a) separate biological processes from the patient;
(b) use the passive voice in describing interventions;
(c) treat medical technology as the agent; and
(d) mark patients' accounts as subjective (the patient "states," "reports," "denies,").

These devices make the physician more powerful by emphasising technology and eliminating the agency of both physician and patient (Anspach, 1988).

Since its publication, Starr's (1982) *The Social Transformation of American Medicine* has quickly become the canonical history of the institutionalisation of professional power, its effect on the organisation of health care, and the profession's metastasised influence in the political sphere. Though Starr draws on many theoretical sources, he paints a picture of the American physician-patient relationship as a successful "collective mobility project" whose contours were not at all determined by the functional prerequisites of society. While Starr does not goes so far as to say that we do not need "physicians" at all, he argues that there are a range of possible structures that medicine could have taken in industrial society, and that American physicians are an extreme within that range.

Marxist and Feminist approaches

Drawing on – and extending – the professional power analysts, the growing school of Marxist sociologists interpreted the physician-patient relationship within the context of capitalism. In the Marxist analysis, the American physician-patient relationship is conditioned by the "medical-industrial complex", where profit-maximisation drives the innovation of technologies and drugs, and constrains physician decision-making.

The most orthodox advocate of this analysis, Vincente Navarro (1974, 1986, 1987), rejects the analyses of those such as Illich (1975), and Freidson and Starr, who see professional power as having some autonomy from – and sometimes being in direct conflict with – capitalism and corporate prerogatives. For Navarro, physicians are both agents and victims of capitalist exploitation, engineers required to fix up the workers and send them back into community and work environments made dangerous and toxic by capitalism.

But the professions are anomalous for traditional Marxist theory; only those who own the means of production are supposed to accrue occupational autonomy and great wealth. This anomaly has led Marxist medical sociologists to propose the thesis of "physician proletarianisation". Theorists of physician proletarianisation point to the rising numbers of salaried physicians, the de-skilling of some medical tasks, and the shifting of some tasks from physicians to less skilled technical personnel.

Parallel to, and often included in the Marxist account, has been the growing feminist literature on medicine. In particular, feminists have focused on the patriarchal nature of the male-physician–female-patient relationship, documenting the history of medical pseudo-science that has portrayed women as congenitally weak and in need of dubious treatments.

Women physicians tend to choose poorly paid primary care fields over the more lucrative, male-oriented surgical specialities, and are more likely to be employed as opposed to working in private practices. Fewer women physicians are likely to be in positions of authority.

The biomedical and biopsychosocial models

More recently, as the medical profession has become sensitive to the income-generating potential of seeing ever more patients, the amount of time spent with patients has, in many cases, been reduced to the absolute minimum. An interview with a general practitioner can last ten minutes or less. The amount of time spent with patients correlates strongly with patient satisfaction (Gross, 1998). This is confirmed by other research, such as that done by Gianakos (1997), in which it is shown that healing benefits from a caring, involved physician.

The physician-patient relationship has recently become an important issue and has been the subject of a great deal of research and writing. For example, physician-patient relationships have been classified according to the question of whether the physician feels that he/she is "in charge and responsible for" the patient's treatment, whether treatment is seen as primarily the responsibility of the patient, or whether treatment is seen as a joint responsibility (Lagerlov, 1998). Similar research classified the physician-patient relationship as either "paternalism" or "mutuality" (Johanson, 1998).

About ten years ago, the "biopsychosocial" model of health care was proposed. This model moved away from the purely physical model and included the individual psyche and social context as being fundamentally important in the management of disease, particularly chronic diseases such as lower back pain (Nordin, 1998). In support of this model, research has shown that even the person who accompanies the patient has an influence on the medical encounter (Brown, 1998).

Mandl (1998) is concerned about the development of electronic communications in the delivery of health care. The telephone took thirty years to be incorporated into 25% of American homes. Television took twenty-five years. The internet has taken less than ten years. E-mail between physicians and patients offers important opportunities for better communication, and is likely to improve the involvement of patients in their own health care. This may, however, widen the social disparities in health outcomes, and create barriers to the accessibility of health care. Mokoena (1998) reviewed the uses of telemedicine, and showed that there is wide scope for the development of this technology to support rural communities or patients in isolated areas. This technology permits the physician to examine and interact with the patient from a remote location, creating a kind of "virtual" patient-physician relationship.

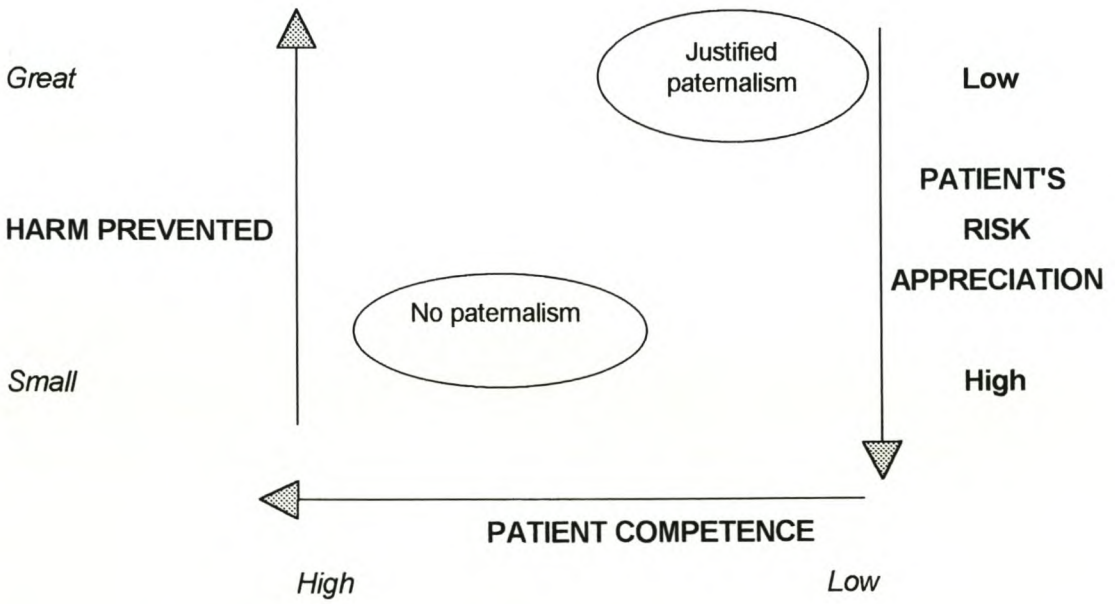
Cassell (1978) takes the liberal view that the whole function of medicine is to preserve autonomy. The preservation of life is neither primary nor secondary, but is, rather,

subservient to the primary goal. Curing the disease is the quickest way of restoring autonomy. He believes that medicine has been diverted from this, its main goal, to the preservation of biological life.

Holistic approach

This approach seeks to balance the biopsychosocial and liberal views. Paternalism is permissible if the harm to be avoided is considerable. It takes into account the *de facto* situation that patients are not always competent to decide or even to be fully informed about risks and benefits. It is also sensitive to the need to move away from the paternalistic model as far as possible.

The holistic approach



Third party interests

There are a number of definable instances where physicians commonly look after third party interests:

(a) *Interests of the community*

The procedure of vaccination is one where each person is exposed to a small risk, partly to immunise themselves, but mainly to decrease the incidence of the disease in the community. Take measles, for example. The disease is endemic only in

communities of over 30 000, approximately, because there has to be a regular rate of new infections for the spread of the virus. However, the vaccination has a risk of its own. The physician, acting only for the interest of the individual patient, should advise against immunisation on the assumption that sufficient numbers of other people will in fact be vaccinated. This allows his own patient to benefit from the reduced risk of acquiring the disease without exposing him to the risks of the vaccination. However, the physician generally does not advise against vaccination on the grounds that it is better for the community that everyone be exposed to a slight risk in order to reduce the overall risk for everyone.

(b) *Interests of an employer*

In South Africa, in the past, a large number of physicians were employed by the State in public sector health institutions. These institutions were racially segregated. While many physicians supported the "apartheid system", others, for a variety of reasons, accepted appointments in these institutions in spite of their abhorrence of the political system in the country. They allowed the State to determine "who" their patients should be, and they were prevented from treating the "wrong colour" patient in particular institutions.

Physicians are often called upon by employers to determine the fitness of an employee for a particular task (for example, a medical for a pilot), or to determine permanent incapacity. While this may sometimes be in the interests of the patient, in general it is specifically to the advantage of the employer.

(b) *Interests of financial organisations such as insurance companies*

The common practice of insurance companies in requiring medical examinations prior to the offering of an insurance contract is a clear case of the physician being expected to act in the interests of a third party. Normally, it is clear that the physician is acting on behalf of the insurance company, and the patient would probably not volunteer information unless it was specifically asked for.

(c) *Interests of the State*

Medical expertise can be put to use in many ways. The development of biological weapons is one, but in this instance, there is not a physician-patient relationship involved. In South Africa, the "district surgeon" has traditionally been the person employed by the State to provide medico-legal services, *inter alia*, for prisoners. In this setting, the physician could be put under pressure to act in a way prescribed by political interests rather than medical considerations alone. The physician called

upon to give evidence about his patient in criminal cases is acting in the interests of the State and not the patient.

(d) *Interest of other third parties*

The physician may be called upon to give evidence in court in a wide variety of civil cases, such as the competence of a patient to draw up a will or make some other personal decision. But the most complex area is that of the patient whose illness poses a threat to some potential third party. The most significant of these is the patient infected with HIV, but there are many other conditions which create similar problems for the physician, such as herpes genitalis, syphilis, homicidal tendencies and Alzheimer's disease.

(e) *Interests of sporting bodies*

Although many sporting bodies make use of physiotherapists or first aid workers to determine fitness to participate, physicians are sometimes required to perform this task. The pronouncement of the physician could possibly terminate a sporting career.

Thus, there are a wide variety of 'third parties' whose interests are taken into account by physicians, sometimes to the detriment of the patient.

The physician-patient relationship

"The physician-patient relationship, once considered the basis of therapy, has been subverted by technology, by the medical education system and, more dramatically, by the intrusive demands of managed care," wrote Elizabeth DeVita, associate editor of *American Health* magazine, in a recent article. Most of the private medical care in South Africa has been on the "fee for service" basis. Analysts, particularly socialists, point out that this system generates perverse incentives. The more that is "done" for the patient, the more money the physician makes. Since payment generally comes through a third party (usually a medical aid), the patient was not concerned with the system, as he/she received the maximum possible care. The system resulted in progressively increased costs up to the point that many societies, even wealthy ones such as the USA, could not afford care on this basis any longer. Today, with the development of "managed care", financial risks have shifted back onto the physicians and hospitals and other healthcare providers. Initially there was simply a system of authorisation and control, so that physicians did not have the unquestioned right to make treatment decisions. Later, under global capitation, where physicians receive a set amount of money per patient per month

to deliver care, the incentive scheme changes dramatically. Under this scenario, the more care that physicians provide and the sicker patients are, the less money they make. Thus physicians have a financial incentive to have healthier patients to begin with, and to keep these patients healthy. The danger is that physicians may now limit care in an effort to preserve a bigger proportion of the capitation money for themselves. Some physicians receive bonuses at the end of the year based on their patients' utilisation of medical services. The less care they provide, the bigger bonuses they get. The thought that your physician will get more money at the end of the year because he or she has limited care to you and your family is unlikely to make the patient trust the physician more.

Ehrenreich (1978) believes that to change the health system at all – much less to create a medical system which maximally utilises self-help and mutual help, and which encourages an active rather than a passive role for the patient – will require radical de-professionalisation. He suggests a radically expand use of community health aides; the spread medical knowledge to patients and to non-physician health workers; and the reduction of the social distance between physicians and patients.

De-professionalisation has nothing to do with eliminating the skills of physicians. Skills are, of course, needed. It is the privileges, the power and the monopolisation of medical knowledge that must be removed through de-professionalisation (Ehrenreich and Ehrenreich, 1978: 70).

Having access to a strong provider-patient relationship, with good participative communication, has been shown to be important for the experienced and objective quality of care. But a number of social trends have converged to reduce the ability of patients to have these relationships with physicians. The critical theorists, in turn, have raised questions about whether radically different relationships, with radically different providers of care, might be possible and preferable.

One trend has been the rapid proliferation of specialisation among American physicians. Only one in ten American physicians are in "general practice" (general or family practitioners, paediatricians and geriatricians), with a claim to a holistic approach to patients' concerns. Many researchers assume that increasing specialisation will continue to "technologise" and "compartmentalise" the physician-patient interaction. As patients see increasing numbers of poorly co-ordinated specialists for their myriad problems, the need for "case-managing" generalists becomes ever more acute.

Ethical aspects of the physician-patient relationship

In the past the physician-patient relationship appears to have been much simpler than it is at present. Then, the patient presented to the physician who paternalistically acted in what he believed to be the interests of the patient, taking into account social and other prevailing conditions. The present-day physician-patient relationship has become complicated over the past few decades, possibly because of increasing concern over individual rights in a rapidly changing therapeutic environment. There has been a vast increase in the number of treatment options, and a widening of the knowledge gap between physician and patient. In the present relationship, the physician is particularly powerful relative to patients.

Beauchamp and Childress (1994) devote a chapter in their textbook, *Principles of Biomedical Ethics*, to an analysis of the ethical aspects of the physician-patient relationship. They assess the physician-patient relationship from a number of ethical viewpoints.

Veracity

It is suggested (Beauchamp and Childress, 1994:397), that veracity is not an absolute requirement. It is, however, important and useful in the establishment of a relationship of trust. They claim that both deception and lying are necessary from time to time, but that under-disclosure or non-disclosure are usually easier to justify than lying. They report a dramatic change in physician attitudes between 1961 and 1979. In 1961, 89 percent of the physicians surveyed stated that they would attempt to conceal their diagnosis from cancer patients. However, by 1979, 90 percent of physicians stated that they would seek to inform the patient fully. The reasons for this change were given as follows:

- More treatment options;
- Improved rates of survival;
- Fear of litigation;
- Involvement of other team members;
- Altered attitudes about cancer;
- Increased attention to patients' rights; and
- Increased recognition that effective communication enhances patient understanding and compliance.

On the other side, the reasons for deception are given as follows:

Benevolent deception

It is sometimes felt that it is in the interests of the patient not to know some or other facts, or, alternatively, the physician does not know all the facts and therefore is not in a position to inform the patient fully (and possibly does not want to admit this fact).

In some instances it is believed that the patient would not want to know the truth. Beauchamp and Childress (1994: 401) quote Edmund Pellegrino as follows: "To thrust the truth or the decision on a patient who expects to be buffered against news of an impending death is a gratuitous and harmful misinterpretation of the moral foundations for respect for autonomy". However, it is generally agreed that in some circumstances it is obligatory to inform the patient in order to protect the rights and interests of others. For example, a patient who is diagnosed HIV positive needs to know that information whether or not he/she wishes to know it.

In spite of this apparent justification for the flexibility of truthfulness, the American Medical Association requires that a physician should deal honestly with patients and colleagues.

Privacy

In the United States, there is a constitutional right to privacy. At present, case law relating to privacy is not well-developed. The concept of privacy includes the right to ensure that sensitive information not be disclosed to any other party without the permission of the patient. Privacy also includes the prevention of intervention in intimate relationships and the protection of bodily parts and objects intimately associated with the person. Privacy is also important in creating and maintaining intimate social relations, and for the development of friendship, love, and trust.

Privacy itself is derived from the principle of autonomy. The principle of respect for autonomy therefore includes the right to decide, insofar as possible, what will happen to one's person, to one's body, to information about one's life, to one's secrets, and so on.

Entering a teaching hospital exposes patients to a considerable loss of privacy, as professionals in training there often seek access to them for reasons that have nothing to do with their care.

Confidentiality

Physicians are obligated not to provide information about the patients to insurers, prospective employers or other third parties without the consent of the patient. Requirements of confidentiality are emobodied in the Hippocratic Oath and are contained in present ethical rules. The American Medical Association holds that the physician shall safeguard patient confidences within the constraints of the law, while the World Medical Association states that the physician should respect secrets which are confided to him/her even after the patient has died.

In various business settings, it is reasonable for physicians to disclose information to employers. Physicians often have dual roles. For example, a physician in military service has a duty to both the patient and to the military.

In some cases, the law requires that the physician reports certain conditions such as child abuse and gunshot wounds. It has not been demonstrated that patients have been unduly compromised by these legislative requirements. In other cases, the physician would be expected to warn third parties if information about the patient suggests that they are at serious risk.

The physician is, however, generally expected to comply with the reasonable expectation of the patient for privacy and confidentiality. Ideally, the physician should discuss with patients the limits of confidentiality to avoid confusion or misconceptions.

Fidelity

Fidelity is the obligation to act in good faith and to keep promises, fulfil agreements and maintain relationships. "A disposition to be true to one's word is the primary condition in this model" (Beauchamp and Childress, 1994: 430). This is often embodied in voluntary promises and professional oaths.

"Both law and medical tradition distinguish the practice of medicine from business practices that rest on contracts and marketplace relationships. The patient-physician relationship is a fiduciary relationship that is founded on trust or confidence; and the physician is therefore necessarily a trustee for the patient's medical welfare" (Beauchamp and Childress, 1994: 430).

Professional fidelity is described as:

- the professional allows patient interests to supercede his own;
- the patient's interests take priority over the interests of others.

Nevertheless, physicians have not been morally obligated to treat patients during epidemics. Agreement to do so has been seen as praiseworthy and noble rather than obligatory.

Recent changes in the structure of medical care has put strain on the concept of fidelity as health workers find themselves increasingly answerable to third parties, such as employers, military, correctional institutions and funding institutions using procedures such as prospective payments systems, diagnosis-related groups, utilisation review, preferred provider arrangements, and various forms of managed care.

It is interesting to note that research done in an intensive care unit, as reported in Beauchamp and Childress (*op cit,* page 437), showed that the vast majority of nurses perceived that they experienced ethical conflicts between themselves and the medical staff. Conversely, however, only one physician in the unit (of twenty-four physicians) perceived there to be any ethical conflicts between themselves and the nursing staff. This kind of report suggests that the relationship between physicians and other health professionals is complicated and also needs addressing from the viewpoint of power relations. Such investigation is beyond the scope of this paper and will not be revisited.

It is not unusual for physicians to perceive conflicts of interest between self-interest and the patient's interests – thereby producing ethical conflict situations.

Additional constraints on the relationship of fidelity are imposed through the introduction of standardised care procedures. While this may, in many instances, be in the interests of the patient and of the providing institution, it is not always so. These procedures significantly reduce the power of the physician, and it is not immediately obvious where the responsibility and power lies in such situations.

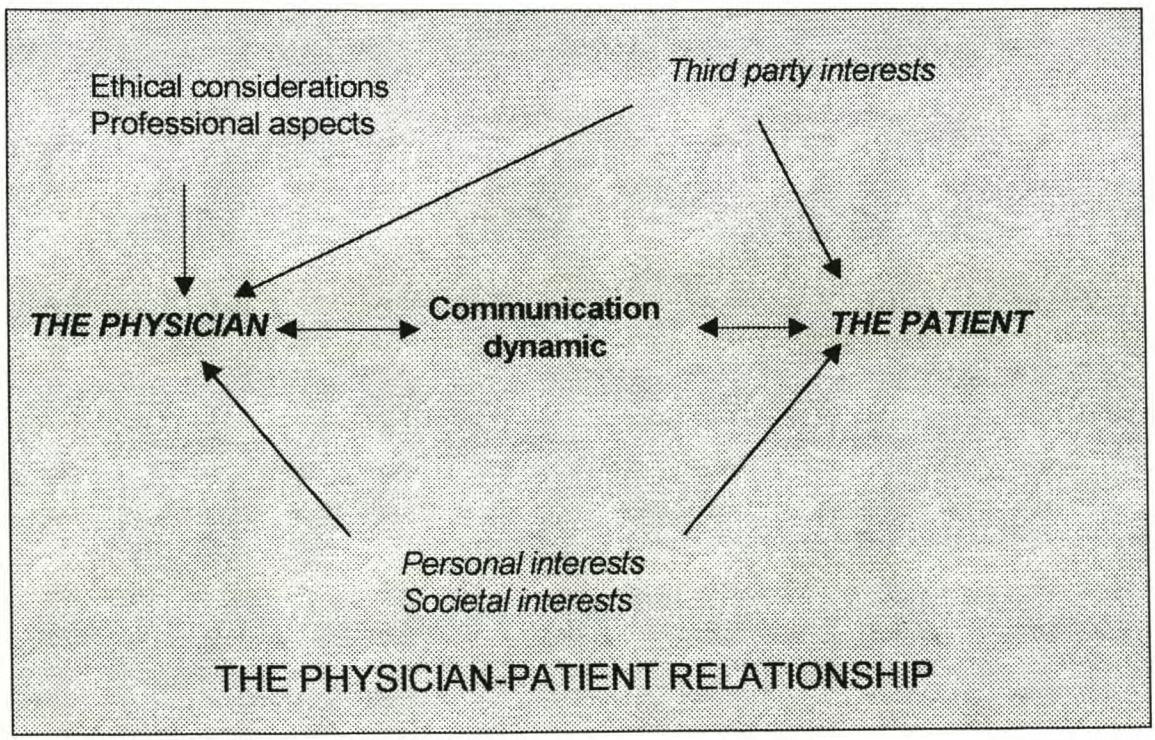
Finally, physicians create significant conflicts of interest for themselves by purchasing shares in treatment facilities, equipment vending companies, and various diagnostic and therapeutic services.

Research

The declaration of Geneva of the World Medical Association affirms that "The health of my patient will be my first consideration". In theory, then, patient interests should be paramount. The physician, though, is often involved in research activities, and here again conflicts of interest can occur. Patients' interests are supposed to be protected by research ethics committees on which physicians who are not directly involved in the research serve. But, while research is generally in the public interest, it almost always involves some risk, however slight, for the patients involved.

Conclusion

In summary, then, the physician-patient relationship is a complicated relationship involving historical precedents and personal and societal interests within a complex communication process. Personal interests include financial, religious, scientific, individual preferences.



The nature of power

Giddens (1996) states that power is an integral component of all human relationships. Such an ubiquitous and important part of our lives should surely have been the focus of innumerable works on the subject. It is, however, surprisingly difficult to find works that concentrate exclusively on the concept other than those which focus on the political arena.

In this Chapter, I intend to review the nature of power and its operation as seen by a number of authors. My intention is to try to determine the importance of power in the physician-patient relationship as a basis for consideration of the ethical implications of power which will be considered in the following Chapter.

There is a crucial prerequisite for the operation of power which is internal to an individual, namely, the ability to choose, without which all other considerations of power are irrelevant. In this paper, the ability to choose will be taken as a given. Attention will be focused on the use of this "ability to choose" in order to obtain or exercise power.

Definition of Power

Power is a difficult concept to define. Morriss (1987:1) states "... we find it very difficult to say exactly what we mean by power. We all have an intuitive understanding of the term, which is (usually) perfectly sufficient for pub conversations. But the rapidly growing mountain of literature on the concept of power indicates that this understanding is not considered adequate for academic discourse".

The World Book Dictionary (1983) defines power as follows:

> Strength or force; might;
> The ability to do or act;
> A particular ability
> Authority; right; control; influence

This definition is not particularly illuminating. Cassell (1962) defines power as follows:

> Ability to do or act so as to effect something; a mental or bodily faculty, or potential capacity; strength, force, energy, especially as actually exerted; influence, dominion, authority (over); right or ability to control; legal authority or authorization; political

ascendancy; a person or body invested with authority; a State having influence on other States.

The Microsoft Word Dictionary (Office 97 Professional) defines power as follows: the skill, physical ability, opportunity or authority to do something; strength or energy; force or effectiveness; an individual faculty or skill; capacity for producing an effect; the moving force of anything; control or influence exercised over others; right to command, authority; political control; rule; governing office; permission to act; a paper giving authority to act; potentiality; a person or group wielding authority or strong influence; that in which such authority or influence resides; a state influential in international affairs; (a state having) military strength of a specified kind;[1]

Lewicki and Litterer (1985:239) state: "Power is a word that has multiple, often overlapping, or even contradictory meanings. It is often used interchangeably with leadership, influence, and even negotiation ... In a broad sense, people have power when they have 'the ability to bring about outcomes they desire', or, 'the ability to get things done the way one wants them to be done'. One way of defining power builds on the observation that with power, one party can get another to do what the latter normally would not do."

Power can be defined as the ability – whether real or perceived, and whether used or not – to cause other people to perform actions or refrain from performing actions which they would otherwise not have performed or refrained from performing. It therefore entails the element of control. Concomitantly, there must be a threat, whether real or perceived, whether carried out or not, of some sanction for failure to comply with the direction of the person holding the power.

Johnson (1981) defines power as "control or influence over the actions of others to promote one's goals without their consent, against their 'will', or without their knowledge or understanding (for example, by the control of the physical, psychological, or sociocultural environment within which others must act). The mechanisms involved may range from naked force, through manipulation of symbols, information, and other environmental conditions, to the dispensing of conditional rewards".

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[1]

However, as will be seen below, this definition of power is more a description of the use of power. Power may also be seen as an emergent phenomenon which develops within relationships. This approach will be discussed below under "power relationships".

Since time immemorial, people have wished to control their environment. In historically early cultures, where the direct ability to control the environment was at best only minimally present, people attempted to manipulate "the gods" and so exert influence indirectly. With the development of science, the ability to control certain features of the environment has developed exponentially. People have capitalised on this knowledge (or perceived knowledge) to manipulate other people – often for personal gain.

It is this exploitation (of others, power) for personal gain that constitutes the type of power to be considered in this section

My own view is that "power" can be seen to be a "desirable good". It enables the user (holder) to gain some benefit, either immediately or in the future. Power is not an end in itself, but rather the means to an end. Perhaps an interesting analogy of power is the place of gold in many economies. Gold itself appears not to have (much) intrinsic value, yet throughout the ages people have been willing to pay for it. Gold therefore acts as a repository of value or wealth. Its value in the future could increase or decrease, but its possession today confers at least some economic potential.

Power works in a similar way. While power *per se* appears to have no intrinsic value, the exercise of power can indeed confer various goods or value on the one who can exercise or manipulate it.

Power may, however, only possess a transient value, and in many circumstances can instantly lose all of its value. A recent example is that of the democratically elected government in Pakistan. Ostensibly the premier had the power to control the country. However, after firing the top military officer, a coup deprived him of all his power within hours.

Power is an abstract concept. In itself, it cannot be seen, only in its operation. Power may therefore be seen as a "virtual" reality.

Putting these concepts together, we can therefore define power as a virtual, perishable, intermediate good, which can confer on its possessor some present or future benefit, or

some *perceived* present or future benefit. The perception of possession of power can reside in the holder or in others.

Sources and types of power

Lewicki (1985:242) sets out the "sources of power" as follows:

Informational power

This type of power is based on an imbalance in the knowledge of the various parties. It is based on the persuasive and influential nature of the information itself, or on the acquisition of information which, when presented, will alter the position of a second party. The way in which such information is presented may alter the power relationship. Information can be deliberately presented in a manner which is "scientific", containing jargon, in order to make understanding of the information difficult. Statistical methods which are unfamiliar to the other party can be quoted. Informational power is the basis of "coming to an agreement" in most situations. Person A wishes to go to the sea for a holiday, while B wishes to stay in town. Each party will try to bring information about the relative health of the beach, or the poor security in town, and so on, trying to get the other party to alter his/her position. Not all information exchanged in such circumstances is necessarily factually correct or true.

Johnson (1981: 560) makes the point that legalised institutional power involves an imbalance of knowledge, while legitimised institutional authority requires maximal sharing of information to assist in the attainment of common goals. Having made the distinction between power and authority, we can see that within an organisation some could see power structures as "legalised", while others see them as both legalised and legitimised. Johnson quotes Buckley: "Historically, most societies have been heavily skewed in favour of the power pole, and most of history – especially modern history – can be seen as a struggle toward the authority pole, that is, toward the institutionalization of a process of informed, consensual self-determination of the whole, which we call democracy". The distinction between power and authority, in relation to the State, is discussed in the paragraph on "legitimate power" below.

Reward power

The basis of this power is the ability of one party to induce the other to exchange one form of perceived "good" (either "doing" or "not doing" something) for another (a benefit perceived to be of some value). Rewards may be tangible (money or position) or intangible (approval, encouragement or praise). Rewards are used when it is assumed that the potential recipient would not comply if the rewards were not present. They are therefore used to bolster a weaker bargaining position. Presumably the recipient would have to factor in some "negative goods" in the event of non-compliance. This form of power is often used in conjunction with coercive power.

Johnson (1981: 367) discusses the phenomenon of reward power in his paragraph entitled "Emergence of Power Structures from Imbalanced Exchanges":

> Eventually and inevitably, the beneficiary of one-sided generosity must assume a position of subordination, at least, if he or she wants to continue the relationship. To assume a position of subordination is to acknowledge one's indebtedness and dependence on the generosity of the other party; it is to recognise one's own inferiority or lesser attractiveness as an exchange partner in comparison with the greater attractiveness of one's benefactor. A status difference emerges as a result of inequality in exchange transactions, with the higher status (or esteem) being earned by those who excel in the unreciprocated benefits they provide to their exchange partners.

Coercive power

This may be defined as the ability directly to control the actions of another. Coercive power is the opposite of reward power. It is the ability of the power-holder to take something away from the target person or to punish the target for noncompliance with a request. In the use of this type of power, one party is dependent on the other in some way. The power-holder controls some form of resource or resources which can be denied or taken away from the other party. Coercive power may be used to express anger or to gain retribution. Often this form of power is used when one party occupies a particular role within an organisation. Normally a job of this nature is carefully specified, and the rules which ought to be applied and the conditions under which they apply are defined. However, it is not unusual for this type of power to be abused for personal gain.

Legitimate power

There are times when people respond to directions from another, even directions they do not like, because they feel it is proper (obligatory) for them to obey, even though they do not like what they are being directed to do. This type of power is legitimate power.

Legitimate power is derived from a number of sources. In most societies, for example, elderly people are obeyed by younger people. The position a person occupies in society (for example, the clergy) or in an organisation (the manager) causes people generally to listen and often to obey them; so a chairman will call a meeting to order. This type of legitimate power may be specific to relationships within a given group or organisation (Pincus 1983: 251). At times, people who hold legitimate power also hold reward and coercive power.

Lewicki and Litterer (page 247) capture the importance of legitimate power: "It can be shown quite convincingly that legitimate power is at the foundation of most of our social structures. Many individuals and groups seek to organize themselves into any form of a social system – based on a family, a combat unit, a union, a workgroup, a sports team, a school, etc. A 'leader' will be elected or appointed; informal rules will evolve on how decisions will be made, work divided, responsibilities allocated and conflict managed. Without this social ordering, chaos would prevail" (Lewicki and Litterer: 247).

"The need for social ordering and social structure, then, creates the basis for legitimate power. People are willing to invest rights, responsibilities and power in an office, title, or role. By their very acceptance of the same social system that gives the power-holder his power base, they are *obligated* to obey his directives and follow his influence" (Lewicki and Litterer: 248).

Legitimate power can be acquired by birth, by election, by appointments, by promotions, by rank, and so on, and are usually backed by coercive powers.

Johnson (1981) differentiates power from authority. He states that institutionalised power can be legitimised, but institutional authority alone has to be legitimised. "Authority" is seen as the control of the behaviour of others for the promotion of collective goals, based on some form of knowledge or consent which can be ascertained.

When considering the notion of power from a South African perspective, the question of the "illegitimacy" of "legitimate power" needs to be examined. The issue was considered by van Niekerk in his contribution to the publication entitled *Staatsgesag en Burgerlike Ongehoorsaamheid* (1987: 7), in which he considers the place of civil disobedience in the situation where the State has lost its legitimacy and is obliged to enforce policy through the use of coercive powers. This is an anomalous situation where the legitimacy (moral high ground) supports an action which, in terms of the statutes and laws of the land, is illegal. Two factors differentiate criminal actions from civil disobedience. Firstly, the criminal performs the action for his own benefit and hopes not to be discovered. In the case of civil disobedience, the action is taken in order to expose an abhorrent policy (from a moral perspective) and to demonstrate the degree of commitment in opposing it. In this case, the attention of the public and the authorities is frequently deliberately drawn to the action. Secondly, the action is generally for the benefit of a group, or the defence of a principle, rather than for the benefit of an individual. Van Niekerk points out that protest action in these circumstances is not the same as revolutionary action. There is not a protest against *all* laws, only *specific* laws. Thus there is a controlled use of coercive power on the part of the protester in an attempt to rectify moral wrongs within the legitimate power structure of the State.

Furthermore, there is a differentiation made by van Niekerk (*op cit,* page 11) between "power" and "authority" with respect to the State. Power is defined as being coercive in nature, while authority is defined as the ability to obtain certain goals *without* the use of coercion. The authority of the State originates from a societal contract in which an administration is established to facilitate the attainment of communal goals. Thus, laws passed by the State should be those agreed to by the citizens. The State should foster and protect the rights and freedoms of autonomous subjects. In situations where the protection of rights requires the use of force (coercion), the use of force is justified. Not only is it justified, it is used to support communal rights and freedoms.

The word "authoritarian" carries quite the opposite meaning: the setting of authority above freedom; relating to, governed by, or stressing the importance and power of authority, or of a small group representing it; domineering, disciplinarian.[2] The authoritarian state places the exercise of power (usually justified in the name of the pursuit of "law and order") above the importance of the freedoms of its subjects. In this

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2 © Larousse.

context, van Niekerk justifies civil disobedience as a "right" in the face of an authoritarian state.

At the time van Niekerk wrote this article, South Africa was in the grip of one of the world's fiercest authoritarian states. The publication of an article of this nature would have been considered subversive or even viewed as treason. I wish to acknowledge those who stood their ground during the dark days of our history.

Expert power

Expert power is a special form of Informational power. Informational power can be used by anyone who has studied and prepared his/her position. Expert power is accorded to those who are seen as having mastered and organised a great wealth of information in a particular field.

There are a number of ways of establishing oneself as an expert. For example:

- Show credentials;
- Hold a university degree;
- Be registered with a particular body;
- Possess a particular license;
- Hold a particular position; and
- Have published an article/book on the topic.

Many professional people display university degrees or certificates on their walls and use letters to follow their names on calling cards and letterheads. Others may use titles such as professor, Doctor, inspector, and so on.

Referent power

Referent power is derived from the personal qualities of the power-holder and the personal relationship created with the other party. It is based on such qualities as admiration, perceived similarity, a desire to be close to someone who is recognised by others as being an important person in some or other sphere, or on the basis of some similarity such as having attended the same college or church, or having been employed in the same organisation. Strong psychological relationships are developed between individuals who have similarly strong political, religious or other beliefs or who participate in common hobbies, jobs or other activities.

An example of an individual with a great deal of referent power is Nelson Mandela. But film stars, fashion models, beauty queens and prominent sportsmen and women also tend to be able to command others through the phenomenon of referent power.

Lewicki and Litterer point out that referent power can be created through the establishment of a relationship with a target person. Similarities of experience or interest are explored. "All of these ... create the basis for gaining a deeper knowledge of the other, increasing the self-disclosure for one's own personal feelings and thoughts, and enhancing the trust between the parties. This process may be greatly speeded up when the relationship develops under conditions of stress or external threat" (Lewicki and Litterer: 252).

Economic power

Morriss (1987:90) discusses the concept of economic power in which power comparisons can be measured by opportunity costs. For example, if two people enter a shop where all items are the same value, the shopper with the least money will foreclose the opportunity to purchase additional items before the wealthier person. "It is always the case that if the raw costs of an action to two people are the same, the opportunity cost is greater to the poorer of the two". Thus, material wealth confers power.

Indirect power

Lewicki points out that all forms of power can be used either directly or indirectly. When it is used indirectly, the power is used to influence an intermediary who, in turn, will influence the target. For example, referent power is used indirectly when a celebrity is used by a supplier to market a product to a particular target group.

Associative power

This is the reverse of indirect power. For example, the individual who associates with the wise, famous or powerful may be attributed some additional power or status based on the perception of the importance of the person concerned (it's not what you know, its who you know).

The hanging of pictures of power-holders in the office is an example of how this form of power can be exercised non-verbally.

Group power

Typically, the power of various labour unions derives from group power. The combined action of a large number of people can form a significant opposition force where individual action would have been insignificant. Conformity to current fashions, acceptance of religious or political ideals or ideas, and so on, can often be ascribed to the pressure applied by the group on the individual.

Resource power

Morriss (1987) describes "resources" as a source of power. An "individual who can offer a service another requires has, in this service, a resource. (A)n individual who can offer another a disservice he would rather be without also has a resource" (page 140). Such resources could include the giving or withholding of affection, sexual availability, physical strength, emotionality, money, firearms, friends, reputation, wisdom, and so on.

Gender power

There is considerable concern in many societies today that men are allocated a position of authority and superiority over women. Often jobs that are uninteresting or carry some risks are "left to women" to perform (for example, radiography).

> Some profound historic reasons have made sex discrimination more virulent in medicine than in any other professional field. As far back as Hippocrates' day, during the fifth and fourth centuries B.C., doctors believed that the female reproductive system was a source of hysteria and even insanity. For more than two thousand years, if a woman stepped out of the expected pattern of subservience and humility, her ovaries and uterus were blamed. The term 'hysterectomy', in fact, derives from the Greek word for hysteria (hysterikos), which means 'suffering in the uterus'. Thus, to remove the uterus was to relieve the patient of hysteria" (Mendelsohn, 1982: 30).

In discussing systems of domination, Wink (1992: 40) records that as far back as 2300 BC in Mesopotamia: "No matter how high in the patriarchal social order a woman might now rise, she was always controlled by men sexually and reproductively". Domination is a contaminant of human society that, once present, precludes the future choice of gender equality in society. The problem, says Wink, is a structural one: "Males *must* dominate women (even if some do so rather gently) if they wish to preserve male ownership of property, the family name, and political control" (*op cit,* page 41).

Wink (*op cit,* page 102) explicates the system of domination: "Systematic injustice is to a high degree invisible to its perpetrators. The man who uses sexist language is generally unaware of the pain of exclusion experienced by conscientized women. A person may be remarkably free of racial prejudice, having as friends people of disadvantaged races, and yet still support structures that perpetuate the systematic control of one racial group by another."

Principle-centred power

"Real leadership power comes from an honorable character and from the exercise of certain power tools and principles" (Covey 1991: 101). Covey looks at the reasons why followers follow, rather than at the individual they are following. His proposition is that there are three reasons involved:

- Coercive power – where the individual is afraid of the consequences of not behaving in a particular way. This type of power has been dealt with above.
- Utility power – where followers follow because of some benefit or good if they do. Power in the relationship is based on the useful exchange of goods and services. "The followers have something the leader wants (time, money, energy, personal resources, interest, talent, support, and so on) and the leader has something they want (information, money, promotions, inclusion, camaraderie, security, opportunity and the like)" (Covey, 1991: 102). Covey states that most organisations are based on utility power. As long as followers feel that they are receiving a fair compensation for their input, they are happy to continue the relationship. Relationships built on utility power tend to favour individualism against the interests of the group. "Each individual is reinforced for paying attention to his own perspectives and desires ... In addition, a form of situational ethics is fostered, in which individuals are continually deciding, in the absence of shared organizational values, what is best and right and fair... At best, utility power reflects a willingness to stay in the relationship, whether business or personal, as long as it has a payoff for both parties" (Covey, 1991: 103).
- Legitimate power is based on trust, common causes, respect and honour. Followers follow because they "want to". "This is not blind faith, mindless obedience, or robotic servitude; this is knowledgeable, wholehearted, uninhibited commitment. This is legitimate power" (Covey, 1991: 102). This type of power is rare. It is founded on a relationship which values quality, distinction, and excellence in all relationships. It is a sustained, proactive influence because it is not dependent on what happens to

individuals in the process, but rather relies on common commitment to the attainment of clearly defined organisational goals. Decisions are taken by individuals not on the basis of what suits them individually, but based constantly on the attainment of the common vision.

While power is visible in relationships of legitimate power, it is not imposed or external. It is sustained as long as the relationship of trust remains.

With legitimate power, ethical behaviour is encouraged. Legitimate power encourages people to risk doing the right things because they are valued and are supported by the leader, and they are reflected in his behaviour. "Sincerity cannot be faked for long. Eventually, leaders reveal themselves. And what a leader is, beyond what the leader can do to or for followers, ultimately determines the depth of legitimate power he has" (Covey 1991: 105).

Covey suggests ten processes or principles that will increase power: persuasion, patience, gentleness, teachableness, acceptance, kindness, openness, compassionate confrontation, consistency and integrity.

Leaders who activate the principle of legitimate power through the leadership choice (that is, the choice of legitimate power rather than coercion or utility), may find they are more careful of what they ask of others but have more confidence in doing so. As their understanding of the relationship between power and leadership increases, their ability to lead others, and to have influence with others without forcing them, will grow. And they may experience an unusual peace of mind that comes with being a wiser, more effective leader (Covey, 1991:108).

Covey introduces an interesting concept, that of the limitation of power. He quotes Alexander Solzhenitsyn: "You only have power over people as long as you don't take everything away from them. But when you've robbed a man of everything, he's no longer in your power – he's free again". Thus power can be exercised only if the subject "has something to lose" by resisting. Where there is "nothing to lose", power loses its power. Morriss (1987) points out that when a tyrant goes into exile, he goes with all his abilities intact – but without power. The power he was utilising was the administrative machinery (legitimate power) previously set in place to ensure law and order and the realisation of collective goals.

Power relationships

Michel Foucault spent a great deal of his work concentrating on the operation of power and the way in which humans beings become subjects. He states: "the goal of my work during the last twenty years... has not been to analyze the phenomena of power, nor to elaborate on the foundations of such an analysis. My objective, instead, has been to create a history of the different modes by which, in our culture, human beings are made subjects" (Foucault, 1982). Foucault did not see the necessity for a "theory of power", but he felt that the phenomenon of power operated in society in a way intimately connected with the way in which society had arrived at its present form. In other words, the historical setting was critical to the analysis of power. Power is seen by Foucault in terms of *relations* built consistently into the flows and practices of everyday life (McHoul, 1993). It is always a discursive relation rather than something which a person or group wields or bears. "Power is everywhere; not because it embraces everything but because it comes from everywhere" (Foucault, 1979).

Stalinism and fascism were abuses of power – but the interesting thing for Foucault is that they were not new ideas. In fact, they owed their success to the "rationality" of our political structures.

Foucault felt that the best way to investigate power would be to look at areas where resistance to power existed, an "antagonism of strategies". Such areas would highlight where power was and how it operated. Some of these areas for analysis were the power of:

- men over women;
- parents over children;
- psychiatry (as a discipline) over the mentally ill;
- medicine (as a profession) over the population; and
- administration over the ways in which people live.

Foucault saw these struggles as "transversal", in that they are not confined to one country or one political or economic system. The aim of an investigation of this nature would be the "power effects as such". He states that "the medical profession is not criticized because it is a profit-making concern, but because it exercises uncontrolled power over people's bodies, their health, their life and death". These struggles, according to Foucault, are "immediate" in both the sense of proximity and time. They are struggles

against people closest to the subject, and the resolution of the struggle cannot wait for a later date or for some later philosophical revelation. In this sense, then, these struggles are anarchistic.

More importantly, Foucault sees these struggles as bringing into focus the "status of the individual". There are inherent conflicts in the situation. On the one hand, the right of an individual to be different is highlighted while, on the other, everything which separates individuals from each other or their communities is attacked. These are struggles against the "government of individualization " .

These struggles are also seen as an opposition to the effects of power, which are linked to knowledge, competence and qualification (that is, a meritocratic society) and also against secrecy and the use of science to impose responses in people.

Finally, Foucault sees these struggles as a search for an answer to the question "who am I?" In responding to this question, there is a rejection of economic and political systems which ignore who we are individually, and also a refusal to accept a purely scientific answer as to whom one is. "To sum up, the main objective of these struggles is to attack not so much 'such or such' an institution of power, or group, or elite, or class but rather a technique, a form of power".

Foucault sees three types of struggle:

- against some form of domination (ethnic, social or religious);
- against some form of exploitation (separation of individuals from what they produce); and
- against some form of subjugation (either to himself or to any form of subjection).

These struggles do not usually occur in isolation but, generally, one or other form is dominant. To Foucault, all three are currently still present, but the dominant form is that against subjugation.

The evolution of the modern state has, since the 16th Century, developed a continuously more intrusive character as far as the individual is concerned. "Never, I think, in the history of human societies – even in the old Chinese society – has there been such a tricky combination in the same political structures of individualization techniques and of totalization procedures". Foucault sees this development as a progression based on an

older power technique developed in Christian institutions – the technique of "pastoral power". It was based on the following:

- power to assure individuals of salvation in the next world;
- power is coupled to a "sacrificial stewardship" entirely different from the previous notions of royal power; and
- a concern equally for the whole community as for each individual throughout his life.

This form of power "cannot be exercised without knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and the ability to direct it". In this it is linked to "truth", that is, the truth about the individual him-/herself.

Foucault sees the modern state as an institution which has further developed a "modern matrix of individualization or a new form of pastoral power". In this new form of pastoral power, salvation is replaced by more visible forms of benefit such as health, economic wellbeing and security. Thus the *objective* of power has changed to a more concrete reality. Secondly, the *number of officials* directing the power apparatus has increased. The family, medicine and hospitals have been drawn into the development of this new society. Thirdly, the aims of power have been both globalising and individualising. So this form of power was subtly taken over from a confined religious institution into society as a whole. A series of individualising powers developed. These included the family, medicine, psychiatry, education and employers.

The exercise of power, Foucault suggests, leads to an examination of how this occurs rather than the investigating of what power is. Foucault suggests that power *per se* does not exist. Power is exerted over things, and gives the ability to modify, use, consume or destroy them – a power which originates in the individual or is conveyed by some external means. Power brings into focus the relationship between individuals (or between groups). In an educational institution, the disposal of its space, the meticulous regulations which govern its internal life, the different activities which are organised there, the diverse persons who live there or meet one another, each with his own function, his well-defined character – all these constitute a block of capacity-communication-power, as do the allocation of "marks" which value each individual and a whole series of power processes such as surveillance (for example, registers), rewards and punishments, and a pyramidal hierarchy.

The exercise of power is not simply a relationship between partners, individual or collective; it is a way in which certain actions modify others.

Power exists only when it is put into action.

In effect, Foucault (1982:790) defines a *relationship of power* as a *mode of action* which does not act directly and immediately. *Instead, it acts upon their actions: an action upon an action, on existing actions or on those actions which may arise in the present of the future. A relationship of violence acts upon a body or upon things; it forces, it bends, it breaks on the wheel, it destroys, or it closes the door on all possibilities. Its opposite pole can only be passivity, and if it comes up against any resistance, it has no other option but to try to minimize it. On the other hand, a power relationship can only be articulated on the basis of two elements which are each indispensable if it is really to be a power relationship: that "the other" (the one over whom power is exercised) be thoroughly recognized and maintained to the very end as a person who acts; and that, faced with a relationship of power, a whole field of responses, reaction, results and possible inventions may open up.*

Obviously the bringing into play of power relations does not exclude the use of violence any more than it does the obtaining of consent; no doubt the exercise of power can never do without one or the other, often both at the same time. But even though consensus and violence are the instruments or the results, they do not constitute the principle or the basic nature of power.

Freedom and power cannot operate simultaneously. There must initially be freedom for power to operate (slavery is not regarded by Foucault as a power relationship, rather a situation of constraint). However, once power operates, freedom is repressed.

To analyse power relations, the following must be considered:

- The system of differentiations – the system which allows one to act on the actions of others and its historical development: status and privilege, economic differences, linguistic and cultural differences and knowledge differences;
- The types of objectives pursued by those who act upon the actions of others (for example, maintenance of privilege, accumulation of profits, the exercise of a function or trade);

- The means of bringing power relations into being: according to whether power is exercised by the threat of arms, by the effects of the word, by means of economic disparities, by other complex means of control, by surveillance, by rules, and so on;
- Forms of institutionalisation such as legal structures, structures relating to customs or fashions (for example, family, educational or military institutions, and so on), the state, regulations and the whole social apparatus within which power relations are distributed; and
- The degrees of rationalization: the effectiveness of instruments of power and the possibility of predictable outcomes and costs.

Ultimately there exist two forces in power relations: one, an individual drive for freedom, and the other, the force of coercion for the sake of an individual or group. When the coercion is profound and institutionalised, the power relation is one of domination. However, presently, these two forces are in constant tension, and either could emerge the stronger at any time.

The most notable feature of the coercive power of the State is the extent to which it has penetrated all aspects of the life of the individual. It has two components, one individualising and the other globalising.

"*Foucault recommends an ascending rather than descending analysis of power. Hegemonic or global forms of power rely, in the first instance on those 'infinitesimal' practices, composed of their own particular techniques and tactics, which exist in those institutions on the fringes or at the micro-level of society (within the family, the classroom, and so on). What Foucault places at issue is how these mechanisms of power have been 'invested, colonized, utilized, involuted, transformed, displaced, extended by more general forms, leading to those types of social domination we can all readily identify*" (McHoul, 1993:90).

Foucault's approach to power is echoed in an analysis by Douwes Dekker (1990: 249) of the workplace, where power is considered in relation to the process of negotiation: *The parties recognize each other and democratic processes are instituted to give workers, as a collectivity, a say in the decision-making process affecting the sale and utilization of their labour. Commentators express concern that such structures and processes can result in compliance, because the authoritarian structure of the workplace is maintained. However, this depends on the degree to which the decision-making process of*

management is influenced, thus emphasizing the importance of the nature of workers' participation established by, and operating in, a society.

The above considerations, held by labour and capital respectively, have led to further understanding about the nature of power. This analysis suggests that as a result of the actual experience in decision-making through processes activated by procedures agreed to by the parties, power can also become, in part, the property of the relationship. This perspective of power as the property of the relationship challenges the parties to design structures and processes which reinforce their continued independence.

This highlights the dual nature of power relationships expounded by Foucault, namely, the totalising effects and the individualising effects. In the above description of the negotiating process, there is a tension between the recognition of group (individual) rights, and those of a wider societal nature. Note that power operates within the relationship as an emergent property which expresses itself in the establishment of new administrative regulations and definitions of relationships.

Foucault tends to be rather deterministic in his analysis of practices. He does not comment on the rightness and wrongness of actions, as they must be evaluated within their own discourses. As Farrell (1994: 272)[3] puts it: *No room is left for an account of self-development that can provide a criterion for evaluating various kinds of intrusion into, and coercion of, individual lives. As everything is swept up into the all-encompassing power of self-relating discursive practices, there can be no more sense in questioning the rightness of those practices than in questioning the rightness of God's interventions in the world. The ways they form selves and objects must be arbitrary enactments concerning which, reason can say nothing at all, since it comes to life only as an artifact of those enactments. And any resistance to those regimes can only be what they themselves have generated as resistance. One must settle for describing the various ways that power is applied.*

The power experience

McClelland (1975: 3) looks at the ways in which power is experienced: "Man has always been fascinated by power. He has reason to be for, as scholars are fond of reminding him, he belongs to a violent species. Look at his history: a long succession of wars with interludes of peace in localized times and places".

McClelland uses Winter's scoring system as the basis for his propositions. He derives a quantifiable *n* Power which stands for the "need for power", and uses this to correlate with various behaviours such as "power reading" (reading of sporty magazines, for example, Playboy and Sports Illustrated), "prestige possessions" (ownership of items like a firearm or a sports car), "competitive sports" (number of non-contact sports played), and "organizational membership" (the number of different organizations in which membership is listed).

The classification of power used by McClelland depends on whether the source of power is outside or inside the self, and whether the object of power is the self or someone or something outside the self.

I External source Internal object	II Internal source Internal objective
III Internal External object	IV External source External objective

A classification of power orientations summarised from McClelland

In this type of analysis, power reading is seen as a Quadrant I activity, since the source of power comes from the racy magazine. Its objective is to strengthen the self. The accumulation of prestige possessions where the individual acts to strengthen the self is characteristic of Quadrant II behaviour. Competitive sports are included in Quadrant III, where the individual acts to overcome others. Organisational memberships belong in Quadrant IV since the individual sees the organization as a "higher power", but this power then acts through the individual to influence others. McClelland links these quadrants to the stages of development described by Freud, Erikson and others (namely, Oral, Anal, Phallic and Genital Mutuality).

Another type of behaviour that belongs in Quadrant III is that of a helping behaviour that does not seem power-related at all. However, it is noted that where help is given, help

[3] This assumes a strong reading of Foucault which Farrell believes is Foucault's actual position, even if intermittently – see page 274.

has also to be received. The act of receiving help is an admission of weakness, thus reinforcing the dominance of the giver. McClelland suggests that giving and receiving should have a "zero sum". To the extent that the one person wins or gives, the other must lose or receive. "Most cultures try to minimize the power relationship implicit in giving by arranging for a mutual exchange of gifts, so that neither party need feel dominated, but this very fact underlines the power aspect of giving relationships" (McClelland 1975: 18). Interestingly, McClelland suggests that men with a high *n* Power are attracted to teaching. Teaching is generally considered to be a helping profession, but the helping is done through a relationship of dominance which satisfies the *n* Power. It is supposed that normal human development requires a learning of responses from each quadrant successively until Quadrant IV has also been mastered. Maturity is reached when the individual can select the most appropriate response for the situation at hand.

Notably, each quadrant has its own "pathology":

Quadrant I:	Hysteria or drug taking;
Quadrant II:	Obsessive compulsive neurosis;
Quadrant III:	Messianism; and
Quadrant IV:	Crime and, perhaps most worrying, holy wars.

McClelland was interested in how individuals determine which quadrant to select. He reviews Stewart's approach to assigning behaviours to quadrants, and noted that she used physical criteria (for example, specific actions or activities) rather than psychological or social ones. This system showed an attitude towards authority that was peculiar to each group.

I	II
Authority: benevolent	Authority: critical
III	**IV**
Authority: to be opposed	Authority is institutionalized

Attitudes to power in the various quadrants from McClelland

Stewart showed that college students responded in Quadrant III (that is, authority has to be opposed), while married men reacted in Quadrant IV. It was determined that men and

women could be classified in the same way. Research showed a strong correlation between Quadrant II and Quadrant III responses and a high *n* Power. Also, not unexpectedly, the mean *n* Power for males was higher than for females.

It was further found that people with a high *n* Power gambled, and did not necessarily drink excessively or smoke, activities which also were associated with a high *n* Power. This was interpreted as an indication that these are different options to express *n* Power rather than groups of related behaviours. Thus, if a person has only developed as far as Quadrant I, his power drive may find one outlet, whereas if he has progressed to Quadrant II, it would find another.

Having set out his theoretical basis, McClelland (1975:22) states: "Our problem, then, is to try to understand two faces of power. When is power bad and when is it good? Why is it often perceived as dangerous? Which aspects of power are viewed favourably, and which unfavourably? When is it proper, and when improper, to exercise influence? And finally, are there different kinds of power motivation.

McClelland described two types of power motivation: *s* Power (a sense of power in a socialised setting) which tended to be more altruistic, and *p* Power (personal power) which was associated with a win-lose outlook. Charismatic leaders, according to McClelland, are not people who make others voluntarily submissive, but rather the opposite. They make their followers feel more powerful (*p* Power). Thus the successful leader is one who turns his followers into leaders. Interestingly, both *p* Power and *s* Power are classified as forms of Quadrant III behaviour.

When looking at "Empire Builders", McClelland adds the concept of *n* Achievement which motivates people to take on large projects "for the good of society".

Finally, McClelland includes the *n* Affiliation as an important factor. This represents the need for friendship, love and acceptance. McClelland points out that few people with both high *n* Power *and* high *n* Affiliation get into top management positions.

An analysis of power

Power as a dispositional concept

Morriss (1987) contrasts power and influence in order to show their differences rather than their similarities. Power is derived from the Latin word *potere,* which means "to be

able". Influence derives from the Latin *influere* which means "to flow in", "and referred to an astrological belief that a substance emanated from the stars and flowed into people in the sublunary world, changing their behaviour or at least affecting them in some way. Hence, 'under the influence', and also 'influenza'." These words have changed their meanings and, while they retain some overlap, are not synonymous. Influence has connotations of imperceptibility, while power, especially legitimate power, is overt. Power is any ability to produce effects, whatever the mechanism. It is an ability, capacity or dispositional property.

An example of a dispositional property is that of the "solubility" of sugar. This describes an enduring quality of sugar, whereas to state that the sugar is "dissolving" describes a current event, an episodic concept, and not an enduring quality. Morriss points out that dispositional qualities can be determined by observation, as in the case of sugar lumps. However, we do not have to observe an event before noting a dispositional quality. The observation of a lion should give us enough information to determine a dispositional quality of being able to devour a person, without our having first to observe the event. But dispositions can go even beyond the senses. So, while actualities can be observed, dispositions cannot be observed. And dispositions never have to be converted into actualities. For example, a fragile cup remains a fragile cup, even though it never breaks. "So power, as a dispositional concept, is neither a thing (a resource or vehicle), nor an event (an exercise of power): it is a capacity". Nevertheless, dispositional concepts do not represent only potential events (for example, the sugar lump is soluble in water), but also actual events which are not presently occurring (χ is a smoker). Thus Morriss sees "influence" as a habitual disposition (for example, by stating that χ is a smoker), while power is a conditional disposition (TNT will explode when the conditions are right). But TNT retains its potential to explode even though it never does. Influence involves affecting, while power involves effecting.

The contexts of power

According to Morriss, power operates in several contexts. These can be reduced to three, namely,

- the practical,
- the moral, and
- the evaluative.

The practical context

People use power, practically, to achieve some defined objective. In order to be successful in this venture, people need to know what sorts of outcomes they can and cannot achieve. The individual needs to know what power he/she has in order to achieve these goals. But it is just as important to know what the powers are of others who may be involved in the process. Their powers could be harnessed to work in your favour, or they may work against you.

The moral context

Power is used to blame, excuse or allocate responsibility. Considering "failure to do something", one fails for two reasons: disinclination and inability. Blame can only be imputed to disinclination. An alibi is a valid excuse as it proves inability, that is, the individual did not possess the power to perform the act since he was not present and the action would have required him to be personally present to have performed it. However, if one has the power to prevent some catastrophic event but fails to intervene, then one can be held responsible for the consequences of the failure to intervene.

The relationship of power to responsibility is a negative one. We can deny responsibility by demonstrating lack of power or by showing that what power we have could not have prevented the unwanted event. If you did not have the power, you are blameless. Thus power is a necessary, but not sufficient, condition for responsibility. In this context, power is the ability to effect something.

The evaluative context

Morriss considers two broad areas: the extent to which citizens have power to effect their own ends, and the extent to which one person is subject to the power of another. It seems to Morriss that the process of mutual co-operation to bring about mutually desirable objectives also produces a society in which other people have increasingly more control over the individual.

This may be an important link with Foucault's analysis of power since this agrees with the development of the mechanism of control as described by Foucault.

Thus societies or individuals can be evaluated, and the evaluation can result in praise or blame.

Epistemic, non-epistemic and effective epistemic power

Morriss considers "influence" as a family of concepts. Individuals can initiate actions. These actions have consequences. If these consequences were unintended, the action is said to be non-epistemic. If the consequences were intended, then the action is epistemic. However, since individuals have choice, they may choose to perform an action in another way – which turns out to be unsuccessful. This does not mean the individual does not have the power to carry out the intended action, but simply failed to do so. If the correct methodology is used, the intended outcome will be achieved. In this case, the individual is demonstrating effective epistemic power.

Morriss proceeds to the comparison of powers. This chapter in his book ought to have been a valuable platform for this essay since I am specifically interested in power relations and the comparison of power between the physician and the patient in particular. Unfortunately, Morriss does not seem to get to the nub of the problem but rather becomes entangled in some logic which is clearly suspect. To cite some examples, he states:

- that in order to compare powers, one has to look at the possible combinations of actions which can be achieved by each party: "... everybody has an extremely large, perhaps infinite, number of compossible sets that they have the power to do... but this does not matter here: as long as anything I can do (including all combinations of things I can do), you can do, and you can do more, you have more power than me" (page 87). If this were the case, all people would have (near/almost) infinite power, and comparisons would be practically impossible;
- that it is "unlikely that one person's set of compossible outcomes is a subset of anyone else's: we want to be able to make comparisons when each of us has some power that 'the other lacks'. To do this we have to assess the worth of these different outcomes". Morriss states that "there is a little difficulty here", in that the "value" of an outcome is subjectively determined;
- "... clearly the power to bring about some disastrous end cannot be a valuable thing; it is only outcomes that are in some way worthwhile that need to be considered". This brushing away of negative outcomes surely limits his conception of power. The threat of the use of power often is based on the very possibility of bringing about some disastrous end; therefore Morriss should have included this possibility in his analysis;
- "Power, itself, is never constant-sum". In other words, Morriss does not believe that for one party to gain power, the other must lose power. However, it is my contention that the only relevant comparison of power is in specific situations in which power is constant-sum. In the example given by Morriss to justify this point, he takes the

situation of a beauty competition which is won by a particular individual. This, according to Morriss, does not imply that all others had less "power" to win the competition because many people who did not enter the contest may have had the ability to win. This example confirms rather than denies my contention that power is a constant-sum calculation because we consider power only in relation to a specific outcome within a particular relationship. If two nations are at war, the existence of a neutral nation of greater power than both is irrelevant to the situation. The war will be decided by the contestants in a constant-sum manner. If the one wins, the other loses.

Studying power

Morriss states that we cannot observe power directly. Thus there is no easy way of establishing how much power an individual or group may have. Furthermore, power cannot be studied in isolation. He suggests five approaches to gaining evidence about power:

- experiments;
- thought experiments;
- natural experiments: examining the relationship between preferences and outcomes;
- consulting experts; and
- resource based approaches.

There are, according to Morriss, three standard methods of studying power, that is, the decisional, reputational and positional methods, and these closely approximate (c), (d) and (e) above. But he suggests that in studying power, we need to ask three important questions (in each of three contexts)(Morriss 1987:146):

- Power to do *what?* Power refers to whatever outcomes the researcher happens to be interested in.
- *Whose* power do you wish to examine? Here, Morriss suggests, one should start by examining the obvious. What things beyond the control of the individual affect his/her life chances? What official statistics and records are there that may reflect what actually happens, rather than what could be possible? For example, if one is interested in the power of a worker in a chemical manufacturing facility in relation to his/her employer, a study of similar case histories could be valuable. The next step should be to gather important information from consulting experts. Thereafter, one

could conduct thought experiments, and, finally direct experiments could be performed or natural experiments examined. This is an *interest orientated approach* (in which the outcomes for each group or individual are considered, as well as the extent to which the group, or a member of the group, has power over the most important outcomes), rather than an *issue orientated approach* in which one studies how the subject (an individual or a group) has handled various selected issues.

- Are there other situations, for example, those in which people elsewhere have been able to achieve similar goals? An analysis of the available resources should be done. However, Morriss points out that we can reach conclusions about power in a society only by first having a deep understanding of that society. A similar approach would be required in the analysis of power of an individual or group.

While Morriss concurs that quantitative measurement of power is fraught with difficulty, he does put forward a quantified proposal, situated in a system of voting. He further quotes the work of Shapley and Shubik (1954) who presented an index of power based on three premises:

- symmetry;
- the various powers sum together to a constant;
- additivity.

This work is designed to determine who, in a group, is the pivotal actor. But the main interest for this essay is point (b) – that the powers sum together to form a constant. Other indices are described, namely the EPW index and the Penrose index, along with the situations in which they could be useful. Generally these indices are described for calculating how much power a particular representative would have in a committee or in parliament, given a formal voting system. These indices are not suited to a calculation of the very specific setting of the physician and the patient.

In his conclusion, Morriss states: "If we want to measure power for some other reason, then we may have to create another index". This is what I intend to do in the following Chapter.

Power in the physician-patient relationship

There is a widespread perception that the physician has too much power. Amongst my own friends and associates, when the topic of this essay was mentioned, there was an immediate and vociferous clamour to ensure that I understood that power should be removed from physicians as soon as possible. The depth of feeling revealed by these responses was astonishing, and suggested that an analysis of the physician-patient power relationship is urgently needed.

In dealing with patients, physicians must encounter a full range of people, ranging from the well-informed who want to take full control of their own health to the ill-informed who expect the physician to diagnose and treat their condition. In his (what can only be described as) vitriolic book about modern medicine, Mendelsohn states (regarding the physician), that "most patients" are "too intimidated by his manner and his credentials to question the treatment he recommends" (Mendelsohn, 1982: 20).

It is evident that, in Western societies, power is being wrested from physicians in a fairly dramatic manner, particularly through the development of managed health care programmes. This initiative is being rapidly expanded, and is altering the physician-patient relationship. The extent and manner of this effect has not, as far as I can see, been researched. It may have unintended adverse consequences as well as benefits for patients. This could be a fruitful area for further research.

In this Chapter I will consider the role of power in the physician-patient relationship based on the overviews provided in the previous chapters. Each type of power mentioned in Chapter 2 will be considered to determine whether or not this type of power is operative in the physician-patient relationship. If it is present, I will attempt to *quantify* the relative power of each party based on the following (original) methodology:

- I will use a *constant sum* approach (compare the *zero sum* approach, page 46 above);
- Where the power appears to be more or less equal, it will be shown as 50% to each party;

- Where one party seems to have more power than the other, a 75% to 25% weighting will be shown, unless it appears that one party has virtually no power at all in the situation, in which case the weighting will be shown as 5% to 95%.

Legitimate power

This form of power is based on "office" rather than any characteristic of the person holding the office. The "office" of the physician is very much intertwined with the perception of the "role" of the physician. Just as, in the military, a major is in a higher office than a captain, so the physician is seen as the leader of the health care team. And since, in society, the concept of "physician" is accorded status *per se*, this form of power is operative in the physician-patient relationship.

There are many different contexts in which medicine is practised. In private medical care, the basis of legitimate power is the status given to physicians by society in general, while in the public sector, physicians are, in addition, given ranks higher than most other members of the health care team. Physicians in both public and private sectors are authorized by Acts of Parliament to examine patients, diagnose diseases, perform certain procedures, prescribe medications and excuse a patient from work through the provision of a sick note. These legal considerations further increase the legitimate power of the physician. The physician may be called on to assess the capability of a patient to perform a particular job, drive a motor vehicle, participate in sport, and so on.

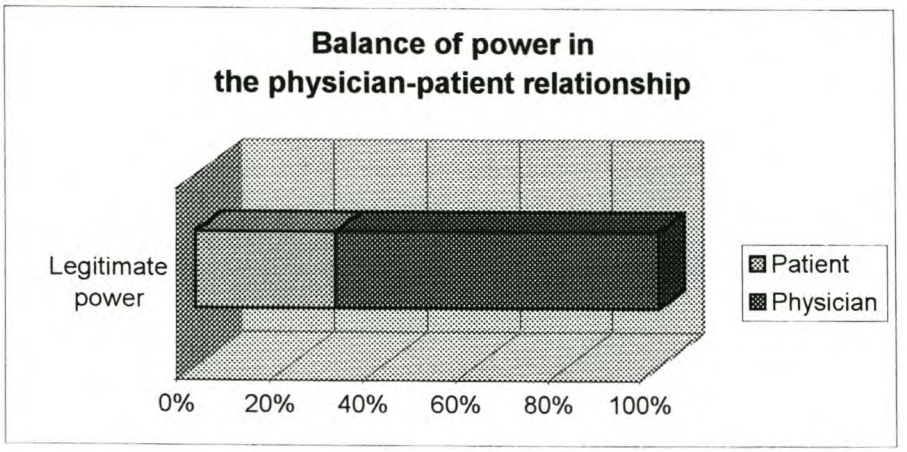
Thus, a physician has considerable legitimate power.

On the other hand, patients also have some legitimate power. There are broad legal frameworks, such as the Constitution and various codes of patients rights, which protect individual citizens. Patients can and do, from time to time, make use of these powers. However, under normal circumstances patients do not make use of these powers, so they do not confer any real powers on the patient within the normal relationship.

Thus the balance of legitimate power rests with the physician.

I will therefore show the physician as having 70% of the legitimate power and the patient 30%. To me, this result seems intuitively correct. Although this is an individual and subjective assessment, I propose to show that these assessments, when taken together,

build a substantial argument to quantitatively demonstrate the power disparity between patient and physician.



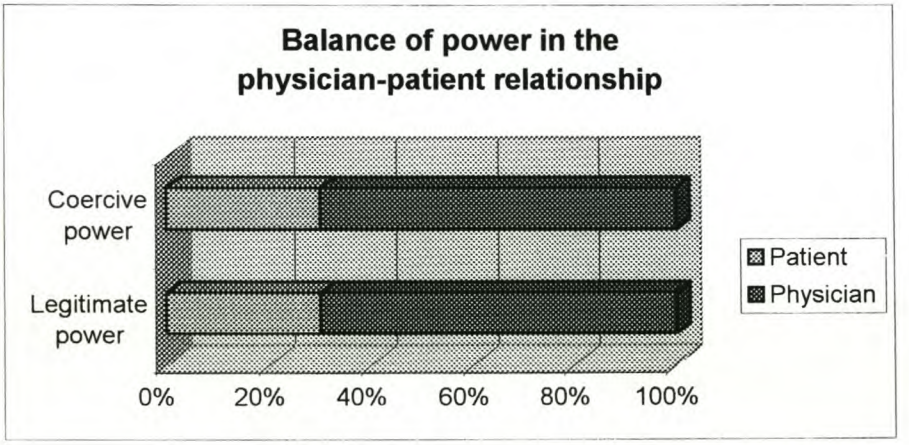
Coercive power

Does the physician have direct power over the behaviour of the patient? In certain circumstances this is undoubtedly the case. The physician can bring great pressure to bear on the patient, for example, in terms of lifestyle modification. The physician can *forbid* the use of cigarettes or alcohol, *insist* on a dietary modification, exercise or the meticulous compliance in taking the prescribed medication. The physician is in a position to force the patient to comply through the use of a number of possible threats. Perhaps the most common threat would be the instillation of fear in patients that some terrible misfortune would befall them unless they complied. Often, there is a threat of refusal by the physician to carry out some procedure until compliance has been confirmed ("I won't operate until you have lost 20kg"). There is also the possibility of a veiled threat that the physician may withdraw from the relationship if the patient does not comply.

The patient, on the other hand, could threaten the physician that he/she will not return to the practice unless the doctor complies with some request of the patient (for example, supply the patient with the demanded sick note, prescription medication, or the like). Generally, this is likely to be only a nominal protest as the average physician has more than enough patients. More substantial patient coercion may come in the form of a threat to lodge a complaint with the regulatory body (Medical Council/Health Council) or, more effectively, a public complaint in the press, should the physician not comply with the patient's demand. In the event that some aspect of the treatment has gone awry, the

patient may have a basis for manipulating (that is, essentially the same as blackmailing) the physician.

In personal discussions with a number of physicians, I became aware that most clinicians had experienced situations in which they felt the patient was "manipulating" them – or, in other words, was exhibiting more power than the physician. These situations arose more commonly where the physician was "employed" by the State or other health care provider, and where the physician did not have the right to refuse to treat a patient or terminate the relationship. In one case, the parent of a patient (a child) was highly irresponsible and manipulative, and the physician felt disempowered when dealing with the patient. The response of physicians in these situations is generally to fall back on to one or more of the many forms of power available to them in order to re-establish the more familiar power relationship. This situation of physician disempowerment, while widely experienced by individual physicians, is a relatively uncommon occurrence. The balance of power is thus largely on the side of the physician and is shown as such in the following chart:



Gender power

Historically, in European culture, the physician has almost always been male. Because of the child-bearing role, females will probably consult a physician more frequently than males. These, taken together with the general authoritarian and paternalistic male role in society, have resulted in the feminist view discussed above (see page 17).

In many societies in which infanticide was practised, it was generally the female children who were destroyed rather than males. Today there is a widespread practice, although not necessarily consciously performed, to ensure that male children receive the better

educational opportunities. While legislation has been introduced in many countries to try to enforce gender equity in employment practices, the necessity for the legislation underlines the preference given to males over females.

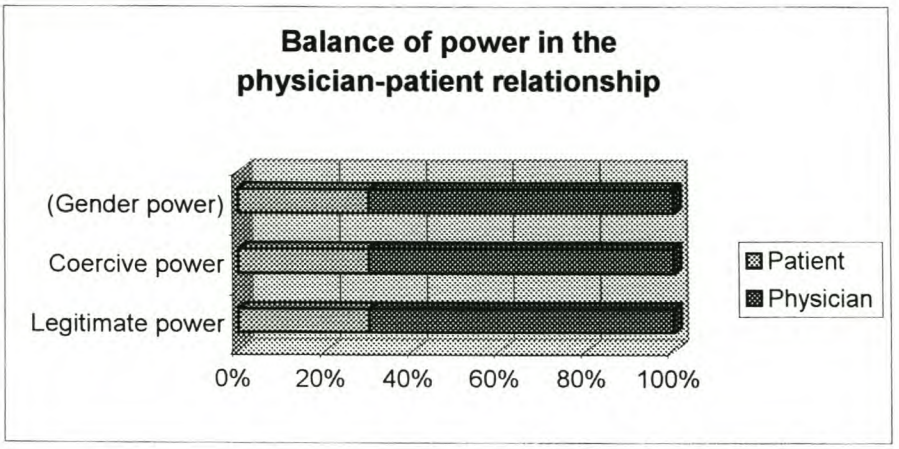
This preference is reflected in health care in many ways. For example, in 1975, women in the USA received only 13 percent of the medical degrees. By 1985 this figure had increased to 30 percent. It is currently estimated that only one-third of all medical students today are female.

Thus, social construction places men in a more favourable position than women in the allocation of resources and jobs. In marriage relationships, in most countries, the husband is regarded as the authority, and this is often enshrined in legislation.

These attitudes are translated into an acceptance by males that they are entitled to this favoured status, and the acceptance by women that they must accept this male domination, that is, gender power.

A significant proportion of physician-patient interactions involve same-gender interactions in which gender power is not present. Thus "gender power" will be shown on the chart in parenthesis. Only in the physician-patient relationships, where the physician is male and the patient female, does gender power operate. In this case it operates in favour of the male.

It is interesting, though, to consider the reverse situation where the physician is female and the patient male. How does gender power operate in this situation? Although I have not come across any specific research which investigates this situation, it would seem logical that, since the balance of power is in favour of the physician, gender power in this situation would serve to balance the power of the two parties and therefore operate in a beneficial way. Since this would account for only a relatively small proportion of physician-patient interactions, the more usual situation will be scored.



Informational power

This form of power originates from an imbalance in the knowledge of the various parties. It is particularly forceful if it is able to cause a change in the behaviour or lifestyle of the patient. It is operative in the physician-patient relationship for the following reasons:

(a) *Quantitative knowledge*

The training of a physician is one of the longest training courses of any of the professions. The reason for this is the large volume of knowledge that has to be mastered in order to be licensed to practise medicine. On the other hand, the amount of knowledge available to the patient is greater now than ever before. Many newspapers, magazines and other publications carry reports which relate to medical conditions. The internet is a source of vast amounts of very detailed information which is readily available to patients. It is true that, at present, not a large proportion of patients have access to, or use, the internet prior to consulting a physician, but even if they had done so, the context of the information is also important. In situations where patients do appear knowledgeable, and the physicians feels even somewhat threatened, just a few words of medical jargon will be sufficient to re-establish the acceptable power distance.

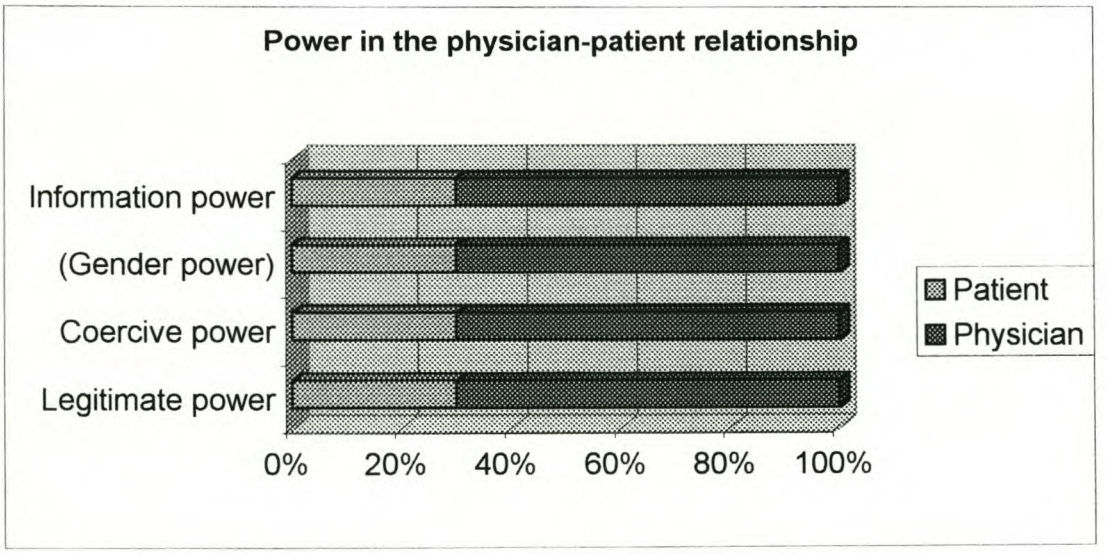
(b) *Contextual knowledge*

Special Interest Groups have developed to assist patients with specific conditions, such as diabetes or serious head injuries. Members of these groups acquire a considerable amount of information about the specific condition and, in some instances, their knowledge relating to their specific condition may be more complete and up-to-date than that of the physician. Even so, it is unlikely that the power would sway in favour of the patient for the reason mentioned above,

namely, the context of the information obtained from an examination of the patient and knowledge of the social setting in which the patient lives. Furthermore, in this situation, it is the clinical experience of the physician which will sway the power back to the physician.

(c) One would also have to consider the situation in which a physician him/herself is the patient. In this situation, it is unlikely that a physician-patient would consult a colleague who knows less than he or she does themselves. It can be assumed then, that the physician-patient and the physician, in the extreme case, both know the same, that is, they have equal quantitative knowledge. However, the physician still has to examine the patient and, based on knowledge of the life circumstances of the patient, interpret the findings. This places the physician in a position of power over the patient-physician. "For it is here, as the patient bares the chest to the listening ear of the doctor's stethoscope, that power has its immediate effects in creating the corporeal objects of human experience" (Butchart 1998: 9).

The conclusion here is, again, that the physician has a considerable power advantage over the patient:



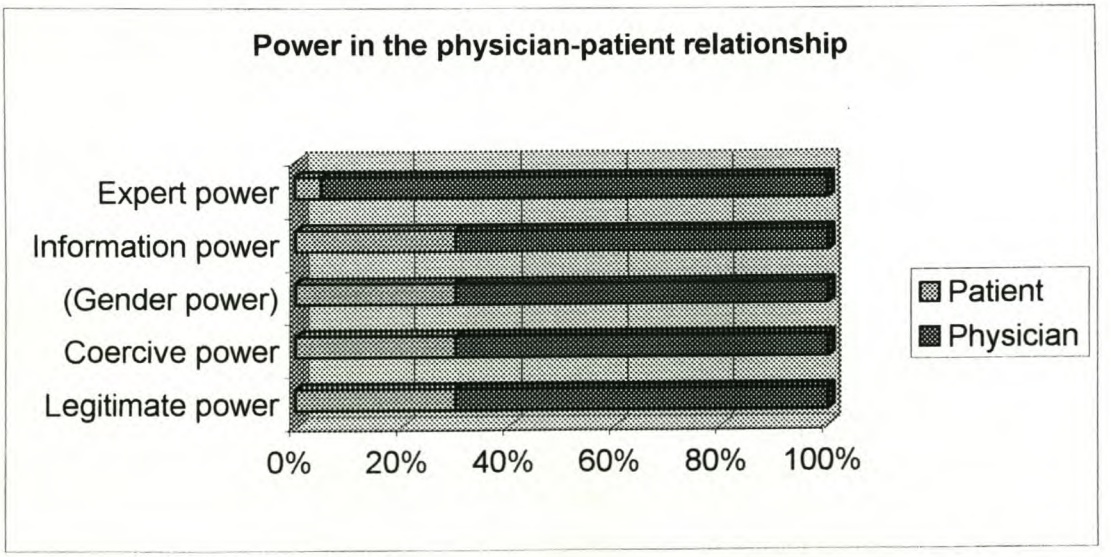
Expert Power

This is a special form of Informational power. It forms a significant component of the physician-patient relationship. The "quantity" of power is communicated to the patient through a variety of methods:

- Name plate: Most physicians advertise their rooms by means of a name plate (in brass) in a prominent position outside their rooms. This name plate clearly bears the title "Dr" which proclaims the "expert" status of the physician. It also has, prominently displayed, the University degrees held by the physician.
- University degrees: The degrees held by the physician are usually repeated within the physician's rooms through the use of framed degree certificates hung prominently on the walls, and on prescription forms and letterheads.
- Registration: The physician usually displays a registration certificate showing current registration with an "official" registering body.
- Membership: A certificate of membership of a Medical Association or other bodies of experts (Research Societies, Special Interest Group, and so on) is often displayed. While this also is a form of referent power, it helps to establish the physician as an expert.
- The physician may also be a *specialist* within medicine. This status is acknowledged by the profession and society as "expert status".

The patient, on the other hand, may well be an expert in physics, mathematics, finance, and so on. In the health environment, expertise other than medical knowledge is not recognised by the physician or other members of the health team as being of any significant value.

Thus the balance of expert power lies almost exclusively with the physician:

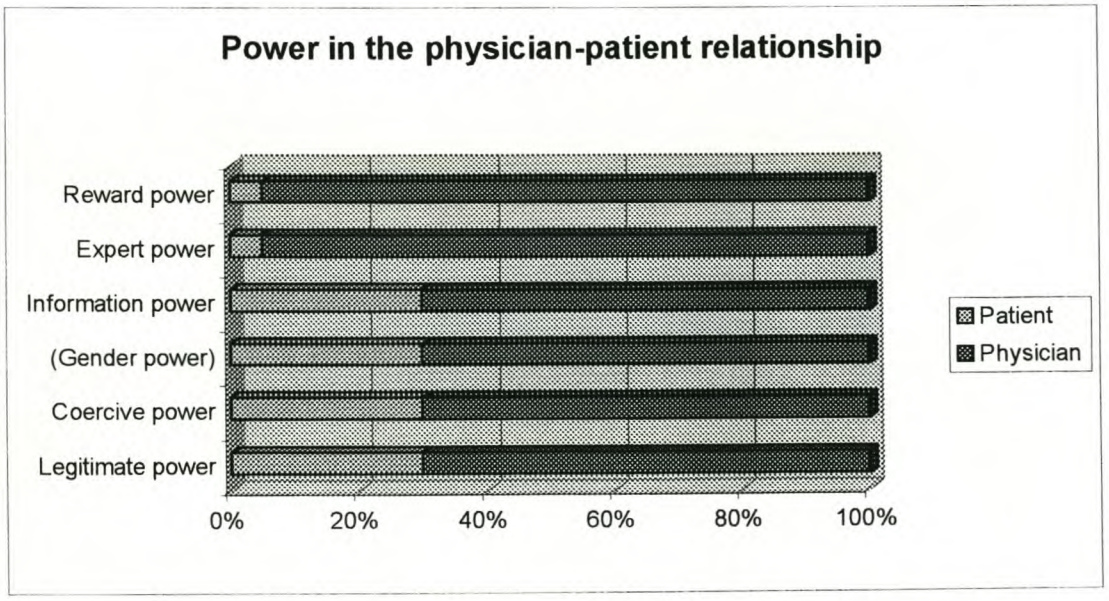


Reward power

In the patient-physician interface, the physician is not in a position to offer tangible rewards for compliance. The physician rather uses persuasion to change the patient's perceptions about the value of various rewards. For example, cigarette smoking provides an instant reward to the smoker. The physician attempts to develop in the patient a greater value for long-term "health" than instant gratification. This is a reward in itself for which the patient should strive. However, the reward offered by the physician is not simply the long-term value; it is rather an intermediate benefit – that of "approval". The patient who agrees to implement some difficult lifestyle change will receive affirmation and approval from the physician. Because the physician is a person of stature in the community, this approval is perceived as being valuable.

As stated above, reward power is often used in conjunction with coercive power. This is true of the physician-patient relationship where it is common practice for the physician to use "scare tactics" to try to get a patient to change some aspect of his/her lifestyle or to agree to some or other treatment.

The patient, on the other hand, has really very little to offer the physician in terms of reward power.



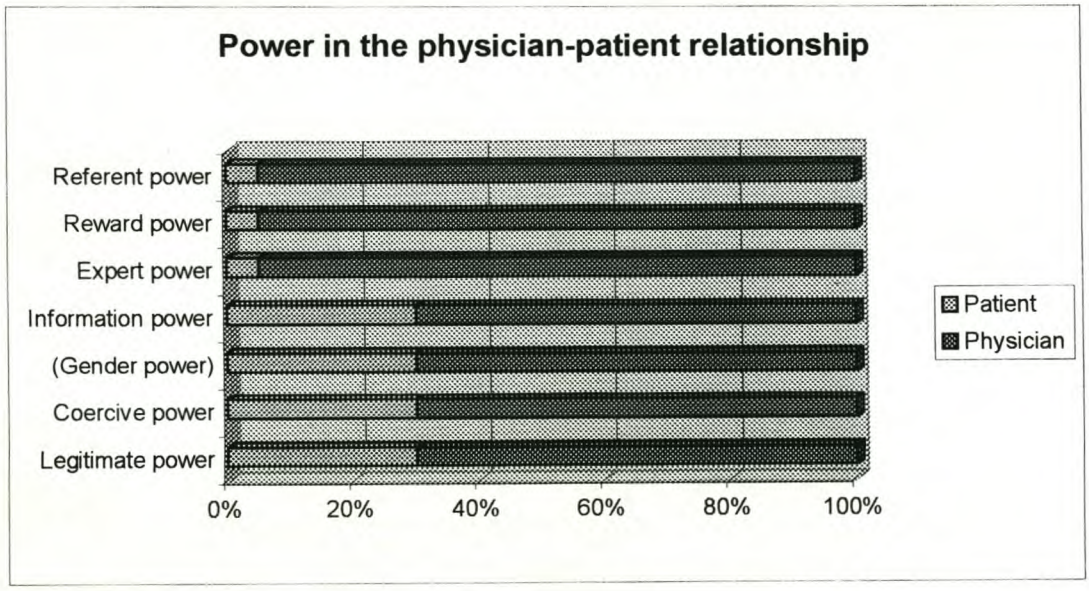
Referent power

Famous people are frequently used by businesses to market their products. In many cases, simple the attachment of the name of such a person is sufficient to give a completely unrelated product a competitive advantage (for example, the name "Gary Player" on boxes of tissues). Practices of this nature exploit referent power

Great strides have been made in medical science over the last two hundred years. The pace of discovery has dramatically increased over the past few decades. Physicians, regardless of their own scientific knowledge or abilities, are seen as part of this whole scientific development. As pointed out earlier, all people value health as one of the most fundamental goods. Taking these two aspects together, particularly within most Western societies, physicians are allocated awesome status, and are therefore seen as persons who are worthy of trust.

Most patients will be "ordinary" folk who do not possess any referent power. In the situation where the patient is also a person who has referent power, such as an army general, the president, a film star, and the like, it would seem, at first glance, that this form of personal power would restore some of the power imbalance in the physician-patient relationship. However, referent power seems to act paradoxically in this situation. Rather than producing a more equitable balance of power, the fact of their patronage seems to further enhance the referent power of the physician.

Physicians are thus placed on a pedestal and, no matter who the patient may be, referent power will reside almost exclusively with the physician.



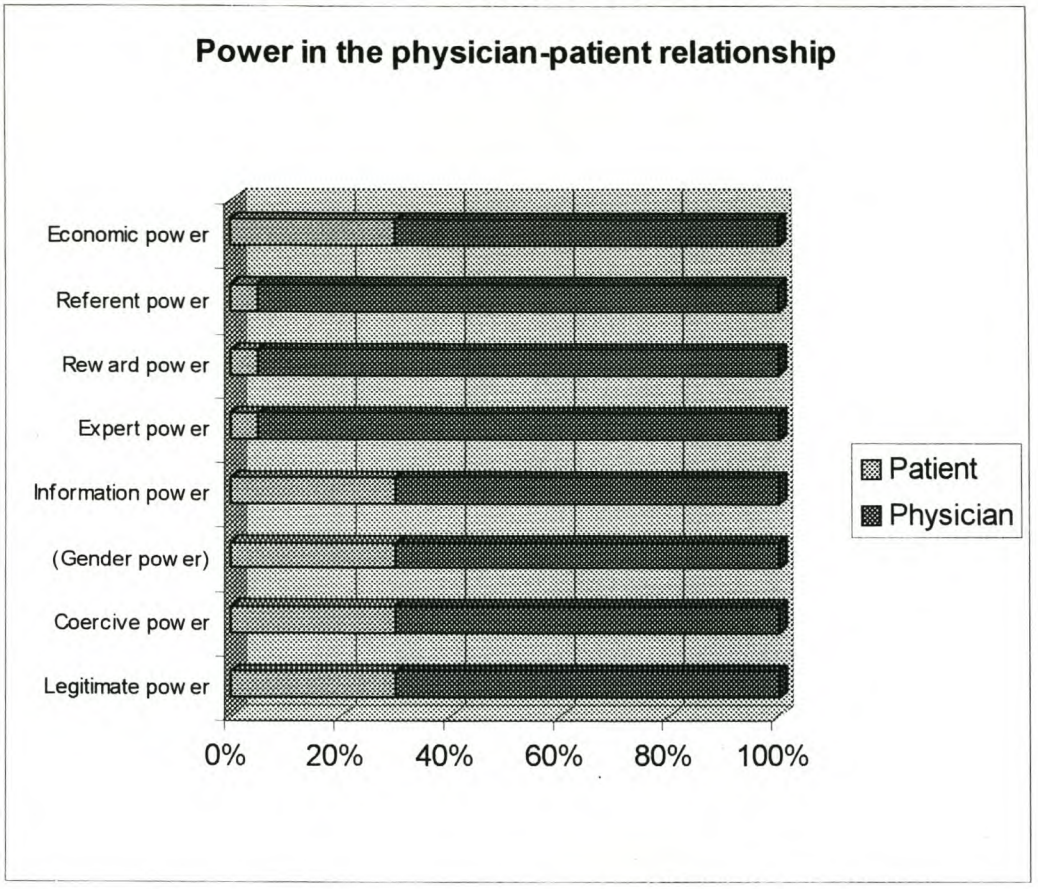
Economic power

Most patients would like their physicians to have a reasonably high standard of living. One would not willingly place one's life (or the life of a child or significant other) in the hands of a "man of straw". However, physicians, particularly in the Western world, have used their knowledge and skills to justify extreme wealth. In general, people seem to resent this state of affairs. Part of the reason for the development of administrative systems in health care delivery, such as "managed care", is the perception that doctors are taking an unfairly large slice of the national resources. Managed care takes away a number of decision-making powers from the physician and transfers them to a team of "assessors" who monitor the "recommendations" of the physicians. Managed Health Care organisations make decisions on medical treatments which are based on statistical and actuarial analyses and research into "best practice" protocols, rather than the decree of the physician. This will, over time, decrease the income-generating potential of physicians and render them less wealthy, so decreasing their power.

However, at present, physicians are usually amongst the upper income earners in Western society and, since material wealth confers power, the physician is usually in a more powerful position than the patient.

It is noted that wealthy patients probably regard wealth as a sign both of success and expertise. They are therefore likely to patronise the wealthiest of physicians, thus reducing some of the power imbalance.

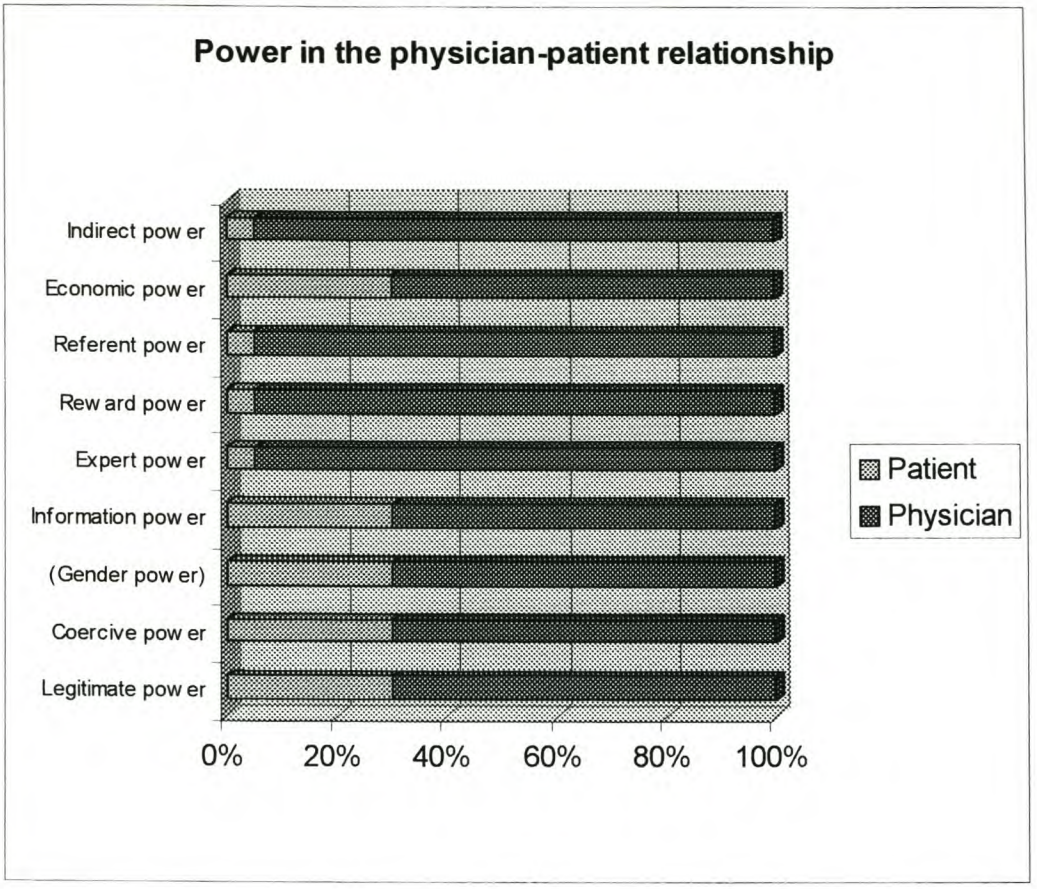
Since it is difficult for either the patient or the physician, to know exactly how much wealth the other party has, perceptions play a very significant role in determining where the economic power would lie. The average patient, of course, earns an average salary, and so would have less economic power than the physician. In countries like South Africa, where a large proportion of the population is poor, the relative economic power of the physician is accentuated.



Indirect power

The use of indirect power is not uncommon amongst physicians. For example, the physician could turn to the child of the patient and say "You must make sure your mother doesn't smoke". Or a wife is instructed to see that her husband exercises regularly or eats a healthy diet.

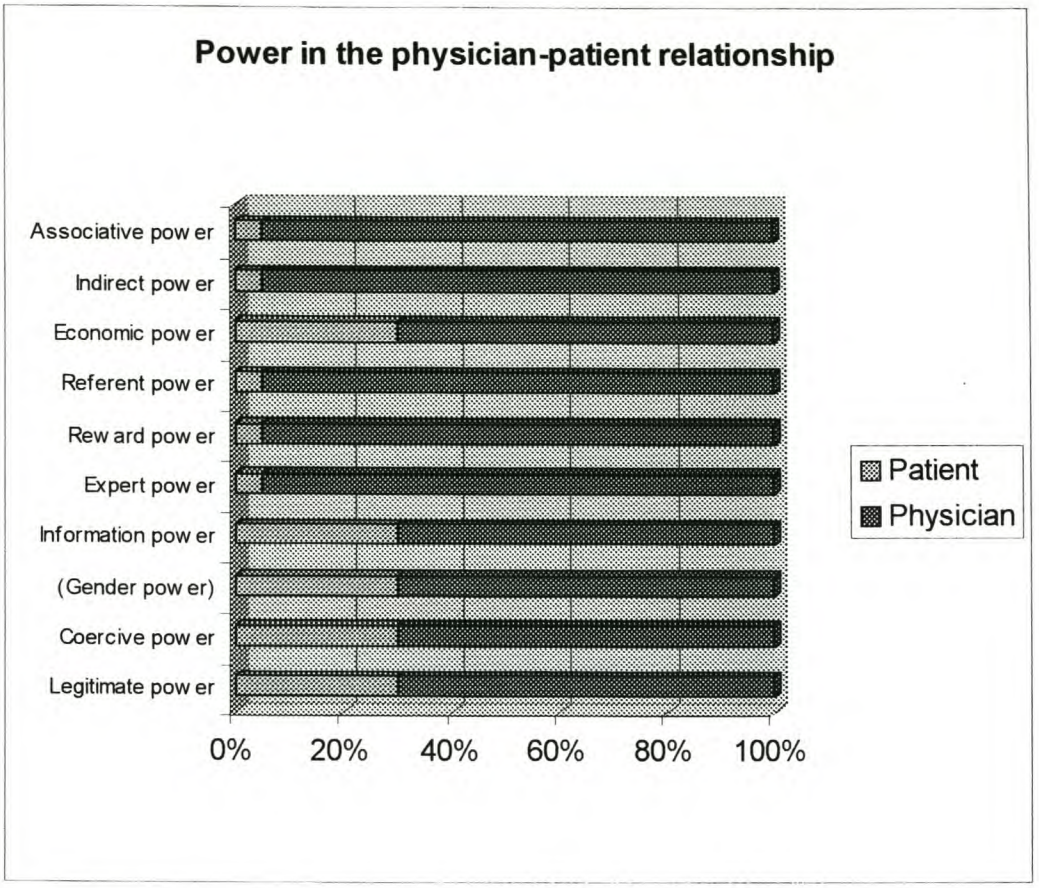
There seems very little opportunity, if any at all, for a patient to use indirect power over the physician.



Associative power

Association with the rich and famous confers power. In this area, the physician has a wealth of opportunity. Wall hangings depicting anyone from Hippocrates to the current president of the local medical association would suffice. Or a graphic of the atomic structure of some medication or the human genome serves to associate the physician with the latest in scientific advancement.

Occasionally, a physician will visit a patient at home. On these occasions, the patient is usually examined in the bedroom. If the patient has any pictures of famous relatives, they are likely to be in the sitting room, unnoticed by the physician. Even if present, associative power in the patient is so offset by the fact of their dependency in this relationship that it appears to be of no benefit in balancing the power differential.



Group power

Initially it would appear that, since the physician-patient relationship is usually a one-to-one relationship, group power would not apply. However, both the patient and the physician represent groups in various ways.

The physician represents the profession of medicine and is backed in his/her work by the society of physicians. A patient who attacks a physician will probably find that almost the entire medical establishment unites in defending the physician. Specialists, in particular, have closely knit groups which could protect members by obfuscation or concealment of information. Often, the group of physicians will support the action of a colleague, even if his action was not "ideal". Because circumstances differ between patients and over time, it is very difficult to be prescriptive or dogmatic and reasonable doubt can easily be introduced.

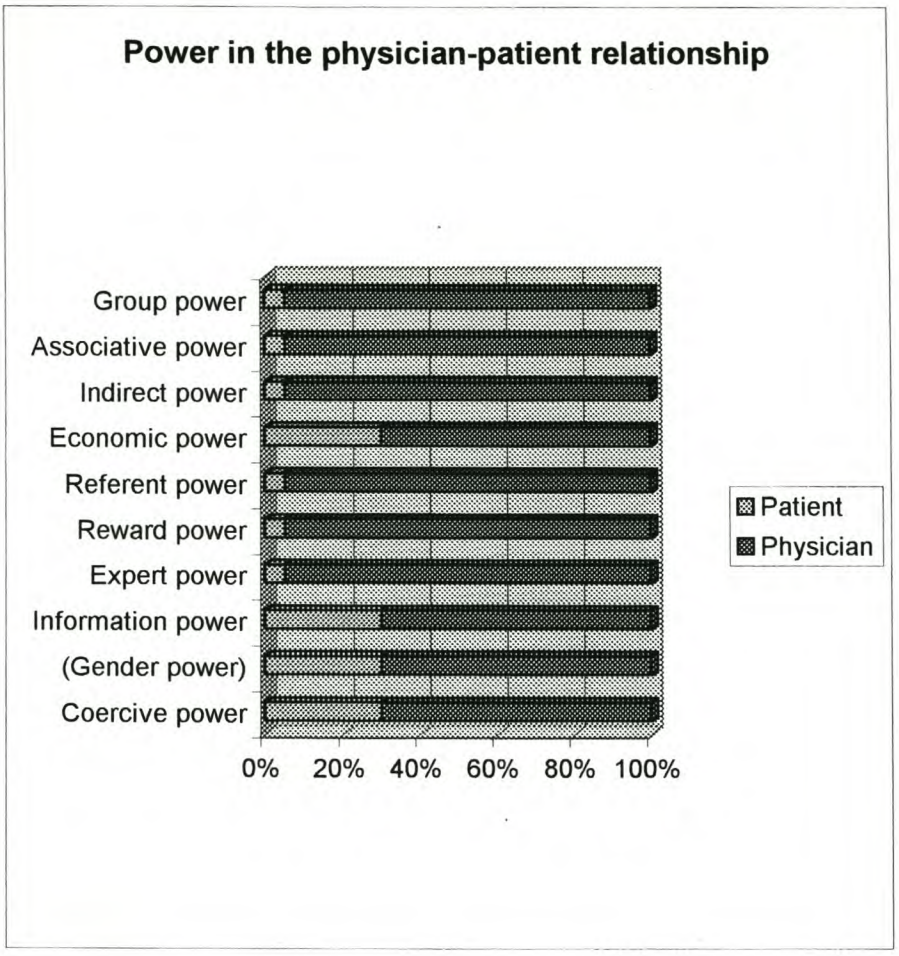
Patients also represent a group – the group of "patients". Not infrequently, patients will write to newspapers and magazines to complain about some aspect of care. In this they are frequently supported by others who have had similar experiences. However, should

they wish to take the matter further and to litigate, they would have to think twice, since physicians are likely to have greater financial resources.

Professional associations of physicians and specialists are very much more powerful than ad hoc groups of patients.

While the introduction of managed care has ostensibly created groups to benefit the patient and level the playing fields, it may only represent a new authority with which the patient must contend in order to obtain what he or she perceives to be the necessary treatment. Physicians, under managed care, have to report to external agents to justify clinical and therapeutic decisions. While this certainly diminishes deliberate medical malpractice and fraud, it is only a matter of time before physicians learn how to manipulate these controls and restore the balance of power in their favour.

My overall assessment is that group power considerably favours the physician.



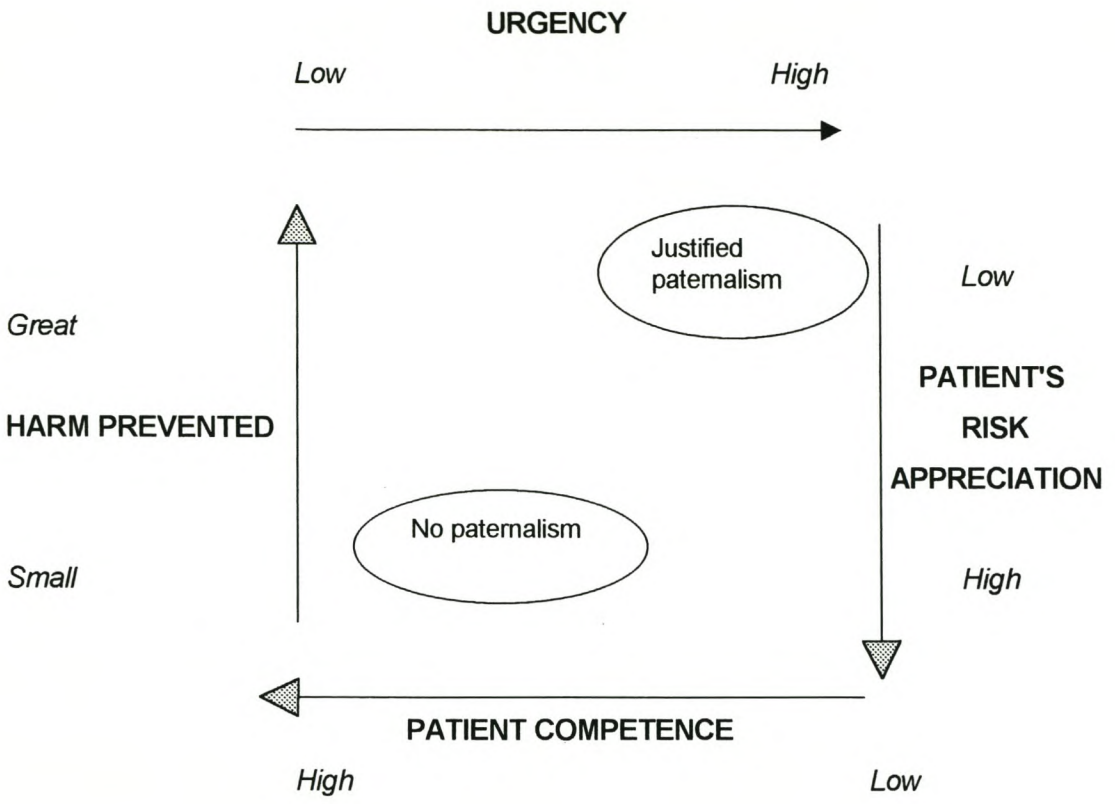
Resource power

If we accept Morriss's contention (1987: 140), that "an individual who can offer a service another requires has, in this service, a resource", and that the availability of a resource confers power, then this type of power exists in the physician-patient relationship. The patient is in need, sometimes in desperate need, of a service which can be provided by the physician. Similarly, the physician has control over resources which can be withheld in certain circumstances. In particular, the ability to make available various pain killers confers great power on the physician.

The provision of emergency care is of particular importance here. A person who has been injured in a motor vehicle accident or some other traumatic or violent incident urgently needs assessment by the physician. Sometimes bleeding has to be stopped and intravenous lines inserted. In the situation of urgency, the patient has very little choice and simply accedes to the physician's judgements and procedures.

Perhaps we could add the dimension of "urgency" to the holistic approach as follows:

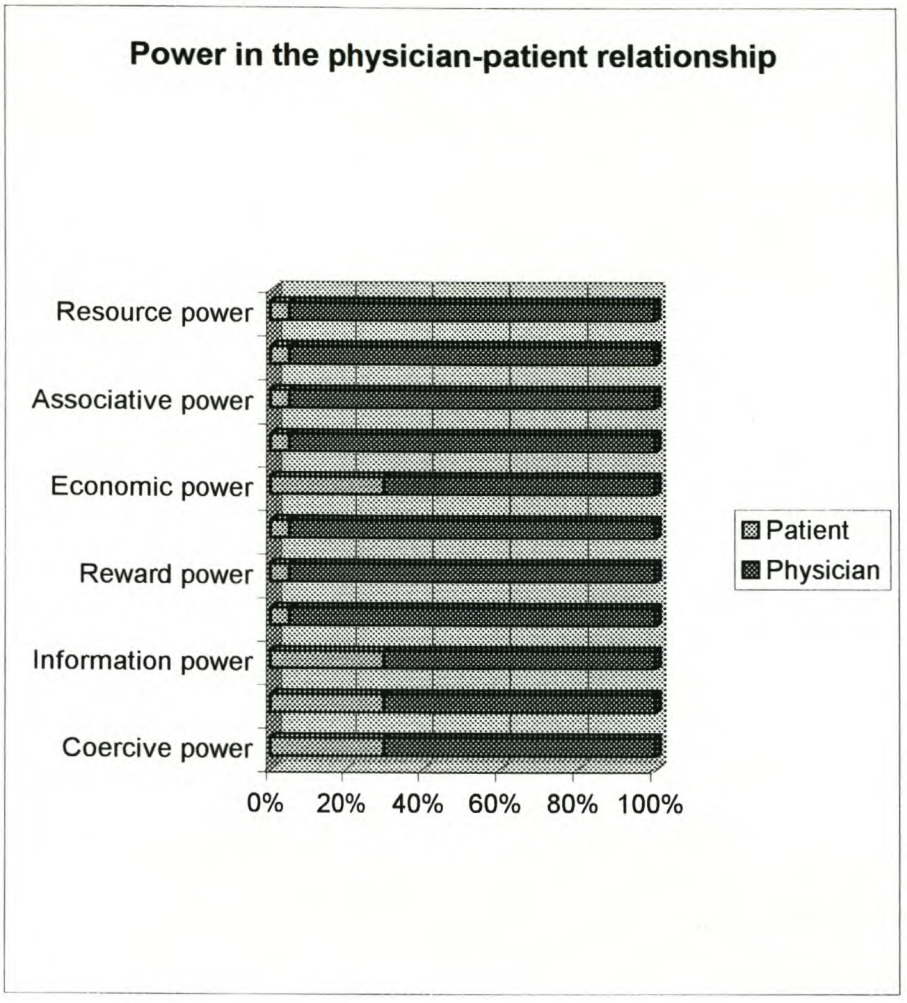
The holistic approach



Resource power would be higher in the top right than the bottom left quadrant because the patient is more dependent on the physician at that point. However, even in the lower left area, where we are dealing with a competent patient, the patient is still dependent on the physician to make the needed resource available.

There seems to be no resource which the patient can utilise to balance this form of power. If the patient refuses to pay the physician, either legal action could be taken against the patient, or the physician could refuse to treat the patient further.

This form of power, therefore, also heavily favours the physician.



Principle-centred power

Principle-centred power, as described by Covey, could probably be termed "character ethics". Power of this type would emanate from the "noble character" of the physician and honest concern for the patient. Ideally, physicians should be people of this type.

Generally, the public perceive their physicians to be this type of person. Occasional surveys cross my desk in which it is shown that physicians are amongst those most trusted in society, along with ministers of religion and bank managers. Furthermore, the training of physicians stresses the importance of ethical conduct. Patients are distressed when physicians act in a manner which does not portray the nobility of character they assume them to have.

Thus, whether or not physicians are persons of noble character, the public in general perceive them to be so. As described above in the definition of power, where power is

perceived to be, there it is. Thus power is ascribed to physicians through the perception that they indeed do have principle-centred power.

It is interesting to consider whether or not a "principle-centred patient" could produce a balance in this type of power. Would the physician be in awe of a Mother Theresa or some similarly acknowledged person of principle?

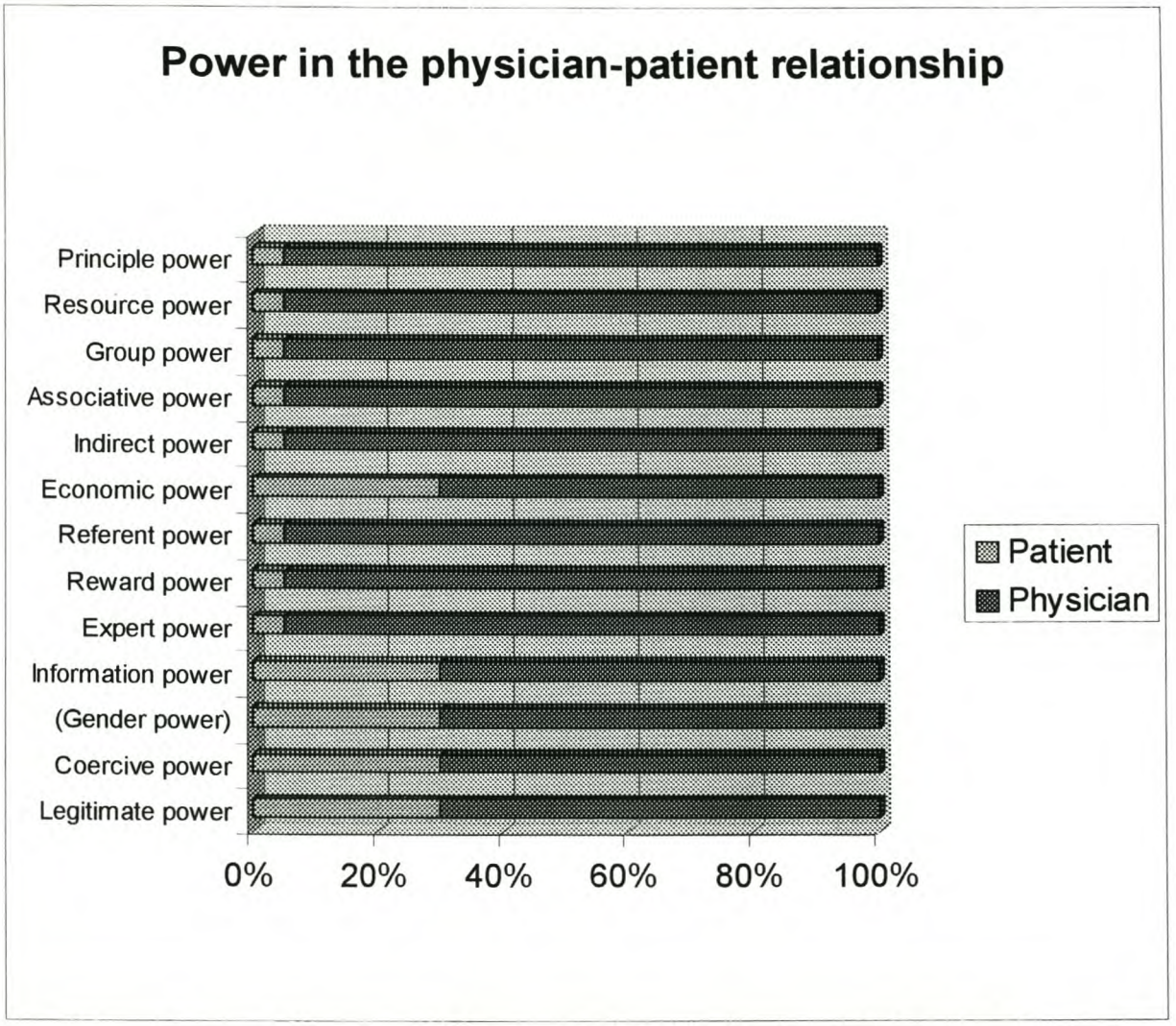
It seems that the moral standing of the patient is, in practice, never taken into account in the relationship.

The existence of principle-centred power can, perhaps, be demonstrated by its loss. In the first place, we can examine whether or not the patient can lose any principle-centred power. The physician is supposed to treat all patients alike, whatever their moral status. Frequently, a presenting complaint has nothing to do with lifestyle issues, and only a physical consideration of the problem is required. In this case, the physician would have no idea about the moral status of the patient. And even if this were known, it would in all likelihood make no difference. In the event that a presenting complaint, or some complaint discovered during the examination, reflected on the moral status of the patient, additional power would accrue to the physician through the medium of "knowledge power".

On the other hand, should the physician be sexually suggestive or offer to enter into a shady deal with a patient, all the principle-centred power normally accruing to the physician would immediately be lost.

This may not result in any increased power for the patient (although knowledge power could be gained in some circumstances).

Thus, while "referent power" in the patient has a paradoxical effect, principle-centred power *in the patient* is simply not brought into the reckoning. It does not count.



Power relationships

Michel Foucault looks at the way in which human beings become subjects. In particular, he looks at the power of men over women (which we have considered above under "gender power"); parents over children; the discipline of psychiatry over the mentally ill; and administration over the ways in which people live.

Certainly, in the physician-patient relationship, the power of parents over children is a factor. Much of this parental power, in its medical aspects, has been controlled through legislation. For example, a parent may not refuse an operation or treatment for a child, if the operation or treatment is deemed to be in the interests of the child. Thus, parents

who are Jehovah's Witnesses cannot refuse blood transfusions for their children – or if they do, the courts can overrule them. The fact that physicians can call on the power of the courts to overrule parents confers additional power on physicians.

Perhaps the concept of the power of "adults over children" could be an issue to consider under this section. In almost all societies, adults have more power than children, and the mere fact of being an adult confers power. The physician would similarly have power over patients who are children simply by virtue of being an adult.

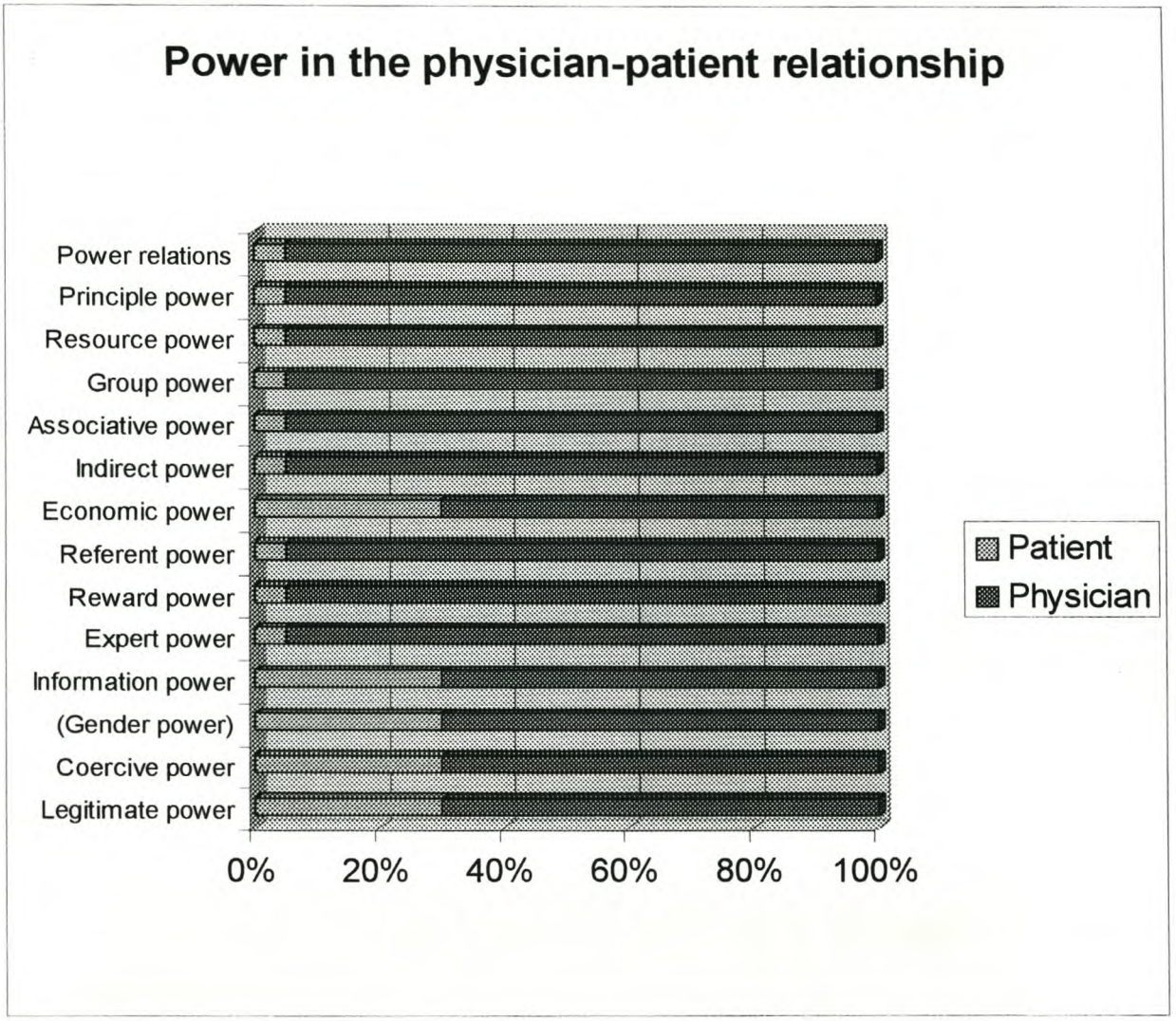
The power of psychiatrists over the mentally ill is a special physician-patient relationship. In this case, the patient is disempowered in proportion to the degree of mental incapacity. Those who are completely incapacitated have no power. Conversely, psychiatrists are trained as specialised physicians to deal with patients who have this type of problem. They have a very significant degree of knowledge power and, in addition, a considerable amount of legitimate power, as they can determine that a person should be certified or restrained or admitted even against their wishes. This relationship shows one of the greatest power disparities of all relationships and is particularly severe if gender power is also operative.

The power of medicine over the population is the next area of Foucault's interest. The "power of the confessional" certainly operates in the medical interview. Patients are expected to disclose their most intimate secrets in order to assist the physician to make a diagnosis.

Thus power relations – from the Foucauldean point of view – are heavily weighted in favour of the physician.

Finally, the administrative control over the ways people live is certainly operative in the physician-patient situation. As was noted above, Dworkin discusses the "sick role" which requires that the ill person must present themselves to a professional so they can be returned to the workplace as soon as possible. This administrative arrangement is an example of how the whole social structure places physicians in positions of power.

Foucault notes the system of differentiations which confer power on one over another: status and privilege, economic differences, linguistic and cultural differences, and knowledge differences. Most of these factors have been discussed above. It is sufficient to note that Foucault shows that it is not only the large issues that are important in conferring power, but also infinitesimal practices. The whole of our society is so structured that physicians are accorded power in relation to ordinary citizens.



Summary

The purpose of this Chapter was to demonstrate the imbalance of power in the physician-patient relationship. Intuitively, it was felt that the balance of power lay with the physician. To demonstrate this, an index of power was developed. This index scored the assessed relative power balance for each factor on a "constant sum" percentage scale.

Sources of power were considered individually to determine where the balance of power lay. Approaches to power were also considered and the implications for the physician-patient relationship assessed.

Three areas of analysis were of particular interest in this philosophical analysis: economic power can in some instances give patients power over physicians (although this is only the case rarely); referent power *in the patient* has the paradoxical effect of increasing the referent power of the physician, and any principle-power belonging the patient "doesn't count" in the physician-patient relationship.

As each source of power was considered, it was included into a chart on a cumulative basis. The purpose of this approach was to "build up" a quantitative case for declaring that power in physician-patient relationships is disturbingly weighted in favour of the physician. The ethical consequences of this situation will be considered in the following Chapter.

How defensible is this approach?

There are a number of possibilities:

(a) All (or most) forms of power have been erroneously analysed and are in fact weighted in favour of the patient. Our common experience of life and relationships so strongly rejects this option that it will not be considered further.

(b) All (or most) forms of power are equally balanced, and there is no real power differential between physicians and patients. To suggest this would really be to deny the existence of power at all. Power, by definition, implies a disparity between two or more parties. An analysis of each form of power in relation to the physician-patient relationship suggests there is an imbalance in at least the majority of cases.

(c) Some of the forms of power which have been weighted in favour, or strongly in favour, of the physician are in fact neutral or should be weighted in favour, or strongly in favour, of the patient. It is entirely possible that assessments of the various forms of power when made by different people may differ, and this could alter the relative weightings. It would, however, only undermine the conclusion of this Chapter if a large proportion (more than half) which, above, are weighted in favour, or strongly in favour, of the physician are weighted in favour, or strongly in

favour, of the patient. Again, our experience tells us that the balance of power is not in favour of the patient, so this scenario is highly unlikely.

This Chapter has therefore demonstrated a large disparity in power between physicians and patients. The disparity has been intuitively quantified. It lies heavily in favour of the physician.

Ethical Considerations

> **Power tends to corrupt, and absolute power corrupts absolutely. Great men are almost always bad men... There is no worse heresy than that the office sanctifies the holder of it** —Acton, 1834

The above quotation has been remembered for more than 150 years because of its accurate reflection of our experience. It encapsulates what we intuitively feel about power. Given that this is so, is it likely that physicians – who are in positions of great power over patients – will never abuse their power in this relationship? If there is abuse, what form(s) may it take? What can be done to protect the patient?

Mendelsohn (1982: 1) states that "The door to the doctor's office ought to bear a Surgeon General's warning that routine physical examinations are dangerous to your health". Mendelsohn attacks the profession of medicine as a whole, and points out many examples of how physicians have been creating business for themselves by making diagnoses of diseases (or non-diseases) that they can treat. Mendelsohn (1982: 5) states:

> I don't believe for a moment that all doctors, or even a majority of them, consciously attempt to mistreat, mislead, deceive, or cheat their patients. Some do, for in my profession, as in all others, there are idiots, crooks, incompetents, and scallywags. My criticism is directed toward the institution of medicine – the religion of medicine. Every patient is threatened by the subtle influence its traditions and teachings have on doctors who were brainwashed in medical school and then overwhelmed by peer pressure after they launched their medical careers.

In my own experience, I have frequently been concerned that the indication for a surgical procedure is the fact that it can be safely performed rather than that it is needed by the patient. In some areas, there are few women over forty years of age who still have their uterus. A large proportion of children and young adults have had their appendices removed. In some instances, even cardiac bypass operations have been performed without good reason. Excessive surgery of this kind can be detected by comparing populations of patients in public hospitals with those in private systems. Where there is a great disparity in the performance of certain kinds of procedure, once differences in

patient mix have been taken into account, abuse explains the difference. Behind this type of abuse is the profit motive.

Over and above this form of abuse are a wide variety of other ways in which physicians subtly, or not-so-subtly, dominate their patients. It is the power disparity which permits, or even encourages, various forms of abuse. The purpose of this Chapter is to look at ways in which this disparity could be managed so that a more balanced relationship may result.

Rebalancing power

The ethics-driven physician

If we can determine the ideal solution, then we have at least defined the target at which we should aim. There may, though, be many practical reasons why the ideal may not be realised. However, having defined the ideal, the compromises that may be required can be made through rational processes. Thus a controlled process could be introduced, rather than random, uncoordinated efforts with less predictable results.

In the first place, we need to consider whether or not the power disparity is *inherently bad*, in which case every effort should be made to reduce or eliminate power disparities in the physician-patient relationship. If it is not, could the disparity be managed to the advantage of both parties? As mentioned previously, patients want their physicians to be people of wisdom and integrity. Why else would they entrust their lives, or the lives of their families, to a physician? Even in the current climate, in which moves are being made to limit, control or reverse the power of physicians, physicians are still being identified as the decision-makers in ethically difficult areas such as assisted suicides and euthanasia. There seems, therefore, to be a benefit to having the physician in a potentially powerful position.

If this is the case, the ideal situation would be one in which the physician knows and fully understands the power disparity in the physician-patient relationship. With each patient, the physician would be required to build up the patient's power to a level appropriate for the occasion. For example, if the patient presents with a viral pharyngitis (a common cause of a sore throat) for which no treatment is indicated, the physician would not need to expend a great deal of effort to build up the power level of the patient in that circumstance. Whereas, if the patient presented with a leukaemia (a malignant blood disorder), there would be a critical requirement for the physician to build the patient into (even) a positive power balance with respect to the physician.

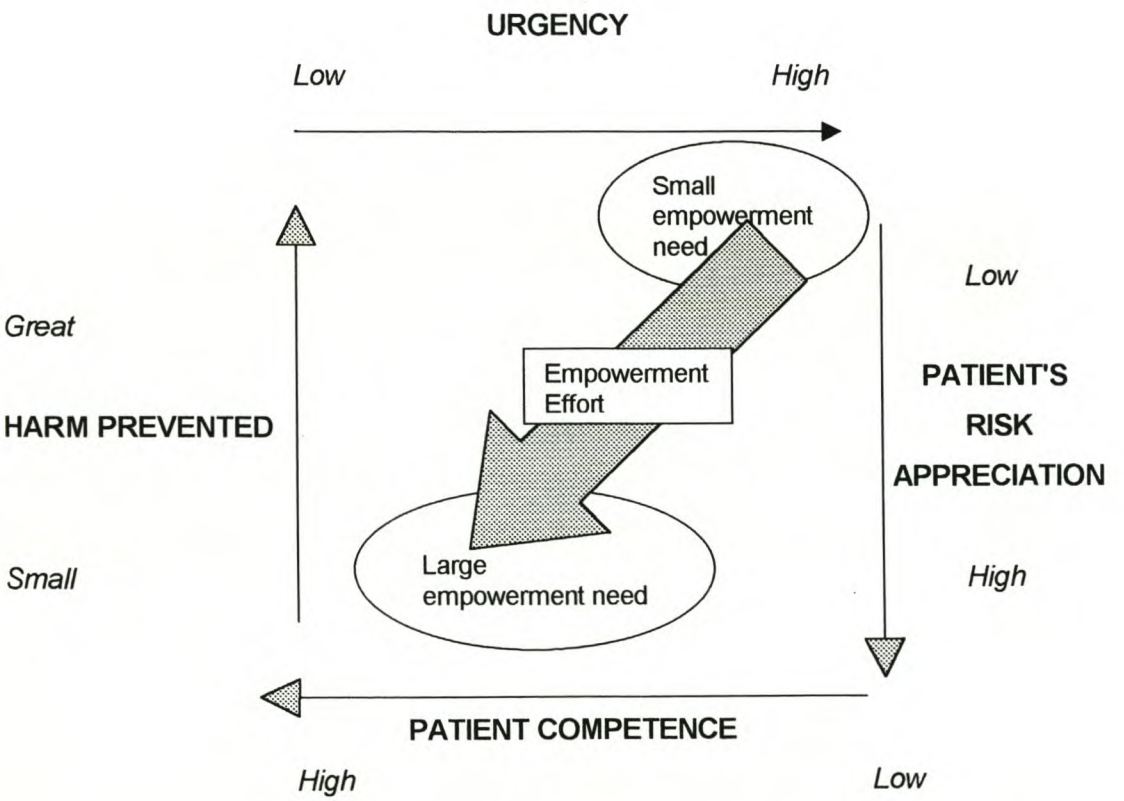
What is being described here is, in fact, very similar in concept to the modified "holistic approach" described above. The model shows an area of "justified paternalism". This may give the impression that the physician would be justified in *not attempting to empower the patient* in these circumstances. This is not at all what is required. The objective ought to be to empower the patient in order to maximise autonomy at all times; but in the chart area labelled "justified paternalism" this should rather read "empowerment requirements generally small", whereas in the area of the chart where paternalism is rejected, empowerment – to the full extent possible in the circumstances – is the ideal.

Restating this concept, it is evident that in the chart area where "no paternalism" is permitted, the physician "must attempt to swing the balance of power in favour of the patient".

Both of these requirements would have the aim of making the patient as fully autonomous in the situation as possible.

So we can add the dimension of "empowerment effort" to the model as follows:

EMPOWERMENT EFFORT CHART



The process of patient empowerment will not occur spontaneously. It would have to be based on an educational process, the underlying theme of which is the moral value of autonomy. Physicians would have to be socialised into developing a new major objective – that of empowering the patient to maximum autonomy until full autonomy is achieved (that is, when the disease is cured).

Implementation would not be easy even after the education process, as a consistent and conscious effort would be required of the physician – with every patient – throughout his/her career. The advantage would be that, in this way, health care would become at least a partnership, and at best, the physician would become the trusted friend and confidant who professionally assists another human being in managing those things, both physical and mental, which limit autonomy. There would no longer be the concept of a "patient" (dependent, help-seeking). The concept "client" (or "associate" in health care) may become more appropriate.

In this model, the balance of power remains with the physician, who through personal effort, uses this power to empower the patient.

The rights-driven patient

A second approach might be to ensure that the patient is fully briefed about his/her rights, such as the right to information, the right to decide on treatment, the right to get a second opinion, the right to complain to the appropriate body, and the right to sue, and so on.

The relationship with the physician would be a business relationship with the patient requiring/expecting a service of a given quality. Should the patient be disappointed, normal business consequences would apply.

This approach would require that almost all patients should be suitably educated and trained to manage the relationship with their physicians in this way. Since almost everybody is a patient at some stage, it would require that the whole population be educated to this very sophisticated level.

There are, of course, many patients who manage their relationships with physicians (and other service suppliers) on this business-like basis. However, it is unlikely that progress, even in the most advanced countries, would enable the majority of patients to act in this way.

One drawback of this approach would be that most physicians in private practice are in fact in business. Their experience in the "health business" would be likely to give them an

advantage over most patients. Nevertheless, it would certainly make patients aware of what they should expect, and many excesses could thus be prevented.

In this model, the power would be balanced in favour of the patient. The physician would come to be viewed as a "servant" or "contractor" who has to be managed.

The empowered patient

This model would be "softer" than the rights-driven model. Here, the patient would be less litigious or businesslike and would be more open to discussion with, and receive recommendations from, the physician. The patient would still be assertive, but not dominant.

Here, the empowerment of the patient does not emanate from the beneficence of the physician, but from a societal socialisation of people, probably during schooling, in which they are trained to take control of their own lives in a wide variety of situations, one of which would be the physician-patient relationship.

The balance of power would be equal between patient and physician.

The "patient advocate"

Practically, it is difficult to conceive of a situation where all patients are empowered. It would also not be practical to introduce a third party into the equation. For example, it is conceivable that physicians could be required by law to have a "communication specialist" (social worker, clinical psychologist, or suitably trained nurse), who is not directly employed by the physician, work *with* the physician, with the intention of seeing to it that the interests of patients are given due consideration. Such a person could report to an independent medical council who would investigate complaints and discipline physicians.

Although this might be a theoretical solution, it would certainly not be appreciated by physicians. Even patients may resent the presence of a third party during the consultation and examination process.

Possibly, a compromise could be made by ensuring that independent "patient advocates" are appointed in various centres, whose services are free to the patient. Should any patient feel that he or she has not been fully respected in their interaction with the physician, the advocate would take up the issue with the physician concerned. The advocate would be empowered to provide training for physicians, or even to insist on the physician undergoing a suitable training course, if there are recurrent complaints about

him or her. The two basic features here are the availability of "patient advocates" and the education of patients to the fact that this service is freely available to them. As mentioned above, there are suitable professionals who could take on this role. The educational process would not be difficult. Physicians could be required to display notices of the advocacy service at their rooms.

To reinforce the principles of autonomy, physicians could be required to contribute to a fund which is used to employ local patient advocates. The number of advocates employed in an area would be proportional to the amount of demand for their services. So, the more physicians are ethically driven, the less would be the requirement of patients for advocacy services. Thus there would be a financial incentive for physicians to act ethically and in the interests of the patient.

The disempowered physician

Just as nature abhors a vacuum, so society abhors an unjustified power differential and moves to eliminate it. We do not like monopolies or dictators. Similarly, modern society will not tolerate physicians with unjustified power levels. In reality, it is unlikely that physicians will take the "high road" described in the "ethics driven physician" scenario. An alternative strategy would be to disempower physicians. This seems to be a popular and practical approach. Considerable progress has been made in this direction, much to the chagrin of physicians.

The realisation, especially by funders of health care, that abuses of power by physicians were rife, was a major factor in the move towards the development of managed care systems. In managed care, the physicians' reason(s) for particular treatment is reviewed by a third party. Only after review will the funders be prepared to pay for the service. Thus an economic battle is being fought. While this system began basically as a cost-control measure, there is considerable spin-off towards physician disempowerment.

Further disempowerment has occurred through the de-professionalisation of many functions previously the preserve of the physician. Pharmacists may diagnose and treat diseases, primary health care nurses can examine and treat patients, and medications, previously only available on prescription, are being made available to patients for self-medication. Hospital management and health care planning are some of the previous preserves of physicians which are being re-distributed to trained managers, whether or not they have health care backgrounds.

Multiple pathways approach

No single model as set out above is likely to solve all the problems of power relations in the physician-patient relationship. Procedures to further control physicians will continue to be introduced, wherever deemed to be practical and effective, until the patients and funders alike are satisfied with the resultant power balance and cost-effectiveness considerations.

Physicians would do well to become aware of these processes and their effects on their own autonomy. They should understand that this process of disempowerment of physicians and the empowerment of patients will continue to the extent that the perception of an unjustified power differential still exists.

Unless physicians act in a concerted manner to impose stringent ethical requirements on themselves, the process of patient empowerment and physician disempowerment will continue. Thus there is something for physicians to do – put their own house in order.

Managing a power differential

Since, for the foreseeable future, the physician-patient relationship will be characterised by a serious power disparity, it will be important to ensure that physicians are both aware of, and are trained to, manage this disparity. Just as it is irresponsible to provide a novice driver with a powerful motor car, or a child with a firearm, it is irresponsible of medical schools to train physicians and other health professionals and allow them to be placed in positions of high power, without having given them the training and moral enthusiasm to manage the situation.

There are two main target areas for teaching and training: students and qualified professionals.

The teaching of students about the management of power should form part of the standard training course. This would not be a particularly easy undertaking. Medical students are generally highly "task orientated" and do not give much attention to subjects which are not examinable. The objective assessment of morality is fraught with difficulty. Nevertheless, it has been encouraging to see most medical schools in this country beginning to look for "ethicists" to teach ethics to undergraduate students and to expand the ethics teaching in all health curricula.

Teaching qualified professionals is the other task. In South Africa, as in many other countries, physicians are required to participate in continuing professional development.

A considerable proportion of this is directed towards exposure to "ethics". However, it is likely that this exposure will be more directed at helping physicians to help patients come to terms with ethical dilemmas, rather that getting the profession to do some serious introspection.

Monitoring professionals

In the surgical disciplines, doctors often are required to work together. But in most branches of medicine, the relationship with patients is more of a one-on-one nature. It is therefore very difficult for a physician to assess how a colleague is working.

There are, however, other health professionals who also interact with the patient, for example, nurses, physiotherapists, occupational therapists, and technologists, amongst others. It is possible that in the education of health care workers in these professions, the nature of the patient-physician relationship could be explicated, with special reference to the power differential. Thus made aware, they would be able to identify abuses of power. The possible role of these allied health professionals as "monitors" of the physician's use of power should be explored.

Physicians, however, would not take kindly to being corrected or challenged by members of "inferior" professions. The effects of centuries of professional arrogance would have to be undone before this inter-professional communication could become a useful tool in the normalisation of the power disparity between physician and patient.

Managing complaints

It would be interesting to determine whether patients who feel disempowered would be more likely or less likely to complain about a physician. Either way, since physicians have the upper hand, complaints should be handled in a manner which will uncover the true situation. This would require the services of experienced and perceptive clinicians who are respected for their own ethical standards and moral character.

Conclusion

The historical development of the physician-patient relationship was reviewed. It was noted that there was, historically, no ethical imperative for physicians to be concerned exclusively with the interests of the patient. Third party interests and personal interests have always been part of the relationship. (Chapter 1)

The relationship between a patient and his or her physician is a complex one. Concepts such as "stewardship", "paternalism" and "beneficence" interact with "profit motives", "professional arrogance" and "power". (Chapter 2)

There are both historical and immediate societal processes which empower physicians. In addition, physicians can draw on a large range of power sources to maintain their position of dominance in the relationship. Power can be coarsely quantified to give an overall impression of the extent of the disparity between patient power and physician power. (Chapter 3)

Since human beings have a propensity to abuse power, it is of concern that the disparity should be so large – or even present at all. A variety of societal pressures are being brought to bear on the physician, which will serve to reduce the power of the physician or increase the power of the patient. Some indications have been given as to what steps the profession itself could take to reduce the effects of these pressures (and maintain a reasonably positive power balance for the physician) and what societies could do to monitor physicians, investigate complaints and ensure a balanced relationship. (Chapter 4)

It is hoped that this broad analysis of power in the physician-patient relationship will help to spark interest amongst health professionals and interested others, and generate an active debate on these issues. Most importantly, physicians should be aware of the extent of power disparity they have inherited, and be aware of the ease with which (and the ways in which) this degree of power can be abused.

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