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3.1 *Agency and hegemony in the patient-physician encounter. Use of coat and other devices in the construction of general practitioners' therapeutic space*

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Notwithstanding the common stereotypes spread at a "common sense" level [(1)] by a large and heterogeneous literature on this theme, medical anthropology disposes today of a theoretical-critical knowledge to affirm that the patient-physician relationship is never a merely one to one relationship and never assumes a pure technical character.

Even when the outpatient space is shared by a single physician and his patient, it's something much more complex than a simple meeting between two individuals. Through both their voices a huge chorus is actually voiced: the therapeutic space is indeed fuelled by dynamics which have origin in each of the cultural universes that every patient and every physician transversally bring. I'm not only referring to the obviously different (being elaborated inside specific and different contexts) representations concerning illness in general as well as everyone of its histories. I'm speaking also about a more generalized and constant dialogue, often implicit, established at different levels between each of the actors and the social structure, its various forms, subjects and institutions. Health and illness social meanings project the patient-physician interaction in the setting of a collective drama, a performance in which both the actors – although in different ways – express sometimes belonging and membership, sometimes refusal, uneasiness, alienation: «both these bodily expressions exist in a dialectic relationship, expressing the tensions between belonging and alienation which occur everywhere in the social life» [(2)] (Scheper-Hughes N. 2000 [1994]: 285). As every social sphere in which concrete people act, the

therapeutic encounter can also be read as a place in which sense and dissent meanings are produced. Or, to say it with Gramsci's words, as one of the places in which the hegemonic dynamics take form.

The hegemonic institutional pressure is indeed put on the patients bodies as well as the physicians', through apparently opposite processes which in practice seem to be aimed to grant conformity and agreement. Already in the fifties, Parsons recognized the strategic importance of the institutionalization of doctors and patients roles in order to guarantee the continuity of social system. To elaborate behavioural structures with intensely positive values means to regulate and coordinate people's answer to the fundamental problems of life, which are potentially threatening for the established order (Parsons T. 1965 [1951], Seppilli T. - Guaitini Abbozzo G. 1974 [1973]). Nevertheless, the over simplification of Parsons' discourse about the relationship between patient and physicians (actually rich in critical elements) had a share in the feeding and reinforcing of the physicians' image as exclusively "power" holder, contrasting the patients' representation as exclusively victims of such a power. That is still the tone currently used by a certain medical anthropology to define the patient-physician relationship: «the physician today is an essentially new breed of professional whose scientific body of knowledge and professional freedom place him in a class of his own: he has obtained unrivalled power to control his own practice and the affairs which impinge upon it and the patient, depersonalised by medical technology, is increasingly being reduced to a mere raw material» (Senah K. A. 2002: 45).

The latest critic medical anthropology's considerations on the body as metonymy, of illness as resistance and illness behaviours as attitudes of social criticism, crumble this stereotype, giving the possibility of a different reading of Parsons' message itself. On one hand, indeed, if we want to talk of "roles" for the patient as well as for the physician, we ought to talk about an identical – but two-sided – device of social control: the aim is in fact, in both the cases, conformity. On the other hand, the observation of clinical practice and the study of therapeutic itineraries have pointed out the great agency power patients actually possess (Ainsworth-Vaughn N. 1998).

But what I would like to propose, here, is a further point of reflection: the physician's position is as ambiguous as the patients', and the game between "endured" and exerted power is played in a very similar way by both, even though with different modalities. In both the cases what is performed is the drama of the individual assertion of the subject and the resistance to the hegemonic forms, the medical institution's in particular. To this end, each actor uses the instruments he has: these are often para-

doxically the same – but sometimes used in a "subversive" way – supplied by hegemony in order to control them, to confirm and delimit their position on the social scene.

The space of the therapeutic encounter represents to the patient the opportunity to reaffirm – even to the doctor, identified as the medical authority tout court – the right to self-management of his own body. For the physician [3], it represents the place where he can put in field a neverending confrontation/clash with medical institution and the professional "identity" it has stringed together for him. In other words, the therapeutic encounter represents for the physician the place where he can continuously act to claim his own way of being a "doctor". That's why it is reductive to show as being only in opposition the patient-physician relationship: sometimes allies, sometimes adversaries, each one's challenge is launched far beyond the consulting-room's limits. The rhetorical strategy which represents these roles as in contrast, one against the other, seems therefore to respond to the will to cancel out and render innocuous the disruptive drive of such a challenge.

The concept of "negotiation" too, if read in this key, acquires wider and more complex features: it is not just a kind of "tug of war" between two people bringing different cultural values. It is actually like an arena in which each of them uses the other's presence to affirm his own subjectivity on the social scene, in the ways which become by and by most available and fitting.

The rhetorical and performative tools with which this game is played are many, but I would like to dwell here upon those performed by physicians, and in particular by the general practitioners I worked with during the period of my PhD, finished last springtime (April 28, 2003).

The store with which every single physician constructs his own therapeutic space and, within this, his own relationship with every single patient, is made from a set of tools and ways to manage such tools; from different ways to occupy spaces; from rhetorics of verbal and non verbal communication, and so on. All these elements seem to be acquired during the training period, embodied through the exposure of the aspirant doctors to the medical institution's hegemony. I refer here again above all to Nancy Scheper-Hughes and particularly to the way she critically revisited the concept of embodiment: she distempered the passivity features of the subject to the social structure with which this concept was charged in the 80s by social and symbolic anthropology. What is to stress now is no more only the violence of institutions on the individual body, but the incessant struggle be-

tween hegemony and the bodies' subversives skills to re-manipulate hegemonic meanings in a critical key referring to the dominant system [4].

In that sense, the most powerful tools – that is to say the most "ambiguous" ones and therefore, paradoxically, the most malleable by subjects – are the "identity based" ones. In the medical sphere the most "evident" one is the white coat: «les formes d'identités qui sont marquées ou portées sur le corps [...] semblent plus faciles à maintenir que les autres formes d'identité, parce qu'elles sont définies comme internes à la personne et donc plus stables» (GAGNÉ N. 2001: 105). The practical function of the coat (however dubious, in a non-aseptic environment) seems indeed clearly secondary to a certain number of "semantic" functions that distinguish it as a sort of "position marker". The main symbolic function officially assigned to the white coat seems to be the construction, for the coming doctors, of a special identity fitting with the specific "biomedical" way of managing health and illness, epistemologically grounded on oppositions and dualisms, on separation: separation between technique and emotion, between rules and creativity, between scientific rigour and humanization, between what can be dominate and what is uncertain. Lastly, between obedience and resistance.

The coat is therefore one of the elements to which is assigned the task of safeguarding these limits: however, what cannot be controlled is the way each individual will act with it once he has "incorporated" it. The ambiguity every symbolic form brings – due to the frailty of the link connecting significant and significance – makes the coat a very powerful semantic tool, and therefore a privileged one in the dialogue with the social system. One can choose to wear it or not: the conformity or socially critical message is not necessarily communicated by the former or the latter action, but by the meaning one assigns to either choice, each time it should occur.

> «Just wearing the white coat makes you feel like another person!! There are some rituals, mm? The coat, measuring blood pressure, wearing the stethoscope round your neck... the first blood-test, the first intravenous injection, the first time you look on the microscope at your first blood smear... you feel like a real doctor!! You stop feeling like a student and you start to feel like a doctor!» [doctor D., 50 years old].

The coat identifies, it certifies, it exposes, it hides, it protects, it reassures: from being a hegemonic taming tool it becomes a raw material used in the sense attribution process, in the relationships of force determination, in both physical and metaphoric relational spaces connotation. Shortly, in the social relationships construction. To this aim, as a bricoleur, every phy-

sician uses the available rhetorical and performative tools to represent, to mean, to mark, to differentiate his own way of "doing medicine": «the bricoleur, facing a task, uses the materials he has at hand giving them another meaning, if I can say so, in respect of the one they had at first» (LÉVI-STRAUSS C. 1990: 155) [5]. The repertory is bounded, strongly marked in hegemonic sense (the hegemonic power is inherent to the white coat itself, not only in the way the physician uses it), but a certain variability margin is always found out and "exploited". Nevertheless, this operation always occurs and acquires a proper meaning in the dialectical relationship with the individuals introduced in the consulting-room in the role of patients, acting such a role equally as actively and strategically:

> «[I] never [wear it]! [...] My patients appreciate that, otherwise they wouldn't come, that's obvious, isn't it? Anyway, the choice is reciprocal... doctor D., who always wears a white coat, probably has the kind of patient typologically different from mine. This selection takes place with passing time, do you get me?» [doctor F., 48 years old].

It sometimes concerns strategies, sometimes tactics (DE CERTEAU M. 2001 [1990]), which enliven that complex strengths' field that is the therapeutic encounter. A field in which different "knowledge" and therefore different "powers" are facing, comparing, undergoing continuous decoding and recoding processes, with the aim of establishing the position coordinates of those present in that specific field of action. Every physician seems to manipulate at will the semantic area of an object which therefore assumes a clear function of interfacial mediator at various levels: between the individual and his perception of his own way of being a doctor; between the "physician" and his "patients"; between the physician as a "professional" and the medical institution which he belongs. What is needed is to single out, each time, the discursive sphere opened by the act of wearing it in that particular moment and in that specific situation. Therefore re-connecting it to the general hegemonic biomedical discourse with which it is however in a constantly dialectical relationship.

It is also interesting to notice, for instance, that even the physician who usually received patients in the consulting-room in "civilian clothes", reserved the possibility to wear the white coat in those situations in which the kind of intervention requested could be interpreted as more "invasive" from a relational point of view: for instance, during an inspection of the auditory duct or an auscultation of breast and shoulders. Actually, in those occasions in which although only a slightly bodily "compromise" was requested, a sort of "violation" of people's physical intimacy (which means also the physician's own physical intimacy) comes into play. To reduce,

then, the destabilising impact provoked by physical contact among extraneous people, it seems necessary, on one hand, a sort of "legitimacy to proceed", attributed to the white coat's power to underline medical "identity". On the other hand, at the same time, a real defensive action seems to be needed, and it is supplied by the "estranging" power of the coat (Cozzi D. - Nigris D. 1996: 311-320). It is due just to this estranging character if some physicians choose not to wear it at all, convinced that making medicine inevitably means – even if in the limits of a correct hygienic prophylaxis – to have direct physical contact with the patient:

> «normally I don't wear it, because I think the coat creates distance. So, if I have to do a dressing I go over there and I put on my white coat, but if I have to stay here measuring blood pressure, auscultating a breast, palpating a stomach, I don't get dirty if I leave my normal clothes on! [...] the white coat is for not getting dirty: it is not for seeing who the doctor is, because it is evident that I am the doctor! Therefore I don't need the white uniform to be recognized!» [doctor D., 50 years old].

However, in many cases the way in which the coat is used seems to communicate a precise message: when it is to welcome the patient in the consulting-room, to make him feel really at ease and to establish an informal and empathic relationship with him, the absence of the white uniform ("official" symbol of professional, and therefore of detachment and differentiation) is fundamental. When instead "acting" on the patient's body, it is necessary to call upon specific technical competences for the exercise of which the emotional component is of great disturbance, since it creates a sharing space with the patient that weakens the "power" – that is to say the "identity" – of the physician.

The white coat, better than other medical tools, seems able to represent what we could define the epistemological core of biomedical knowledge, the element which founds and legitimates the power of the ones practicing such a knowledge: the hierarchical opposition between technique and emotion. Forcing the separation between rationality and sensibility, between "mind" and "body", such assumption can be seen as one of the most violent of medical training: by admitting as its own specific field exclusively the first of the dilemma's two horns, it violates the consubstantial unity of the human body and it ratifies such a division with the indisputable mark of science. But clinical practice constitutes for every single physician the occasion not really to cancel, but at least to re-discuss such limits: in a continuum going from the exclusive and rigid selection of the technical element, to its refusal in the perspective of a totally emotional empathy, the white coat is often used as position marker, each time outlining the therapeutic space.

It is very frequent, for instance, among physicians who have personally experienced a dramatic illness, the choice to wear the white coat as little as possible, above all while treating patients with the most compromised and emotionally involving illness histories. Nevertheless, in many cases it remains hanging up well in view, as a reminder that it is not its absence but its having being removed, the element to which the physician entrust his message. The message is always twofold: it communicates intimate sharing to the patient, whereas it is strongly critical towards medical hegemony. It denounces the conflict that a certain way of managing emotions, handed down during medical training, generates in those applying medicine to "real" bodies, to those that someone would define mindful bodies (Scheper-Hughes N. - Lock M. 1987). It seems, indeed, that the sufferance embodied in oneself or in one's own family is one of the most powerful elements in the breaking up of a central biomedical device: that which biomedical system assigns the control of destabilising risks introduced by the emotional element. The choice of hanging up the white coat in these cases is the declaration that there is an attempt in progress for its reinstatement.

Nevertheless, the recent pressures towards a managerial organisation of sanitary institutions and the resulting tendency to transform health into a commercial and marketable product, have introduced – not only in Italy – elements of further complexity. In the perspective of a more general calibration in a neo-laissez-faire sense of the politics of a large part of the highly industrialized countries, in fact, the role of patient tends to be more and more compared to that of a client consumer. Competitiveness becomes the exchange currency for the management of the resources and capital also in the sanitary field. Every "weak" element ends up to render less spendable – in the terms of consumers "pleasure" – the sanitary "product."

So, the same pressures insisting from "above" on the promotion of a "humanization" of medicine and "patient-physician relationship", seem to result deeply and strategically marked in that sense. In other words, one can be more competitive if the formula of the correct patient-physician relationship is found: once the necessary calculations comparing costs and benefits are made, the best strategy seems to be that of the revitalization of general practice, to which all responsibilities regarding of relationships' "humanization" can be delegated. Here therefore the blooming of training courses, seminars and stages to "teach" physicians (above all general practitioners) to "understand" their own patients. But for many of them the strategy is unmasked:

> «They "technicized" also the human element... now they say we must be "human", they pretend to teach us this too! It's becoming foolish...» [lady

> doctor M., 51 years old, during a training course on "patient-physician relationship"].

If the hegemonic pressure goes toward the "technical" construction of "non-technical" physicians, that is to say toward the production of "humanized" physicians, more pleasing to the consumers' public, it is not rare to notice in some physicians lesser or more greatly aware attitudes of deep criticism and refusal of such manipulation. Also in these cases, the physician assigns his own message in a certain way of organizing spaces and technical tools: if the risk is a sort of "lowering" of the general practitioner's role into a simple "entertainer" accompanying the patients to the places where the "true medicine" (the specialist and hyper-technological one) is practised, the exhibition and manipulation of white coat and other diagnostic tools, such as the electronic measurer of diabetes and other blood values, seem to be used as a reminder that the general practitioner is always however an authoritative "scientist" and a highly competent physician. The same message seems to be assigned to the identity claims of "category" in play for the construction of a specific institutional role for general practitioners.

Paradoxically, one seems to express an analogous claim of autonomy also when appropriating some over simplification (general practitioner = friendly physician). Herzfeld, for instance, emphasizes how the stereotype is never a simple "prejudice", but rather a real weapon of power, a tool used to hide specific advantages and strategies: «the resort to stereotypes is in fact inevitably connected to situations in which "identities" are at the stake, since their production allows to people grasping them to develop self-justification strategies» (Herzfeld M. 1992: 67) [6].

> «The effort we have been making in the past years has been just to give a connotation, an image and a role, tasks and functions, to the general practitioners that can be codified and recognized, do you understand? Because what is important for us is that even Universities recognize this...» [doctor G., 52 years old].

In conclusion, we could say that biomedical knowledge founds its own hegemony also on the construction of some devices in which it condenses its more salient features, in order to reproduce and strengthen them throughout their inoculation in the bodies of the coming doctors and – according to other strategies that it was impossible to discuss here – in those of the patients. But it would seem that both patients and physicians learn equally well to make good use of "ways out", that is to say tactics of alternative manipulation of the acquired tools, thanks to which they can "perform" in a dialectical way a proper autonomous dialogue with medical institutions and, in general, with the social order.

A system always has the necessity, to preserve its own setting and internal order, to control centrifugal forces: for this reason containment devices seem to be put in action which, although powerful and effective (the white coat is a good example), acquire ambiguous outlines because they can constantly be overturned and used in a critical way against the system itself (above all when the tactics adopted by physicians are combined with those effected by patients). All this seems to be actually put into play in the midst of the therapeutic encounter, which therefore assumes the shape of a privileged space in which medicine really becomes "creative", that is to say "vital" and then "human."

Notes

(1) The reference is Gramsci's notion of the whole widespread opinions people has about life's matters (Gramsci A. 1975 [1929-1935]).

(2) The translation in English is mine: I worked with the Italian version of the book, so I readapted here a provisional translation that is not correspondent to the original edition. For the complete, correct citation, see the bibliographic references.

(3) Here I refer above all to general practitioners, which most of others are founding their own professional specificity on profound, wide and lasting relationships with their patients.

(4) We must to stress that on the basis of a certain reading of concepts like "embodiment", "agency", and so on, it is evident as United States' anthropology has received as well – profitably but lately – Gramsci's teachings.

(5) Translation is mine (see note 2).

(6) Translation is mine (see note 2).

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