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# 8 Exploring gender and power in clinical encounters

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> I am the nurse from hell and do not try any of that communication shit with me.
> (Robillard,1999, p. 56)

## INTRODUCTION

The purpose of this chapter is to explore issues of power and gender in clinical discourse: specifically between individuals with communication disorders and the speech and hearing clinicians they may encounter. These topics have been somewhat neglected in health care research, which is surprising, given the relatively high numbers of female professionals in areas such as speech-language therapy and audiology. While power in clinical interactions has been explored relatively extensively, it tends to be generally considered in the context of doctor–patient interactions and from the perspective of the doctor. I will therefore incorporate the client's perspective in this chapter, by exploring some first person accounts of power in health care settings. Similarly, I will examine the interactions of professionals in training. In addition, I will examine speech-language therapy clients' experiences of power in institutional settings; and how these clients attempt to resist the established roles institutions encourage them to adopt. Finally, I aim to provide the reader with an opportunity to reflect on their interaction styles in practice and what they may unwittingly be communicating to their clients.

## POWER AND INSTITUTIONAL CONTROL OF THE CLIENT

Many investigations of power in medical or health care interactions have been carried out to date (Danziger-Klein, 1978; Mishler, 1986; Fisher, 1986; Tannen & Wallat, 1993; Heritage & Maynard, 2006). However, these investigations have tended to focus on the perceived "powerful" member of such dyads, such as the doctors in doctor–patient interactions; or nurses in a nurse–patient interaction. Consequently, the client or patient's activity or perspective within these studies is sometimes obscured.

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According to Wang (2006, p. 529), power is "inherent in all dialogues, whether in casual conversation or in an institutional dialogue". In a general sense, power tends to be associated with rank and status, with power being determined by the institutional role of the "professional". The central concern of this chapter is power in a discursive sense; specifically in the context of clinical interactions involving speech, language, or hearing clinicians. Fairclough (2001, p. 46) states that "power in discourse has to do with powerful participants controlling and constraining the contributions of non-powerful participants." In institutional settings, the distribution of power may be clear to participants before the beginning of a verbal interaction, with clear role expectations existing in advance of the clinical encounter. Moreover, institutional discourse tends to be highly conventionalized, such as when question–answer–evaluation/next question exchange structures are used in clinical encounters (Mishler, 1984).

Institutional interactions tend to be goal-oriented, for example, when doctors conduct a physical examination, or when speech-language therapists assess language comprehension, or when audiologists test hearing and give feedback on test results, and so on (Danziger-Klein 1980). This goal orientation of clinicians may in turn, lead to certain biases or inferences with regard to how interlocutors interpret client utterances. More specifically, Wang believes that "due to various asymmetries of knowledge and interests, participants are often thought unequal in institutional settings, where professionals tend to ask questions, and laymen have to respond" (Wang, 2006, p. 535).

Another example of clinician-controlled power relations can be seen in the overt use of questions to control the conversations within clinical encounters. This is illustrated by Wang (2006), who examined the use of Yes/No and Wh-questions in such interactions, resulting in the differential exercise of power. To illustrate, the relative higher frequency of Yes/No questions in institutional domains such as courtroom cross examination and medical interactions can be interpreted as an attempt to restrict and control topics and to thereby exercise power. Similarly, Yes/No questions constrain the addressee's possible responses to a greater degree than Wh-questions. Wang concludes that powerful participants' Yes/No questions and Wh-questions "serve the function of maintaining control over the content of conversation and exercising dominance over the less powerful" (Wang, 2006, p. 545). Accordingly, such a pattern could result in the assured dominance of "the biomedical perspective within which patients' statements are interpreted and allows doctors to accomplish the medical tasks of diagnosis and prescription" (Mishler, 1984, pp. 62–63).

O'Malley (2005) examined the silencing of service users' perspectives in conversation, as a means of sustaining the *status quo* in relation to antenatal care. The women in this study were all attending a midwives' clinic for their antenatal care. The researcher showed them how to introduce their own life world perspectives on pregnancy and birth in interaction, with midwives. Specifically, they learned how to append their stories to their responses to

midwives' questions. By introducing such spontaneous accounts at transition-relevant places during their visits, service users were able to be more powerful in such interactions (Fisher & Groce, 1990; Sacks, Schegloff & Jefferson, 1974). The midwives, however, were found to have ultimate control in terms of responding to these narratives or not, and to interpret these stories of participants' subjective experiences of pregnancy according to a medical model of pregnancy and birth. Therefore, the medical model of pregnancy and birth was found to prevail in this context and alternatives that did occasionally surface, essentially remained irrelevant to the midwives, with the ultimate preservation of the *status quo* in relation to pregnancy and birth as a result.

Menz and Al-Roubaie (2008) explored whether doctors and patients exhibited different patterns of nonsupportive interruptions in their communication with each other, and found this was indeed the case. For example, doctors in general used more non-supportive interruptions than their patients did. However, this difference was more prominent when the doctor was a senior one, and less prominent when the doctor was female. Supportive interruptions were defined as those "characterised by the physicians' maintenance and co-construction of patient-initiated topics" (Menz & Al Roubaie, 2008, p. 649). Nonsupportive interruptions were described as those which constituted a "violation of a speaker's rights and/or being dominance-related due to their non-supportive interruption style" (Menz & Al-Roubaie, 2008, p. 651). Contrary to what might be expected, the more physicians interrupted, the lengthier were the interviews, as the patients repeatedly endeavored to have their main complaint heard. They found that status may be the decisive variable in medical encounters, rather than gender, with those of higher status interrupting more often than those of lower status. They report that "aside from minor significance, however, our data do not reflect any statistically significant difference regarding gender" (Menz & Al-Roubaie, 2008, p. 660). However, they did find that both female patients and female doctors produced more supportive interruptions and maintained the speakers' interests, despite interruption, thus supporting Tannen's findings that women's linguistic style tend to be more relationship oriented (Tannen, 1990).

Gender in relation to communication gives rise to contradictory results arising from differences in methodologies and contexts of data collection. For instance, while Holmes (1992) and West (1998) report that female doctors were interrupted more often by patients, regardless of patient gender, Menz and Al-Roubaie (2008), found status to be the more influential variable in relation to nonsupportive interruptions.

## REDRESSING THE BALANCE IN THE CLIENT'S FAVOR

There are some attempts to redress the balance in terms of paying attention to the voice of the client in institutional encounters (Lorentzen, 2008;

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O'Malley, 2005). Faber and Mazlish (1995), in relation to the field of educa-
tion, consider teachers and pupils not necessarily equal in knowledge or
experience but equal in dignity and it is the element of dignity in relation to
service users that stands out in the accounts below.

## The lived experience of communication in clinical encounters

The opening quote of this chapter is taken from Robillard's autoethno-
graphic account of his experience of motor neuron disease and refers to a
first encounter with a nurse in an intensive care unit in Hawaii, where he spent
3½ months following an acute episode of pneumonia.

In the intensive care unit, his main means of communication with the
doctors and nurses was through the use of an alphabet board; which gave rise
to several problems. The most common problem encountered was that the
nurses did not appear to be able to remember the letters of the words as
he selected them from the board and they "would not write the letters and
words down" (Robillard, 1999, p. 55). Furthermore, he observed that they
would reverse letters, forget the last letter of the sequence, and forget the first
word, by the time he had spelled out a third word. He also noticed that the
nurses had difficulty translating the combination of letters into a word that
they recognized. Other problems included people anticipating words as he
was spelling and completing his sentences thereby "making me say something
that I had not intended" (Robillard, 1999, p. 61). Short-term contract nurses,
anticipating such communication troubles with the alphabet board, often
refused to use it, leading Robillard to conclude that they thought that
working with someone in his condition could be accomplished without com-
munication. He reports that "my insistence on talking and being heard,
expecting what I said to influence behavior, led to a spiral of mutual antagon-
ism between myself and the flying nurses" (Robillard, 1999, p. 56). No male
nurse attempted to use the alphabet board to communicate with him and he
also reports that "males, in general, appear not to have the patience or the
multiple communication rhythms to be able to use alternative means of
communication" (Robillard, 1999, pp. 57–58).

Other problems in communication that he encountered in this setting were
described as "not now" and "out of context". He noticed that he would be
told "not now", either when he indicated that he wanted to say something; or
while he was formulating a sentence, "as a way of breaking the interactional
focus, rearranging the interaction to permit something else to happen." He
was likely to be "cut off" when he was speaking about a particular procedure
that he was undergoing, although he may have been trying to communicate
to the nursing staff important information about how to best handle his
body during the procedure in question. Nursing staff appeared to have three
avenues for "not now." The first avenue was simply saying the words when
Robillard was attempting to communicate. The second was when he was
mid-communication and nurses could cut him off by attending to another

task and by walking away while he was in mid-sentence. The third avenue was when another person interrupted his conversation, "taking over the inter-actional focus."

"Out of context" occurred when he was able to resume the initial topic but nurses had forgotten the original topic and therefore were unable to appreciate the relevance of his contribution. He writes in detail of his experience in intensive care, reporting that he could not control what was happening to his body, nor could he control "the interactions that largely made up my person." Doctors, under time pressure suggested that he formulate what he had to say before they visited him, omitting the possibility that he may have wanted to participate in the conversation as it was taking place in the room. Robillard's account highlights the relatively powerless position of the patient in this context. However, he together with his wife, devised a communication system that involved him communicating by spelling out words by moving his lips, with his wife or graduate students acting as translators or interpreters of his messages. Later he recounts his meeting with the speech-language therapist in the same hospital:

> Speech therapy was first, I will always remember the frown of disap-proval on the speech therapist's face as I failed one speech assessment after another. She told me I had a collapsed upper palate and would never recover. The therapist seemed particularly officious when she told Divina and me that the lip- signing and lip-reading system we had fash-ioned on our own was inefficient. She assumed no-one could learn it and I would be restricted in communication if I did not acquire an artificial voice. "You know, no-one will understand you. You will be dependent on your wife and mother-in-law. Don't you want to be independent?" I was dismissed from the presence of the speech therapist with this question. I had no opportunity to respond.
>
> (Robillard, 1999, p.124)

Robillard's detailed autoethnographic account provides rich insights into the client's experience of clinical encounters, both with staff trained specifically to work with people with communication disorders and with other health care staff. In terms of clinical education, his account can be considered a valuable resource both for introducing clinicians in training in the participa-tion elements of the International Classification of Function (WHO 2001), the social and medical models of impairment, and to autoethnography as a methodology for exploring experiences of disability.

Smith (2008) in his account of his experience of hospital and rehabilitation following the discovery of a demyelinating lesion of the medulla oblongata, recounts his own experience of speech-language therapy. The focus of the extract below is a group speech-language therapy session:

> I can't recall what the group was talking about and it doesn't matter

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anyway but I remember it was this man's turn. He could not find the words. He struggled like a man in chains as we willed him on. Tears of frustration were waiting but he was holding them back, holding it all back. Finally, he burst out:

"This . . ."

"Yes?"

"This fucking illness."

With passion. It was a magnificent, triumphant moment. I applauded. Well I would have done but my hands missed like some spastic seal, but the thought was there. I turned to the young speech-language therapist taking the group and saw she was horrified. Not at his predicament but at his *behavior*. She began to tell him off. For swearing. This gentle man who had so articulated with his small profanity the huge profanity perpetrated upon him and his family was being scolded by some jumped-up, buttoned-up little bitch of a girl who did not have one ounce of his wit or grace.

(Smith 2008, pp. 223–224)

Lorentzen (2008), explored resistance in women's experiences of medical interactions that she found took the form of direct challenges to medical truth claims, avoiding confrontation altogether by ending the relationship, and locating what she describes as "compliant physicians" (Lorentzen, 2008, p. 74). Robillard (1999) engages in resistance by directly challenging the nurses in the intensive care unit regarding their use of time and their treatment of patients, while Smith (2008) attempts to unsettle the balance of power in an interaction with the speech-language therapist in the extract below. The setting for this extract is a group therapy session focussing on swallowing with which Smith was experiencing difficulty:

I'm on a mission to swallow and it becomes clear as she talks in a very slow voice to us dribbling maniacs that she apparently knows as much about it as the primary school teacher she should have been in the first place. She draws a bad diagram of the mouth, oesophagus and larynx. I tell her she's missed out the soft palate and the pyriform sinuses and she knows she's in for a bad afternoon. She decides attack is the best form of defence. "Why don't *you* tell us how swallowing works, Nigel?" she challenges. So I do. In ludicrous detail, with some bits I chuck in just to sound good . . . there was some proper stuff in there just to let her know I quite possibly knew more than she did. I gave a Nobel performance. I stopped. "But I could be wrong," I sneered. "How do *you* think it works?" We stared at each other and suddenly there was a wonderful power shift. First I knew somehow we were equal. Then astoundingly, something gave and I was in charge. I was back in my office, she was a stupid researcher who'd pressed the wrong button on the TV Avid recording machine and wiped the tape. And I was going to discuss that with her. In my fucking

office. Over a hot P45. She met my eyes and that was astounding because
very few people had. And I don't know what she saw in there because
I wasn't entirely sure what was behind them, but she ran in tears from
the room.

(Smith, 2008, pp. 279–280)

Smith also claimed that from the patient's perspective, "the real battle in
hospital, the one you have to win, is for dignity" (Smith, 2008, p. 280). These
may be seen as two extreme examples in terms of power and gender from
the patients' perspective, which by no means undermines their relevance to
the clinician in training. Beck (1999) described her experience of the language
and cognitive testing of her son who had Down syndrome. During testing, it
became apparent to her that her son Adam, had realized that testing stopped
after a certain number of items were failed, and was deliberately responding
incorrectly to get the reward for finishing: a can of Sprite. However, when
she broached this possibility with the tester, she reported him as replying that
"I know it's hard to accept, but we need to be realistic about your son's
abilities" (Beck, 1999, p. 113). She reports:

eventually I did get the examiner to write my interpretation of that test
down on his records. I caught a glance of it later on. It said, "Subject
unable to answer Level One vocabulary. Mother claims subject is 'faking
it'." . . . I can still picture the school board sitting with that document,
sadly shaking their heads over my inability to come to terms with my
child's limitations.

(Beck, 1999, p. 113)

The above examples suggest that "being a client" involves being in a relatively
powerless position in terms of topic initiation, maintenance, termination
and, meaning; mirroring what Fairclough describes as "powerful participants
controlling and constraining the contributions of the non-powerful partici-
pants" (Fairclough, 2001, p. 46). It appears difficult for the client to resist
the structures of power imposed in institutional discourse, possibly resulting
in what may appear to be extreme responses. The examples further reflect
the preponderance of the medical model of disability where the "problem"
is construed as located within the individual as opposed to the social
model of disability where the disabling nature of society is equal, if not
more pertinent (Threats, 2006). Within the social model, "disability is per-
haps not a tragedy but part of life" (Holland, 2007, p. 6). Holland construes
the client as one expert in a constellation; the expert living in the disorder,
in addition to those living with the disorder (family members and sig-
nificant others) (Holland, 2007). These accounts raise complex issues in rela-
tion to gender and power, that in turn raise the question of how clinicians
in training handle power in clinical interactions. The next section explores
this topic.

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## LEARNING TO DO "BEING PROFESSIONAL"

For the clinician in training, there appear to be several delicate factors at play when dealing with clients. For instance, they may be dealing with somebody who has many more years of life experience than they do; or someone of a similar age, someone of a different gender, someone experiencing the receipt of a difficult diagnosis of which the clinician in training has no direct experience. All of these factors may make it difficult to interact in a way that facilitates a sense of equality in terms of the dignity of both participants. Alternative approaches can be found such as narrative-based therapy that facilitates clients telling their personal stories to "increase insight into their problems, promote motivation to change, and . . create the circumstances wherein psychological change can occur" (Leahy & Warren, 2006, p. 320). Furthermore, direct instruction in relation to clinical discourse is an important element of undergraduate training for speech-language therapists at least, in some degree programes (Leahy & Walsh, 2008), involving them in recording, transcribing, and analyzing discourse in various contexts. In some programes, clinicians in training also use methods of discourse analysis applied to clinical discourse for example in the discipline of speech-language therapy at the National University of Ireland, Galway. This section focusses on speech-language therapy interactions, and draws on a session in which two clinicians in training are involved in information gathering with a male client of a similar age to the clinicians. The first extract is from the start of their second session. In this chapter transcription conventions are taken from Silverman, 2006 – see Appendix.

*Extract 1 SLT = Speech-language therapist, C = client*

  1  *SLT1:*   so how have you been keeping since the last day we were speaking to you? (.)
  2  *C:*      ahm alright now (.)
  3  *SLT1:*   yeah
  4  *C:*      ((block)) ah I'm doing a lot of long hours at school like
  5  *SLT1:*   really studying away
  6  *C:*      (2.0) mm I'm home at like (.) half ahm nine or ten at night so
  7  *SLT1:*   god that's tough going
  8  *C:*      [rough stuff rough stuff]
  9  *SLT1:*   [yeah yeah sixth year all over]
 10  *C:*      yeah ((laughs))
 11  *SLT1:*   well what I want to say to you today is that I'm going to do the start of the session
 12  *C:*      yeah
 13  *SLT1:*   and just kind of ask more questions kinda more questions about what we were speaking about last
 14             week
 15  *C:*      kay

16  *SLT1:*  'cos we felt you were so good last week and you were really open about how you felt and

17  every (.) stuff about your stutter and just we kinda just wanna kinda get more into kinda the details

18  of it and be a bit more specific a bit things like that (.) so I'm gonna do the first bit and ask you

19  more questions and stuff like that and then I'm gonna hand you over to X

21  *C:*  right ((smiles and looks at SLT2))

22  *SLT1:*  and she's gonna do (.) she's a couple of things to do with you as well

23  *C:*  okay

24  *SLT1:*  if that's okay (.) and em (.) the first thing I just need to get some of your details like surname date

25  of birth and stuff like that cause we didn't get them the last day

The interpretation of this extract draws on Brown and Levinson's (1987) framework for politeness, Tannen's (1993) work on framing, and Fairclough's (2001) work on the manifestation of power in discourse. I have found these resources can be used in exploring discourse analysis with clinicians in training. The participants in this interaction have met at a previous session and the early part of the extract (Lines 1–10) appear to focus on rapport building. At the start of the extract, the participants appeared to be aligned to what Walsh (2007) describes as a sociorelational frame of talk. The participants of this conversation are engaging in small talk at the start of the session before the therapy tasks are commenced. However, this early phase of the encounter can be seen as suffused with what Fairclough terms power in discourse as the speech-language therapist in training opens the interaction with a question (Fairclough, 2001).

However, in line 3, which could have represented a turn transition in which one clinician could have legitimately taken the floor again, instead responds with a back channel response (*yeah*); following which, the client introduces the topic of school work and long days (Lines 4–6). Then, the clinician, having recently been in a similar position in terms of phase education is able to draw on shared experience. She can then be seen as attempting to convey empathy using similar informal lexical choice e.g. "that's tough going, yeah yeah sixth year all over."

Although the client laughs, the clinician in training does not take up the invitation to laugh (Glenn, 2003), possibly because she is readying herself for a transition to therapy tasks and therefore has difficulty being attentive to the sociorelational efforts of the client. This is a delicate transition for the clinician in training as she attempts to balance rapport building with the goals that have been established for the session. She takes the floor in line 11 and directly introduces *her* agenda for the session using a discourse marker ("well") which Kovarsky (1990) has described as being used as

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session-regulating devices. This discourse marker indicates a transition from rapport building or small talk to therapy tasks: "well what I want to say to you today is that I'm going to do the start of the session . . . and then I'm going to hand you over to X and she's gonna do (.) she's a couple of things to do with you as well . . if that's okay (.) and em (.) the first thing." Here it appears as if the clinician is *announcing* the format of the session in terms of therapy tasks that need to be completed by her and the second clinician in training who also participates in the session ("I'm going to do the start of the session . . . she's a couple of things to do with you as well"). Her use of *I* in "what I'm going to do" and "I'm going to hand you over to X" can be seen as representing the clinicians in training as the more powerful participants controlling the agenda.

There is a sense of the client being informed about what is to take place without being offered an opportunity to actively engage at this point. What may be influencing the clinician in training is her awareness of background information that needs to be collected and which was forgotten in the previous session (line 25), "cause we didn't get them the last day." The clinicians in training at this point can be seen as juggling tasks in term of establishing rapport and gathering contact information. Their position as clinicians in training may make it difficult for them to relinquish control of the proceedings. They would have completed a session plan in preparation for the session and there may be an inclination for clinicians in training to rely on the plan to manage the session, thereby unwittingly heightening the asymmetry in the interaction and effectively excluding the client from choices about the direction of the session.

Furthermore, her explanation for the rationale for the proposed agenda, can be seen as communicating to the client what constitutes a "good client" in this context. In line 16, having introduced her intention to ask questions, the clinician in training talks about her rationale for asking questions using what Wodak (1996) refers to as *pluralis hospitalis*, that is the use of *we*; which can be seen as a marker of power in the interaction:

16  *SLT1:*   'cos <u>we</u> felt you were so good last week and you were really open about how you felt and
17         every (.) stuff about your stutter and just <u>we</u> kinda just wanna kinda get more into kinda the
18         details of it and be a bit more specific a bit things like that

These utterances are interesting from an analytic point of view in that they can be seen as revealing discourses concerning what constitutes a "good client". From the clinician in training's comment here ("we felt you were so good last week") co-located with "and you were really open about how you felt and . . stuff about your stutter", it may be inferred that a good client is one who is open about how they feel, which may place pressure on the client to perform in a particular way in the session.

Politeness theory can be used to explore expressions such as "just kind of ask more questions kinda more questions" (line 13), "just we kinda just wanna kinda get more into kinda the details of it" (lines 17–18), and line 18 "*so I'm gonna do the first bit and ask you more questions and stuff like that*." The clinician in training may be seen as attempting to lessen any sense of imposition on the client in the requests for information by her unspecific and informal use of vocabulary i.e. she can be seen as paying attention to the client's negative face needs (Brown & Levinson, 1987) here while maintaining the focus on therapy tasks. However, the frequent use of unspecific vocabulary such as "*kinda, the first bit, stuff like that*" and so on may be heard as vague and confusing to the client. The difficulty of juggling relationship building and therapy tasks may be a significant burden on the clinicians in training, who in this instance are being video recorded and observed by her clinical supervisor.

Other potentially influential factors that need to be considered here are age and gender. The two therapists in training are female and the client is male and of a similar age; and while this may be facilitative in terms of rapport building, it may also create discomfort, as the clinicians in training attempt to move into more formal therapy tasks, where they are attempting to apply theoretical knowledge in a real-life context. Davies (2003) examined gendered discourse styles in small classroom discussions and found that all-girl groups tended to produce friendly talk that fulfilled both social and educational work goals. This was similar to Coates' observations of how talk forms the basis of women's friendships (Coates, 1996). On the other hand, the talk in the all-boy groups was characterized by using talk to "police each others' behavior and to establish a pecking order of masculinity" (Davies, 2003, p 125). Similarly, Mills (2003) considered gender as an act or a verb; something which is enacted within specific environments. In relation to this encounter here, gender is considered as a potential variable to be borne in mind with the clinicians possibly attempting to use friendly talk to accomplish both social and therapy goals. On the other hand, status may be the more significant variable at work here as evidenced by the setting of the agenda by speech-language therapist 1 in lines 11–19.

**CONCLUSION**

Leahy and Walsh (2008) point out the importance of discourse analysis for attending to the role of the client *and* the role of the clinician in clinical encounters. Gender and power in institutional encounters are useful entry points for clinicians in training to examine their interactions with clients. By exploring their own contributions in interactions, as part of their clinical training, learners can draw on the rich body of extant work in discourse analysis. Moreover, discourse analysis as part of health care curricula could allow clinicians in training to analyze and reflect on their own styles of

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interaction with clients and to understand the influences of their talk on what develops in the clinical encounter; and on the representation of the client that emerges. Also, it can be useful for identifying ideology in relation to what constitutes a "good client". Exploring clinical discourse can also be useful for educators and clinicians in training alike in terms of understanding sessions that do not appear to have gone as planned; and to understand the variables that could be at play in negatively impacting upon clinical interactions.