The limitations of a negotiation model for perimenopausal women

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Abstract

The clinical negotiation model proposed by Katon and Kleinman (1981) puts culture at the very heart of the patient-doctor relationship. As opposed to the asymmetric model that stresses an unequal power relationship between a dominant physician and a powerless patient, this transactional model suggests that we view the clinical encounter as the locus of a negotiation that takes place between two kinds of knowledge (lay and professional), and between two agendas: the doctor's and the patient's. According to such a model, the doctor is taught to listen to the patient's own explanatory model of disease. Using an in-depth analysis of clinical encounters between perimenopausal women and female physicians, and of separate interviews with individual doctors and patients concerning their respective explanatory models, this pilot study puts emphasis on both the limitations of a transactional model and on the strategies deployed by doctors for enhancing the credibility of hormonal replacement therapy.

Keywords: menopause, clinical encounter, negotiation model, transactional model, practice patterns

Introduction

The difficulties in the doctor-patient relationship in Western medicine have been treated as emblematic of its profit-oriented, dehumanising system of health care and as mirroring, in the local setting of the clinical encounter, asymmetric power structures in the wider society. Through a rich diversity of hermeneutic, constructivist, case-study or discourse-analysis methodologies, social scientists have tried to identify the factors that make these doctor-patient relationships problematic (Roter et al. 1988, Cosnier et al. 1993, Roter and Frankel 1992).
As an alternative to functionalist and critical asymmetric models of the doctor-patient relationship which emphasise the cultural dimensions of the medical encounter, some medical anthropologists and sociologists have suggested focusing on more symmetric ‘negotiation’ models. As early as the 1950s, as illustrated by Tuckett (1978), and drawing on the literature on negotiated order in the realm of health care (Strauss 1979), a number of medical sociology studies suggest that beyond the activity-passivity and guidance co-operation models of a doctor-patient interaction there has emerged a mutual participation model that stresses the active role of the patient and a mutual negotiation process. While recognising that ‘the basic consideration in situations of bargaining and negotiation is where the power lies’ (Tuckett 1978: 206), research now focuses on the conditions (local, interactionist or structural) that influence this negotiation. One interesting variant of this negotiation model, developed from a cultural-interpretativist approach, is the cognitive-interpretative ‘transactional model’ developed by Katon and Kleinman (1981). This model stresses the negotiation process between two divergent explanatory models of illness: the medical-clinical model and the patient-popular model. Tensions and ineffectiveness in clinical encounters are thus explained by communication problems, not only between two active actors (doctor and patient), but between models that contain the patient’s and doctor’s ‘understanding of the cause of his illness, its pathophysiology, expected course and prognosis, and the treatment that he believes will be or should be administered’ (Katon and Kleinman 1981: 259).

The clinical encounter is the local setting in which the patient meets the health care system, and talks not only about the disease itself, but about his/her experience of illness and sees his/her lay interpretations and socio-cultural construction of illness confront those of the professional (Kleinman 1988).

This model is ‘cognitive’ since it ‘focuses on what sickness and health mean to individuals and how, as a consequence of these meanings, people act in specific ways regarding treatment’ (Lazarus 1988: 34). As Cicourel (1987) suggests doctors, using schematized and procedural knowledge, work to ‘translate’ the patient’s idiomatic, ambiguous, and unstructured explanations into unambiguous language. The model is also ‘transactional’ in that ‘Patient-doctor interactions are transactions between explanatory models, transactions often involving major discrepancies in cognitive content as well as therapeutic values, expectations, and goals’ (Kleinman et al. 1978: 254).

Katon and Kleinman, then, propose three practical clinical social science ‘methods’ to enhance the quality of clinical teaching and practice: (1) eliciting the patient’s explanatory model, as the first step in a general psycho-social assessment; (2) determining the patient’s illness problems i.e. ‘the experiential, family, economic, interpersonal, occupational, and daily life problems created by the disease and its treatment’ (Katon and Kleinman 1981: 260); (3) the negotiation between the patient’s and the doctor’s
explanatory models of that illness episode. To respect these methods, Katon and Kleinman suggest that the clinical encounter should follow six stages: (1) the development of a therapeutic or working alliance through the establishment of an empathic milieu; (2) the eliciting of the patient’s explanatory model and illness problems; (3) the presentation, by the doctor, of his explanatory model in layman’s terms; (4) the shifting by the patient toward the doctor’s model in order to make a working alliance possible; (5) the open acknowledgement by the doctor of discrepancies between exposed models. The final result of this negotiation process is: (6) ‘the change of position of one or both of the doctor and patient in order to set up a mutually agreed position’ (Katon and Kleinman 1981: 269).

The contributions of this transactional clinical negotiation model have been widely recognised by the medical profession itself. Models of the doctor-patient relationship now integrate a patient-centred approach (Keller and Gregory 1994, Stewart et al. 1995) that transcends the traditional paternalistic and informative model in favour of an interpretative and deliberative model based on respect for folk knowledge and values (Emmanuel and Emmanuel 1992), on the encouragement of active participation in the decision-making process (Ballard-Reisch 1990), and on the negotiation of a prescription (DiMatteo et al. 1994) that satisfies both patient and doctor. Moreover, it has been suggested that the sharing of control between less assertive physicians and their patients increases the level of patient compliance, improves outcomes of patient care (Wigginton Cecil 1998), and best corresponds to patient-centred approaches (DiMatteo et al. 1994).

Katon and Kleinman’s cognitive-interpretive transactional model rests more or less explicitly on the following assumptions: first, that both doctor and patient each have explicit models that define the symptoms, causes, outcomes and adequate therapies of a given health problem; secondly, that elements of these models are made clear in the clinical encounter; and thirdly, that the models are negotiated in such a way that both patient and doctor reach a consensus on the nature and course of the problem and its treatment.

The menopausal transition, perimenopause, defines a context in which medical caregivers and middle-aged women are susceptible to clashes over the meaning of this event (MacPherson 1992, Kaufert and Lock 1997). Solutions provided by the medical community tend to encounter doubt and animosity on the part of women. For example, in the province of Québec, 75 per cent of middle-aged women will consult their physician at menopause, while a third of those aged 45–54 are said to be dissatisfied with the support and information they have received (College of Physicians, Québec 1988). Within the limits of a qualitative in-depth analysis of a limited number of clinical encounters, the first purpose of this paper is to pursue the theoretical analyses of the doctor-patient relationship. To do this, we shall compare patients’ and physicians’ explanatory models of menopause, and
look at the extent to which the methods, stages and assumptions, on which the Katon and Kleinman transactional model is based, are respected.

Source of data

Data gathered in this pilot project came from three sources: individual interviews with physicians and with their female patients visiting for symptoms related to the menopausal transition, and from audio recordings of clinical encounters in doctors' offices.

One of the goals of this pilot project was to assess the best strategy for randomly recruiting physicians and perimenopausal patients for a larger study. Criteria for including general practitioners (GPs) were: to treat middle-aged women for perimenopausal-related reasons, to agree to participate in an audiotaped, semi-structured interview, to recruit three perimenopausal women who would also participate in an individual audiotaped interview, and to audiotape the clinical encounters. During the process it became obvious that only female physicians were able to recruit patients. Finally, seven general practitioners (five females; two males) were interviewed in their offices using open-ended questions. Topics investigated were related to their understanding of menopause, its causes, consequences, and symptoms, as well as non-biological factors (i.e., family, marital, social, economic) that might be responsible for symptoms usually associated with menopause. Doctors were also questioned on the advantages and disadvantages of hormonal replacement (HRT) and alternatives to such medication. They were each invited to audiotape clinical interviews with women who had mentioned perimenopausal problems at the very onset of the interview or at a previous consultation for another health problem. Patients were then informed of the general research topic and invited to agree to the audiotape and the confidential treatment of the data. Only four of these seven doctors (all female, with 10 to 15 years experience) succeeded in doing so and 12 clinical interviews were audiotaped and analyzed. The 12 women were white French-Canadians from various socio-economic backgrounds, aged between 40 and 55 years; five had a university degree). Some days after the medical encounters, they were interviewed. An open-ended structured interview schedule covered questions on their beliefs related to menopause, its meanings, its symptomatology, its causes, and its physiological, marital, familial and sociopsychological consequences. They were also invited to talk about what they knew about HRT. Other topics included their goals for and expectations of the visit, as well as how much they knew about the benefits of modifications in lifestyle.

All the audiotaped individual interviews and clinical encounters were transcribed verbatim and were codified with the help of NUDIST software. Data analysis was combined with features of process analysis, looking at...
how discursive processes (i.e. how well divergent explanatory models were negotiated) correlated with outcome (i.e. the prescription or not of hormonotherapy). Doctor-patient conversations and individual interviews were microanalysed, using content and discourse analysis. This multi-dimensional interaction analysis (Charon et al. 1994) captured the content, process, and context of the medical encounter.

Results

Clinical encounters and the components of explanatory models

Menopause as a period of transition

For all the women in this study, menopause was not considered a disease. While it was experienced as a change in their reproductive system accompanied by symptoms, it was primarily a transition towards a new phase in their lives. The women’s narratives spoke of the transient phase of progressive loss of menstruation, not of the future 30 years or so of life without it. This transition, which they defined as ‘becoming menopausal’ was not automatically seen as negative. Some women saw it as a transition toward a ‘second adolescence’ and for others it represented a new beginning in their lives as women.

I see my menopause as a second adolescence, in the sense that it’s an upheaval. It’s a physiological upheaval that changes every aspect of my life . . . I personally can’t make a distinction between the inconveniences of menopause and the lifestyle issue. I see my early menopause at 40 as a chance to say that there are maybe things in my life that aren’t right. Maybe I’m worn out. My attitude to that has been: okay, then I have to change certain things in my life, make some different choices, change my way of life, look at my life differently rather than take hormones . . . I can’t look at this like an illness, it’s a natural stage that all women go through and that’s really why I have trouble taking HRT. I think it’s a natural change (Patient # 12).

They also, however, felt that the medical impacts were just around the corner: menopause also meant symptoms, physiological as well as psychological disorders, that had brought them to consult their physicians. The women established a link between modifications in their menstrual cycle and physical symptoms such as sleeping disorders, night sweats, sudden perspiration and hot flashes, the latter acting as the core symbol of menopause in this population. All women associated menopause not just with physiological experiences but also with psychological symptoms such as depressive effects, nervous tension or irritability.
Similarities were to be found in the physicians’ discourses. Here too, menopause was not a disease but ‘a transition between two ages, like puberty’, a normal ageing process. Evidently, the physicians’ discourse was more technical: Menopause is related to a slowing down in ovarian function and a reduction in hormonal production. It is also associated with a list of somatic (e.g. hot flashes, night sweats, vaginal discomfort, insomnia) and psychological (e.g. irritability, mood modifications, depressive effects) symptoms. According to the physicians it was mostly somatic symptoms that triggered the process of seeking medical help. But what characterised the physician’s discourse was its insistence on the long-term impact of menopause on women’s health through an increase of the risks related to cardiovascular disease or osteoporosis. ‘It is a normal physiological process related to ageing, but can generate disease if not treated’ said a physician. Menopause is seen not as a disease, but as a major risk factor for disease.

In the clinical encounter, as opposed to the interviews, however, in both the patients’ and the physicians’ discourse, it was the technical, symptom-based, and biomedical perception of menopause that dominated. Women were looking for information about the normality of the symptoms they had experienced. Physicians gave comprehensive explanations of these symptoms and questioned patients on other clinical signs related to menopause. In fact, neither physicians nor patients ever talked of menopause as a period of transition, a theme that dominated individual interviews. Physicians relied on lab tests to prove that menopause had occurred. Though menopause is a clinical entity to be judged upon clinical grounds, physicians tested for Follicle Stimulating Hormone (FSH) and Lutenizing Hormone (LH), two biological markers for ovarian failure. Furthermore, physicians emphasised the long-term consequences of oestrogen deficiency and gave plenty of information on heart disease and osteoporosis. A large portion of the clinical interview was thus used to convey those aspects that might threaten a healthy ageing process and by extension, a woman’s ability to look after herself.

The impact of individual situations and lifestyle

Women’s explanatory models recognised that menopause-related symptoms cannot be explained by hormonal imbalance alone. In what may be considered as a lay ‘social ecological model’, all of them established a link between somatic as well as psychological manifestations and either lifestyle or life context. Women were conscious of the fact that socioenvironmental conditions such as stress, caused by professional activities and/or by domestic responsibilities, could sometimes explain the onset of those symptoms. Furthermore, the impact of menopause on marital, social, and professional life was recognised in the form of irritability, loss of energy or psychological distress. But what interfered with daily life was not menopause per se, but the psychological manifestations of somatic symptoms. The women (10 out of 12) explicitly referred to menopause symptoms as related to professional,
familial and social pressures. They were also concerned about the impact of menopause on the quality of their interpersonal relationships. Three women explicitly referred to menopause in terms of a necessary transformation in their life philosophy, especially towards social relationships. They had become more selective in their friendships.

I don’t feel like making any more compromises with friends that do not accept me as I am, that do not think like me. I know, now, that I will not change and that I don’t have to please everybody. I will keep the friends that accept me as I am, who won’t make me unhappy (Patient # 2).

The very justification of this new form of sociability was that ‘we have spent our lives thinking and acting for others. We must now take care of ourselves’ (Patient #6). So menopause was not thought of as a mere constellation of symptoms, but was seen as a trigger for adopting a new life philosophy: ‘we must look deep down for the reasons for symptoms, such as our dissatisfaction toward our way of life’ (Patient #7). This new quest for wellbeing opened the door to the medical discourse on the preventive benefits of HRT on the quality of life, which, as we shall see, was central in the medical strategy to promote hormone consumption. All the women also agreed that improvements in diet, an increase in physical activities, good sleep patterns and abstinence from smoking would reduce the symptoms related to menopause.

Doctors also recognised the impact of living situations on menopause-related symptomatology. All of them referred to sociocultural causes such as the stress related to performance of familial and professional duties, or to overall changes in women’s social roles. Menopause, in the physicians discourse, happens at a particularly stressful stage of a woman’s personal and social life, and cannot be reduced to physiological modifications.

They see themselves getting older, and to face this requires good psychological preparation, especially if these women have dedicated their whole lives to their family members. . . . It implies an in-depth redefinition of a woman’s social and familiar role, especially for those who had found the source of their self-esteem in their role as mother and spouse. Those who work outside of the home, who have a professional occupation, they are anticipating retirement. It is the degree of psychological preparation over the past 30 years that will determine how big an impact menopause will have. Menopause crystallises the shock of the transition toward the 50s (Doctor #3).

The adoption of healthy habits (e.g. quitting smoking, improved diet, physical exercise) is not enough to counterbalance the impacts of hormonal imbalance. Better living situations and healthier behaviour could modify but not erase the physical and psychological manifestations of menopause.

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Within the clinical encounters, however, there were few references to the impact of the living situation, stress, healthy behaviour, or to the positive impacts of the adoption of a new life philosophy. Only one physician questioned the patient on topics related to family or professional factors. Seven women tackled the topic of the impact on family life of the onset of menopause-related symptoms, and four out of five of those who had a profession talked about it, although it took a little encouragement. But it never became a subject of further investigation by doctors. Only marginal references were made to the benefits of appropriate management of socio-environmental conditions and lifestyle.

**Prescription of HRT**

A last component of explanatory models consists of discourses on treatment. Ultimately, it is this issue that was supposed to be the subject of intense negotiation between doctors and patients. The doctors’ assumptions are very clear: once the start of menopause is confirmed by laboratory tests, and once they have established which possible side-effects might affect which women, HRT should be prescribed to all menopausal women. In four encounters out of 12, two doctors applied some pressure for HRT prescription, convincing an unwilling patient to take it. But on the whole, physicians limited their role to answering the patient’s questions, and to explaining the benefits of HRT in terms of symptom control and in terms of the quality of life and well-being. One physician was even on the defensive when insistently questioned on the relevance of HRT. However, four of the women admitted they had changed their position to being in favour of HRT after the information received in the clinical encounter. In total, four encounters resulted in a formal prescription of HRT, while in the other the decision was postponed until the results of laboratory tests had been received and a further clinical investigation undertaken. In only one encounter, in which both doctor and patient showed a strong commitment to listening to one another, could we say that true negotiation took place.

**Strategies for enhancing the credibility of HRT prescriptions**

*The clinical encounter as a source of information and of reassurance*

Women identified three main sources of influence on their portrayal of menopause: the media, discussion with friends, and medical visits. But they complained about the plurality of opinions available on the topic and the many contradictions implied. These divergent messages were a source of stress, insecurity and powerlessness. The ‘divinatory’ function of blood tests, mammography and other technical devices used in assessing the risks related to HRT prescriptions, also constituted for the women a somewhat frightening experience in their ‘rite of passage’ to menopausal status.
The patients saw information accessible through the media as both a tool for empowerment and a source of insecurity. But they did not perceive this information as neutral. They were conscious that the media tended to medicalise menopause and treat it as a disease. Some of the women recognised that the more they read on menopause, the more they came to see it as a threat to their health. The media were said to be apt to promote the benefits of HRT, and to claim that without it one was exposing oneself to cardiovascular disease, osteoporosis, or other illnesses. One patient even talked of media ‘brain-washing’. Another saw the media as an additional source of insecurity:

The media talks a lot about HRT and about cancer. In my personal case, as soon as I started menopause I also started to worry about being ill. . . . Good health has always been very important to me, and they say that once you start menopause you become more fragile, that you’ll have sensations that you won’t recognise. In terms of the media, it’s threatening. If you don’t take hormones, you don’t take this or that medication, you’re going to get this or that illness. I think that, in itself, is basically a very unhealthy message, and that we’re really swamped with negative and threatening messages, far more so than men (Patient #9).

In such a context of divergent and worrying messages, for some of the women, the physician had become the last somewhat objective and credible source of information, and appeared less biased than the media: ‘If it’s a doctor who talks to me, I will listen. If it’s a journalist, I will not’ (Patient #12). Here again, it didn’t mean that these patients had lost all critical analysis of doctors’ discourses. For two of the patients, doctors appeared ‘to be party to this enterprise of selling HRT’. The role of doctors, then, was ambiguous: they were the official relay of biomedical discourse, and treated menopause as a physiological dysfunction. At the same time, they were consulted to reassure patients against fears fed by the mass-media that linked menopause to osteoporosis, cardiovascular disease or breast cancer. Doctors were seen as both confidantes, to whom patients felt free to talk about their fears, and as the intermediaries between pharmaceutical companies and their clients.

Some patients recognised that, as soon as they relied on a doctor’s advice, they lost part of their autonomy. One patient even talked of a sort of ‘dispossession of one’s own body’. Reassurance and the alleviation of fears took place through a kind of loss of autonomy:

For sure, we have the responsibility for getting information from the doctors. They are the specialists and we must trust them and their prescriptions. However, this is not as easy as it looks, because it is our bodies that are concerned. We believe that since it is my body, my
symptoms, I must know it better than anybody else. But in the end, we have to accept the doctor’s recommendations. I found the relationship with doctors very difficult, more complicated than with anybody else. I know myself, it is my body, but at the same time I know nothing and must rely on the opinion of someone who is not in my body. It’s an ambiguity I am not comfortable with. As I get older, though, it happens more and more. I have the feeling of being taken away from myself (Patient #4).

The information process was also a source of power for the doctors. The control of knowledge is a modern source of domination and power. As candidly stated by one of our female doctors: ‘information is an asset in our power relationship and our ability to sell compliance to HRT’. Providing information was not a waste of time; it was a strategy that convinced patients of the benefits of biomedicalisation, a strategy that gave credibility to the doctor in the patient’s eyes.

The clinical encounter appeared to be a source of reassurance and of alleviation of fears in the medical as well as in the patient’s discourse. Questioned on their expectations of the medical visit, patients insisted that, in addition to a quest for information, they expected to get reassurance from their visits. This reassurance, they hoped, would come through information adapted to their personal situation, and be based on the doctor’s listening to their individual experience and performing an in-depth analysis of their personal situations. Analysis of the clinical conversations confirmed that a large part of the interview was devoted to answers given by the physicians to patients’ questions. Moreover, for all 12 patients, the level of satisfaction felt about the clinical visit was high, as can be seen from the following comment: ‘I am satisfied with the information I got and I now feel more reassured about the normality of my symptoms’ (patient #7).

The ‘ethical’ argument of prevention and the quality of life
Even if the doctors saw menopause as a normal ageing process, they underlined the long-term consequences of its symptomatology on women’s quality of life. This theme of the quality of life is of the utmost importance in the physicians’ discourse, as it plays a central role in suggesting HRT to patients. The theme cropped up in individual interviews, but still more explicitly in the clinical encounter. It was the major argument used to justify the prescription of hormones to women who ‘often live with the discomforts of this unavoidable condition too easily and passively’ (Doctor #3). Considering the positive impacts of HRT in preventing fractures related to osteoporosis and in preventing cardiovascular disease, HRT in doctors’ discourse was the primary protector of quality of life and wellbeing for women with more than 30 years of post-menopause life expectancy. HRT was also presented as an easy and efficient complement (or even alternative) to changes in lifestyle. Even if physicians were well aware of the importance
of maintaining a balance between the benefits, in terms of symptom control, and the risks, in terms of an increased risk of breast cancer, prevention was still a central argument in justifying the medical treatment of menopause in the doctors’ explanatory models:

Prescription of HRT is justified in order to control short-term symptoms, but mostly for the wellbeing of the patient in 10 or 20 years’ time. That is the way I present it to them. From now on, hot flashes, irritability, fatigue, all those symptoms will be under control. But, exaggerating only a little, I tell them that it will revive their youthfulness (Doctor #5).

Medical power here is thus derived not directly from an organic asymmetry between patients and professions, nor between lay and scientific knowledge, but instead from an ethic of wellbeing, from the commitment to work on behalf of the patient’s quality of life. Beyond the medical management of symptoms, medical discourse is directed toward protection against suffering, and is based on an ‘ethical’ justification of medicating for menopause. At the heart of this ethic of medicalisation are the arguments for a necessary balance between risks and benefits, and on the right to quality of life. Doctors justify their moral duty to prescribe medication (the benevolence principle), even if in the face of another biomedical principle, patient autonomy.

Discussion

The in-depth analysis of this small sample of clinical encounters allows us to suggest that the methods, stages, and assumptions on which Katon and Kleinman’s transactional model depends, are not fully respected, at least in the context of encounters between perimenopausal patients and doctors.

*Presentation by both patient and doctor of their explanatory models of menopause and HRT*

Doctors presented their model (stage #3) through the information given to patients about the symptomatology, the course and the hormonal treatment of menopause. The picture is less clear for the patient’s model (stage #2). The clinical interview followed a somewhat traditional format, based on questions and answers about symptoms, family antecedents of cancer, and so on. While doctors answered patients’ questions on HRT, alternative medicine, or contradictory advice they had received via the mass-media or from significant others, they never encouraged them to reveal their beliefs regarding the symptoms, causes and outcomes of menopause. As we have seen, it was the patients who tackled the topic of the relevance of their life context or lifestyle to their symptoms. Doctors, however, willingly discoursed on their own medical explanatory models. The third stage of the
clinical negotiation model is probably the one that was respected: doctors took a lot of time to explain the relationship between reported symptoms and hormonal imbalance as well as the benefits of HRT in preventing long-term illness.

We may also have doubts that the first assumption could be respected; patients do not seem to have an explicit ‘model’ that defines the symptoms, causes, outcomes and adequate therapies related to menopause. Patients’ folk knowledge is not a model, if we define a model as ‘a way of constructing reality, ways of imposing meaning on the chaos of the phenomenal world’ (Eisenberg 1977: 18). As Cicourel (1987) says, from an ethnomethodological perspective, most of the daily use of knowledge is not accessible to a person’s consciousness, because we are limited in the amount of information we can reflect on in a self-conscious way. Our perceptions are seldom described, and require reflection or self-conscious attention if they are to achieve verbal coherence. On the patient’s part, at least, to postulate the existence of a popular explanatory model of menopause would imply the reification of a vague, indeterminate, unstructured knowledge. This could possibly explain why elements of these models were not made clear in the clinical encounter. Lately, Kleinman himself has felt ‘extremely uncomfortable when [the explanatory model concept] is misapplied as an entification of medical meanings as “beliefs”; things that can be elicited, often outside the vital context of experience’ (Kleinman 1995: 8). So, although we observe that better-informed patients have, in fact, some information and beliefs on menopause-related issues, we cannot talk of a structured model from which the patient can shift in order to reach a mid-term agreement with the physician’s explanatory model and prescription (stage #6). Results suggest that in clinical encounters explanatory models have not been used here ‘as a methodology for clinical self-reflexivity, for pressing against biomedical crystallizations, for laying hold of the sources of clinical miscommunication... for negotiation, and listening, not the usual mode of clinical interrogation’ (Kleinman 1995: 9).

The clinical encounters we reported on were not a milieu that helped overcome the ‘conceptual differences’ that threaten to break down the therapeutic alliance. In spite of the open-mindedness of female doctors to the reality of menopause, they did not modify their clinical explanatory models of menopause. On the patient’s part, even if the women increased their knowledge of menopause and HRT, it would be an exaggeration to say that they modified their explanatory models. Thus, the medical interviews were not a moment of real communication between two orders of knowledge or between two explanatory models. Much work has yet to be done to make the clinical encounter a process of ‘translation between differing “cultural” interpretative systems for deciding what is clinical evidence, rationalizing treatment choice, and assessing outcome’ (Katon and Kleinman 1981: 269). In the perimenopausal context this has been regarded as acutely necessary, since one goal of the initiative named Health People
2000 is to increase to 90 per cent the proportion of perimenopausal women who have been counselled on HRT (Hampson and Hibbard 1996).

**Determination of the patient's illness**

The clinical interviews focused rather on the technical appraisal of menopausal signs, and on the long-term impact of menopause on health. All seven physicians recognised that a more global appraisal would require much more time than the few minutes devoted to the clinical investigation. Consequently, little attention was devoted to the patient's illness problems, by either doctors or patients. Our data, then, are supportive of what has been reported before by similar research. While women acknowledge the importance of psychosocial aspects of their life while they experience the menopausal transition (O’Connor et al. 1995, Legare et al. 2000, Quine and Rubin 1997), they are primarily concerned with short-term symptoms (Hampson and Hibbard 1996) that could impair their functional abilities. Moreover, symptoms, as described in the physicians’ explanatory model of menopause, have often been cited as being more severe than is thought by women themselves (Delorey 1989). Overall, little emphasis has been put on the eliciting of patients’ illness problems related to their daily, family and professional living conditions. This conclusion must be qualified by a new look at the concepts of medical and patient voices.

**A plurality of voices and discourses**

Mishler (1984) has suggested that clinical encounters can be seen as a dialectic between the voice of the lifeworld and the voice of medicine. The voice of the lifeworld, through the patient’s discourse, refers to the events and problems experienced by patients in their sociocultural and biographical context. The medical voice, dominated as it is by technoscientific concerns, such as biophysiological factors and aetiology, decontextualises the lived experience. It thus ignores accounts patients give of their living situations as well as of their emotional needs and expectations. From his analysis of the structure of clinical interviews, Mishler concludes that ‘there is a systematic bias to [the physician’s] focus of attention; the patient’s reports of how the problem developed and how it affects her – the “life contexts” of her symptoms – are systematically ignored. The physician directs his attention solely to physical medical signs that might be associated with the primary specification of a symptom’ (1984: 70).

Based on data presented here, we cannot completely agree with Mishler. While it is true that doctors did not refer to the patient’s life context in the clinical setting, it was not true in the individual interviews. There seemed to be two medical voices: the professional voice, sensitive to the social and psychological context of the symptom manifestations, and a clinical voice, which under productivity imperatives, expert-role and legal concerns, fell back on the classical decontextualised diagnostic interview and on technical investigations. If it is the clinical voice that patients experience in the clinical
encounter, we may hypothesise that it is at least partly conditioned by the professional one. On the other hand, it seems that patients show a similar disinterest in reporting contextual factors, focusing rather on their need for information and reassurance. So, popular knowledge related to menopause seems to be expressed through two different voices: the lay voice of women experiencing and making sense of menopause-related symptoms in the context of their social, familial, professional and affective life; and the patient’s voice that, in the formal clinical context, more or less consciously focuses on symptoms and a quest for reassuring technical advice, and ignores the lifeworld.

We therefore suggest that the clinical encounter could be seen as the locus of a plurality of multidimensional discourses. The physician’s discourse included, in individual interviews if not in the clinical encounter, concerns for the social context of the patient’s lifeworld. At the same time, many patients asked for a strong, credible clinical voice that would reassure them in the context of the multiple contradictory discourses suggested by mass-media as well as by friends. We agree with Lacoste (1993: 53) who criticises the critical approach for two reasons: first, for its exclusive and univocal association between the voice of the lifeworld and patient discourse on the one hand, and the voice of medicine and doctors on the other; secondly, for its lack of dialectical consideration. We suggest, however, that this dialectic should, in addition, be analysed at the level of the somewhat schizophrenic split between the clinical and professional voices on the doctor’s part, and between the lay and the patient voice on the part of the sick person.

Between negotiation and persuasion
After the building of a working alliance and the reciprocal open acknowledgement of discrepancies between exposed models, the negotiation process, according to Katon and Kleinman, should end with ‘the change of position of the doctor or patient, or both, in order to set a mutually agreed position’ (stage #6). In the clinical encounters under study here, doctors showed flexibility, and they adjusted their recommendations to the receptivity of their patients. There was, however, no negotiation on the question of HRT prescription in spite of adaptations to its timing, as the physician waited for results of blood tests. Instead of a negotiation process about the prescription, what seemed to be happening was a process of medical persuasion, utilising some persuasion strategies, to which patients reacted by analysing their specific cases in the light of complementary information supplied by the physician.

Implicitly, for Katon and Kleinman, negotiation presupposes that both parties start from somewhat divergent positions, and then accept at least part of the arguments of the other party in order to reach a consensual position on both the issues of menopause and on the initiation and timing of the actions. In accordance with these premises, results suggest that the interaction between doctors and perimenopausal women is better under-
stood as a complex asymmetric persuasion process than as a negotiation process. We observed that there was a consensus, from the start, between doctors and patients on the nature of menopause. The first component of the patient’s explanatory model was characterised by blurred frontiers between normality and disease, a position shared by physicians. Menopause was not a disease per se, but it could become one if symptoms appeared. This point did not have to be debated. Patients therefore felt justified in consulting a physician.

Was there a consensus on HRT treatment? Our results show that there was a negotiation process in only one of the 12 clinical encounters. In the other 11 encounters, it would be more accurate to talk of a one-way persuasion process, through which doctors tried, albeit gently and prudently, to rally the patient to their own unshakeable position on the clear, positive relation between the advantages and disadvantages of HRT. Patients were active, questioning doctors on the benefits of HRT, its secondary effects, asking information on alternative therapies or medication, and so on. But this was not negotiation, since there was only one possible result: to accept HRT. We believe that even if doctors did not put pressure on patients and seemed to respect their decisions, they did not modify either their own initial positions or that of the patient. This could lead to what has been referred to as poor compliance with HRT, which has developed into a major field of research (Hunter and Liao 1994). Even an attempt to persuade that is civilised and respectful cannot be considered a negotiation.

Although we can hardly speak of a negotiation process, it is not because the clinical encounter is the site of a coercion process. As Griffiths (1999) presented it, ‘... women seemed to resist medicalisation wanting to avoid taking medication except as a last resort, ...’ Our results also suggested that the doctors’ role would be better defined as that of a ‘guide’ which informed the patients in order to convince them of the benefits of taking medication, but which let women make the final decision, free from any excessive authoritarian pressure.

Limitations of the negotiation concept
According to Allen (1997), negotiation models have two limitations. First, ‘A frequent charge is that the approach assumes everything is indefinitely negotiable and is thus unable to deal with limiting factors in negotiation settings’ (1997: 499). Not everything is either equally negotiable or negotiable at all. This is the case for doctors prescribing HRT. The second limitation is the lack of clarity in the definition of negotiation in studies in the social sciences. It is variously referred to as bargaining, compromising, trading off, and reaching a formal agreement. It can range from tacit understandings to explicit contracts, and can vary in its time frame from one-shot to sequential, repeated, serial or on graduating scale from immediate transactions to those occurring over a period of time (Allen 1997:...
We can only agree with Allen that ‘this lack of conceptual clarity is problematic, particularly if the research aim is to compare the extent of negotiation in different settings or make generalizations about the types of conditions that encourage or inhibit negotiations’ (1997: 515). In our study, there was no negotiation on the basis of compromise, or ‘reaching a formal agreement’ between two parties who both had clear objectives. However, both patients and doctors tacitly understood the other’s position. The ultimate issue of the clinical encounter (prescription of HRT) was not bargained for by doctors, but a delay was negotiated. Finally, in the majority of encounters, there was no one-shot decision but a serial (occurring over more than one meeting) and long-term process.

The reassuring power of information

Analysis of the doctor’s discourse in these clinical encounters allowed us to identify two main ‘strategies’ used to convince women of the usefulness of HRT. First, their attempts to convince included a strong emphasis on the positive effects of HRT on the long-term quality of life, and concurrently a very low emphasis on the benefits of modifications of lifestyle. The merits of HRT were treated as part of an ethical discourse in which the doctors’ credibility was based on concern for the long-term health of their patients. Secondly, we suggest that the information they provided can itself be considered a strategy and not simply a list of neutral facts. In contradiction to the asymmetric critical model, the women saw the medical encounter not as a battle in the context of an asymmetric power structure, but as a way of seeking reassurance. Without denying that the provision of information is an indication of an asymmetric relationship between a physician and a vulnerable patient – between lay and professional knowledge – we may still say that patients expect the medical encounter to be a reassuring process. They seek confirmation that their symptoms are linked to menopause, that HRT would be a good idea in their individual case, or as good as alternative medicine. Patients are looking for information based on in-depth personalised clinical analysis. We can suggest, following Silverman’s analysis of (HIV) counselling, that doctors’ ‘medical voice’ can be seen as a ‘discourse of enablement’ that ‘helps [free to choose clients] develop new understandings about how their troubles might be managed’ (Silverman 1997: 193).

It is necessary to distinguish between medicalisation and medical dominance. For ‘medicalising a condition can have constructive outcomes, especially for people with chronic and refractory conditions’ (Broom and Woodward 1996: 359). In this study, it would be inappropriate to talk of medical dominance, in spite of the fact that doctors were engaged in a process of medicalising menopause, through persuasion strategies, to convince women of the benefits of HRT. The moderation shown by both doctors and patients in their discourse confirms the point that ‘neither doctors nor patients have unitary interest in more or less medicalization’, and that ‘the challenge for both doctors and patients is to mobilise

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medicalisation when it is appropriate, and to do so in a collaborative manner rather than under the sway of medical dominance’ (Broom and Woodward 1996: 376).

The limitations of this study

The limitations of our methodology must be acknowledged here. In the context of a pilot study, the sample of clinical encounters is limited. The fact that the doctors who succeeded in recruiting patients were female with more than 10 years’ experience suggests that GPs treating middle-aged women for perimenopausal reasons are distinct from the larger pool of GPs. This introduces an important bias, due to the fact that women are recognised as being more open to a patient-centred approach (West 1990), and more sensitive to a problem like menopause. However, it also confirms that there exists a subspecialisation and a fragmentation of medical practice even in primary care settings (Hennen 1999). The methodological approach nevertheless allows a confrontation between the medical and the popular discourses about menopause and HRT, as expressed in the dynamic context of clinical encounters outside the clinical setting. The analysis of these co-constructed discourses allows us to suggest some hypotheses about the limitations of this transactional model, especially in the context of a health problem that does not need rapid intervention. We must also acknowledge that all seven physicians recognised that a more global appraisal would require much more time than the few minutes devoted to the clinical investigation. Moreover, the cross-sectional nature of our approach might not give full credit to the more longitudinal aspect of the relationship between physicians and their perimenopausal patients. Finally, the methodological limitations of our study do not permit us to make conclusive statements about the impact of medical discourse on women’s decision to take HRT or not. A conclusive analysis would require a longitudinal follow-up of more patients over several clinical encounters and a monitoring of their patterns of HRT consumption in the months following a prescription.

Conclusion

As suggested by the analysis of these clinical encounters, a cognitive-interpretativist clinical negotiation model, based on a constructive communication between lay and medical explanatory models of menopause, and negotiation around the issue of HRT prescription, does not express the multidimensional nature of the clinical encounter. In the context of perimenopause, the methods and stages proposed by Katon and Kleinman (1981) to enhance the quality of clinical practice are only partially applied by physicians. There exists a therapeutic or working alliance based on the
doctors’ response to the patients’ quest for information and reassurance, the sharing of a common conception of blurred frontiers between menopause as a normal ageing process and a disease, and the patients’ responsiveness to the ethical discourse on long-term wellbeing. But, if the clinicians’ explanatory model is clearly elicited, this is not the case for the patients’ model. Doctors are not intolerant of patients’ beliefs and conceptions of menopause, HRT, and alternative medicines; but neither do they encourage patients to elicit their popular explanatory model, nor do they put emphasis on the determination of the patient’s illness problems. Finally, we can hardly talk of ‘negotiated orders of knowledge’ since:

(a) the clinical explanatory model is based on non-negotiable concepts of what the symptoms related to menopause are, and of the risks and benefits of HRT and alternative treatments;

(b) the ultimate goal of the visit initiated by the women is not to reach an ‘agreement’ but to get information that will either reassure her about the symptoms she is experiencing or expects to experience, and then, to allay fears about an experience that is not an illness but can lead to health problems if not ‘treated’. In fact, we may hypothesise that women opposed to the biomedical discourse rely on alternative approaches and do not submit to the clinical encounter at all. Those who engage in a clinical encounter are ambivalent about the consumerist position. On the one hand there is that of a reflexive self, sceptical about expert knowledge, acting in a calculated manner to improve their wellbeing; and on the other, there is the position of submission to an authoritative figure in the context of an asymmetric functionalist approach. As Lupton (1997) has suggested, these are two subject positions that may be viewed as ‘rational’ responses to a distressing situation.

(c) All the implicit assumptions on which the model depends are not fully respected: patients do not have an explicit explanatory model that doctors can help elicit clearly through the clinical encounters; the quest for a consensus on treatment is put aside in favour of a persuasion process enacted by physicians using different strategies to convince the patient of the benefits of HRT. On the whole, if the negotiation model still inspires the patient-centred clinical model, and continues to suggest conceptual tools and ‘methods’ for enhancing the quality of doctor-patient socio-cultural communication, for perimenopausal patients, it appears to be an idealised model that only partially corresponds to the clinical practice.

We suggest that viewing the clinical encounter as a transactional process between two rational actors, each supporting her/his own instrumental truth in the context of a (symmetric or asymmetric) power relationship, is misleading and somewhat reductionist. We may recognise that accounts offered by both patient and physician in the communication process must be
contextualised within institutionally-based medical dominance that is grounded in the social structure. If we also recognise with Fisher and Groce that ‘it is in the micropolitics of this dual relationship that doctors and patients talk social structure’, we cannot agree with them that ‘talking social structure is a moment-by-moment battle that mirrors and largely sustains the institutional authority and status of doctors’ (1990: 225).

The exclusive focus among social scientists on professional dominance, asymmetric social structures, and power relationships threatens to mask the fact that a sharing of core cultural values by both doctor and patient may also take place in the clinical encounter. Some of these are the values of consumerism, autonomy, self-determination and autonomy. These values motivate the self aware patient to look for information and credible advice, and also motivate doctors to offer information through a process what can look like strategies of persuasion. Important additional shared values are the imperative of wellbeing, and the quest for quality of life. These values motivate the patient to initiate the clinical visit. They support an ethic of the long-term quality of life used as a strategy to convince perimenopausal women of the long-term benefits of HRT. The clinical encounter can therefore be seen as the setting in which both patient and doctor express and reproduce these sacred values.

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Notes

1 Les pratiques médicales de premières ligne à l’égard de la prise en charge de la femme périnéopausée. Légaré, F., Massé, R., Côté, L., Dodin, S. Research project funded by Fonds de la Recherche en santé du Québec, #961259.

2 A computer-generated list of 100 GPs from the Québec City regional area was produced. Out of the original list of 100 GPs, 44 were not eligible. After numerous attempts, 34 GPs could not be reached for various reasons (retired, on sick leave, had left the area, unknown), and 17 deemed eligible refused to participate. We decided to randomly contact new GPs but to ask them, if they were not eligible or willing to participate, to identify colleagues who would be interested in the study. Not surprisingly, we were directed towards two females with more than 10 years experience who successfully recruited patients. All participating GPs were active clinicians in private group practice.

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