Interactions between Native American Women and Their White Male Doctor: The Stages of a Health Care Visit at a Public Health Facility*

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Abstract

This paper analyzes the stages of health care visits between a White male doctor and Native American women at a public health facility. The seven stages provide a framework of analysis wherein conflict between the patients and physician emerges. The nonsequential organizing features of the medical visit emerged during analysis using perspectival rhetorical analysis of audio-tape recordings and verbatim transcripts of interactions at a southwestern public health care clinic. The conflicts include (a) time, (b) empathy, (c) respect, (d) economic restrictions, and (e) differing agendas. The stages are a means of analyzing interaction between doctors and patients in order to understand the sites of conflict in the health care visit.

Researchers from communication, psychology, medicine, sociology, anthropology, and linguistics have focused on the problems of health communication and the effects of those problems on patients since the 1950s. Of particular interest to this study is communication between doctors and patients in the medical interview—the health care visit. This paper discusses the stages of the doctor/patient visit that emerged from analysis of the interactions between Native American women and a White male physician at an Indian Health Service clinic (IHSC) (Glenn, 1990/1991). The stages are a series of seven nonsequential, organizing features of the doctor/patient visit that permit access to the perspectives of the interactants. Additionally, this paper discusses the need for more on-site research of the interactions between doctors and cultural diverse patients.

Gender, Culture, and Health

During the last forty years, research in health communication has focused on doctors and patients who are primarily from mainstream populations. Just as more recent medical research has often neglected the critical variables of gender and culture, early health communication research did not address these issues. Research that focused on women was often concerned with mental health and reproductive issues. The few studies that mentioned culture suggested that the culturally different patients should adjust their behavior to reflect mainstream cultural values.

Changes in health communication research in the 1960s, 1970s, and 1980s reflect transitions in societal perceptions of the roles of both patient and health provider. Compliance issues and the interpersonal competencies of caregivers were topics explored. While some studies (Davis, 1968) suggested that low compliance to therapeutic recommendations was correlated to low interpersonal satisfaction levels, other research (Kaplan, Greenfield, & Ware, 1989) did not correlate high compliance rates to high interpersonal communication satisfaction. Issues regarding interpersonal competencies, patients-as-partners, health policy, cultural sensitivity, and gender began to be included in studies (AbouZahr, Vlassoff, & Kumar, 1996; Gabbard-Alley, 1995; Maiboch, 1994; Murrell, Smith, Gill, & Oxley, 1996; Witte & Morrison, 1995). Theoretical perspectives and methodologies expanded from the often-criticized biomedical model (Mishler, 1981) to interpretive, critical studies, feminist, and postmodernism approaches that included naturalistic data and language analysis (Beisecker & Beisecker, 1993; Cary, 1993; Cicourel; 1983; Fisher & Todd, 1983; Frankel, 1984).

More recent research in health communication has called attention to the relationship between health care and culture. Studies point to the influence that cultural beliefs, attitudes, and values have on patients' medical decisions (Duggan & Parrott, 2001). Specifically, scholars examine ways in which culture interacts with perceptions of illness and treatments (Kim, Klingle, & Sharkey, et al., 2000). Also, deficiencies in health care services have been correlated to racial residential segregation (Williams & Collins, 2001) and insufficient federal funds appropriated to marginalized American health programs, American Indians in particular (Noren, Kindig, & Sprenger, 1998; Taylor, 1988). It is suggested that while ethnicity carries only modest biological implications in terms of health status, external resources and environmental risk factors impact health conditions most notably (Williams, Lavizzo-Mourey, & Warren, 1994).

Findings in the 1990s (Beck, C. with S. Ragan & A. du Pre, 1997; Parrott & Condit, 1996; Ragan & Glenn, 1990) suggest that women in particular, as a nondominant co-culture in society, suffer from biased societal perspectives in health settings. As the gender most often seen by doctors, women appear to have less credibility than men do as patients do. The continuing tendency of medical professionals to perceive women's health complaints as psychosomatic or related to mental health or reproductive issues continues to impact health diagnosis negatively. Further, women of color in certain socioeconomic groups are often perceived by caregivers as having little knowledge about their own health status. By ignoring patients' self-knowledge, caregivers deny the potentially helpful patient input (Miller, Seib, & Dennie, 2001). Many caregivers erroneous assume that women from varying religious, ethnic, and social milieus share the health providers' views of sexual activity, marriage/partnerships, levels of pain, propensity for certain illnesses, and so forth. Such false assumptions of the universality of values are barriers to successful health care communication (Dalichman, Kelly, Hunter, Murphy, & Tyler, 1993; Houston-Hamilton, 1995; Vanderpool & Levin, 1990; Varner & Beamer, 1995). Although not addressing health care in particular, Trethewey (1997) identified organizational power constraints that predetermine a woman’s sense of self. It is advocated that women, workers, and/or people of color develop their own identities through resistance strategies.

Research has not carefully or broadly explored the issues of health communication conflict between women patients, particularly women of color, and health providers. Intuitively, the participants know that problems exist, but more research is need in various contexts among many different populations (Helman, 1995; Kreps & Kunimoto, 1995; Parrott & Condit, 1996; Spector, 1996).

Theoretical Perspectives

In this paper, the researcher studies language and behavior as particular to the individuals in their specific context so that the verbal and the environment itself are parts of the interaction (Potter & Wetherell, 1987). These behaviors, when examined through perspectival rhetorical analysis, reveal people's worldviews (Shaver, 1993, 1997, 1998; Shaver & Shaver, 1992; Shaver & Dixon 1998; Dixon & Shaver, 2000).

To illustrate further the relationship of behavior/language, the researcher can look to semiotics and rhetoric. Solomon (1988) refers to semiotics as the "codes and the way that ordinary words, objects, and activities can be signs that point to hidden systems of cultural belief" (p. 2). Semiotics is about the "power we have to define and enforce our own conceptions of reality" (p. 3). Sebeok (1979) defines semiotics as "a science that studies all possible varieties of signs, and the rules governing their generation and production, transmission and exchange, and reception and interpretation. Concisely put, semiotics has two complementary and interdependent aspects: communication and signification" (p. 272).

The importance of semiotics—the science of the sign—is that it does analyze "signs," revealing communication processes and the signification of that communication. By use of semiotic insights, language analysis reveals the codes and the taken-for-granted perspectives of speakers. As Solomon (1988) notes, that which seems natural or common-sensual or the-way-things-should-be is what we call culture. Culture is learned but not always shared. A White male middle-class physician does not share the same culture or worldview as the Native American women who are from a socioeconomic group that is also different from their doctor's.

Several works addressing semiotic issues discuss the relationship of semiotics and health communication (Crookshank, 1938; Eco, 1976; Sebeok, 1979; Shands, 1977; Shapiro, 1960; Solomon, 1988; von Uexkull, 1957, 1934). According to Eco (1976), medical semiotics can be defined in two ways: (a) It is a study of the connection between signs or symptoms and the illness indicated; and (b) semiotics is a means by which one studies on a complex level the patients' verbalization of their own symptoms, providing a systematic codification of the meaning of certain symbols that are furnished by the patient.

Using semiotics and the rhetorical perspectives of Burke (1966, 1969a, 1969b, 1970), Cherwitz and Hikins (1986), and Billig (1987) and Billig et al. (1988), the health communication researcher aims at understanding problems between patients and health providers. The health provider and the patient are both caught in the "webs of significance" (Geertz, 1973), that is their cultures. They are often without the power to analyze to their own participant behaviors or their expectations of the behaviors of the other. The analysis of the behavior/language of the patient and health provider in this study is suggested as the means by which the power of understanding can come to be used both by patient and health provider to decipher the cultural codes. Many elements of these codes are not words; they are objects and social practices with hidden meanings that impact and influence behavior—behavior with dramatic and long-lasting results on the health of patients.

I have analyzed doctor/patient interactions with a methodology drawn from semiotics and rhetoric known as “perspectival rhetoric analysis” (Shaver & Shaver, 1992, 1998; Dixon & Shaver, 2000). The analysis of the behavior/language as presented by the interactants in many organizational settings, including health care institutions, allows the worldviews of the participants to emerge. Further, analysis of the interactions in this study reveals the efforts by both groups to meet their conflicting needs. These "sites of conflict" represent the major agons or dilemmas in the heath visit.

The Study

The study was conducted at a publicly and privately funded clinic in an urban area of the Southwest in 1989 (Glenn, 1990/1991). The audio-taped recordings of the doctor/patient visits were collected during a one week, five-day time in March, 1989.

Indian Health Service, under the direction of the U.S. Public Health Service since 1955, is responsible for the health needs of the enrolled Native Americans in the 36 federally recognized nations represented in this state in the Southwest from among the over 300 nations in the U.S. The clinic is a store-front free/minimum payment clinic. One must have a Certificate of Degree of Native American Blood (CDIB) in order to receive care at such a facility (Native Americans are the only minority that has to prove their ethnicity.). Health providers for the medical portion of the clinic consisted of one family-practice medical doctor, a registered nurse, a licensed practical nurse, a part-time nurse practitioner, and a laboratory/x-ray technician. While nurses and other support staff are generally Native American, primary caregivers and administrators at IHS facilities are generally White and male. Further, physicians are often on a pay-back employment whereby their educational loans are connected to service at a governmental facility such as IHS. Thus, the tenure (often on a rotation basis at various clinics) of most physicians is as short as six weeks or as long as two years. The doctor at this facility spent two years at this facility, leaving within six months of the completion of this project. On an average, 165 patients were seen by one of the health providers during a five-day work week at this clinic.

Twenty-five Native American women patients were audio-taped during their visits with the White male doctor. The clinic, the doctor, and the women gave their consent to be tape recorded. The patients were in either the walk-in clinic (for various non-emergency and non-appointment health needs) or the walk-in diabetic clinic. The women were 1/4 or more Native American, according to their CDIB:

Table 1
Amount of Indian Blood

Quantum	Patients
Full	11
1/2	4
7/16	3
3/8	3
1/3	1
1/4	3

Table 2
Age of Patients

By Decade	Patients
Twenties	5
Thirties	3
Forties	8
Fifties	5
Sixties	4

Patients were (a) asked for their permission, (b) given an explanation about the study to read (or the explanation was read to them), and (c) were given time to say "yes" or "no." This procedure was done in privacy before the health screening for the visit. Either the LPN or RN showed the patients to an examination room after initial screening. The researcher would follow the patient into the room turn on the machine and leave before the doctor entered the room. She would return later to remove the tape before the next patient entered the room. The researcher was not in the room during the visit.

Methodology

This study examined talk between a doctor and Native American women patients in a naturalistic setting at IHSC. The audio tapes were transcribed verbatim with notation for pauses, contiguous speech, simultaneous speech, interruptions, laughter, and so forth. The audio tapes as data were augmented by participant-observer ethnography at IHSC and another IHS clinic elsewhere in the Southwestern. Verbatim written transcripts were examined for (a) worldviews, (b) perceptions of self, (c) how talk was organized, (d) the organization of the visit, and (e) means by which the organizing features of the visit were accomplished.

Analysis

Sebeok (1979) calls attention to the holistic force of semiotics, referring to its properties as a science of science, a step in the unification of science that supplies the foundations for those special sciences of signs: linguistics, logic, mathematics, aesthetics, and rhetoric. Rhetoric, the art of persuasion, is a vital concept in the understanding of the perception of organizations and the members of the organizations. Communication within the organizational setting, the changing of information from one state to another or its movement from one point to another over space, is the means by which the organizational culture is created, recreated, and perpetuated. The persuasive talk—the organizational rhetoric—can be characterized by Sebeok's discussion of von Uexkull's (1938/1958) term *Umweltlehre* or the term *Umwelt. Umwelt* implies the "tenet that any organization necessarily perceives the world (i.e., worldview) in its own image rather than mirror the universe "as it is" (Sebeok, 1979, p.194).

The significance of this insight is that the talk of the health provider (the doctor in this study) is then the "talk" of the organization. That talk is rhetorically—persuasively—representative of the worldview of the organization. Indian Health Service has as its self-declared mission the delivery of aggregate health care for a large population, the members of federally recognized Native American tribes. Within arbitrarily congressional-set budgetary limits, the clinics have a finite amount of personnel, supplies, and resources. The health care mission is in opposition to the Indian's perceived purpose of a health care organization for Native American patients.

Native Americans have a worldview of health care that is derived from expectations of personal needs, cultural values, society stereotypes supported by interaction with users of private health care organizations, and images of health care supported by the entertainment and news media--that is, personal health care from a caring physician. Lotman (1990) posits that the rhetorical "text," a succession of independent signs, is "transformed into a semantic whole with its semantic content 'washed over' the entire space which bears the meaning" (p. 48), with the meanings integrated. Burke (1968) extends this idea saying that paradoxes are expected because "language is primarily a species of action, or expression of attitudes..." (p. 447). Burke (1969) further delineates that master metaphors represent the oppositions that are contesting and combative.

The central opposition between the mission of IHS and the self-perceived needs in health care of the patient is the major agon that permeates the interaction between health providers and patients. In sum, the talk of the doctor represents the worldview of the organization as it perpetuates itself. The patients' talk represents the worldview of the patient, attempting to solicit the health care deemed appropriate.

Stages of the Health Care Visit

While many aspects of the doctor/patient visit were revealed in this study, the primary finding of this present are stages of the doctor/patient visit and their utility as a means of accessing the dilemmatic issues between the culture different caregiver and patients. The seven nonsequential, organizing features or stages are as follows:

1. Openings by the doctor and patient responses
2. Relational interaction between doctor and patient
3. Requests for symptoms by the patient
4. Litany of symptoms by the patient
5. Interruption of the visit by internal means (e.g., the doctor) or external means (e.g., nurse, telephone, and emergency)
6. Diagnosis and treatment information by doctor
7. Closings by the doctor and patient responses

The stages are not considered linear, sequential, or consecutive in nature. The features are not inevitably present in every visit, but analysis of their inclusion or exclusion provides information about how the participants interact and perceive their roles in the visit.

The significance of the stages is that they provide the means by which conflicts between the patient and doctor emerge and can be analyzed. The use of specific language—the signs—can be analyzed for the hidden cultural codes and systems that direct the perceptions of both patient and doctor. The worldview of the doctor, representing the organization, can be seen to be in conflict with the patient's own worldview.

The framework of the organizing features were used to analyze and determine: (a) how and by what means the organizing features are included or excluded, (b) who attempts to include or exclude certain features, (c) what external barriers hinder completion of certain features, (d) what is revealed by the doctor's and patients' language use about health/health care, (e) what perspectives about self and others are shown by their talk, and (f) what means are employed by both doctor and patients to accomplish individual (and not always jointly held or shared) goals of the visit.

Status differences were clearly revealed in several of the stages: (a) openings, (b) closings, and (c) relational talk. The doctor was called by his title and family name. Conversely, the doctor often did not use the patient's name. If the title (e.g., Mrs. or Ms. or Miss) were used, the tone of voice and talk made it a humor ploy. Older women were often called by their first name or by a term of endearment (e.g., sweetie, dear, etc.). Further, older women were often spoken to in a sing-song voice, similar to that used by adults when speaking to small children. The talk from doctor to patient often reflected his assumption about the sociocultural roles of the woman without regard to their culture or their adherence to traditional roles for Indian women (Shaver, 1997).

The doctor was the initiator of relational talk, that is, talk that was of an interpersonal nature. With ten of the patients, the doctor initiated nonmedical conversation topics: a question about a book the patient had brought to the examination room; a query about "how much Native American" the patient was (The question is considered a culturally insensitive question between nonIndians and Indians.); and a follow-up health question that led into a discussion about flowers. These are relational in comparison with the medical talk, but the topics can be characterized as neutral, nonthreatening, and nonrevealing about the doctor as a person. The doctor demonstrates the continued unreachability of a doctor, who is separated from the patient by gender, status, culture, and organizational power.

Further, the patient's responses were basically brief and unelaborated. A few patients would introduce a related, but different topic, but the tone was hesitant. If the doctor did not comment on the new topic, the patient did not pursue the issue or make a demand bid for a response as is common practice. Only one woman initiated relational talk. She also "violated" several rules of status differences during the visit by demanding that the doctor respond to her attempts at humor, answer personal questions, and question his decisions on medical matters.

The doctor maintained control of the visit by being the one most likely to move from one organizing feature to the next. The patients, on the other hand, were clearly not in control of the visit, its progress, or its goals.

Both the analysis of the stages of the visit and the ethnography of the clinic revealed that the limited funding for personnel, medical and support supplies, and diagnostic equipment create by their presence or absence the following:

(a) A climate of deprivation.
(b) Time pressures and inequitable time use.

(c) Low patient priority within the organization on a macro level
(d) Low patient priority with the doctor on a micro level.

The doctor would justify the lack of certain medicine, diagnostic equipment, or technical support by saying that "that's just the way it is" or "you know how IHS is" or "this will work almost as well." The defense of the system or the status quo is clearly perceived in these incidents.

The time demands of any large organization are inflexible. Regardless of the fact that IHSC is a small store-front operation, it reflects the culture of many HIS clinics with its bureaucratic inflexibility. Hence, time usage for the clinic and the doctor are the primary considerations. Threats of withdrawal of services are presented as sanctions against patients who are late or do not show up for appointments. Receptionists inform the patients of these rules. Signs (both professionally printed and handwritten) surround the patient in the waiting rooms, screen rooms, and examination rooms. The signs threaten withdrawal of services or limits of care or suspension of services for certain infractions of rules (Shaver & Dixon, 1998). Unlike private health clinics, Reverse sanctions from patient to the doctor do not exist because the Native American women do not generally have a health care alternative. Confounding factors such as (a) the absence of paid sick leave that permits people to go to the doctor when needed, (b) poor transportation resources, (c) shortage of childcare, (d) inconvenient and far removed locations of IHS facilities, and so forth, represent the various reasons for conflicts arising out of time differences and time management between Native American women patients and the IHS organization represented by the doctor.

The issues of time are also exemplified by the brevity of the physician/patient visit. As Solomon (1988), Sebeok (1979), and Eco (1979) note, signs are not just in the words; they are in proxemics, architecture, and behaviors. The amount of time that a patient is with a doctor is demonstrative of the importance of the patient within the system. In this study, the longest visit with a doctor was 15 minutes; three visits were of this length. The shortest was 3 minutes; two visits were this length. Sixteen of the visits were under seven minutes, considerably under the average time a patient is with a doctor in private health care (O'Hair, 1989).

Further, U.S. Public Health and IHS have a federally imposed budget within which to work. One way to fulfill that responsibility is to cut expenses. Thus, certain drugs are too expensive to be on the approved list; certain supplies are not stocked on a regular basis; and the lag time between bureaucratic change and use of new techniques and treatment delays updated care. The patient who has access to friends in private health care and who has seen or heard about health care in different situations is aware of the discrepancies between her care and that of her friends or that of people in the media. Negative self-images are generated by such deprivations and discrepancies.

The last conflict to be discussed is that of the differences between the patient-perceived agenda for the visit and the doctor-perceived agenda. The traditional Marcus Welby-American Medical Association perception of a patient's needs in a visit is that the patient has a medical problem that has caused them to see a physician and only one problem. This is often not the case for women in general, who must represent their family, and, specifically, not the case for indigent Native American women at IHSC.

The women patients will most likely have a multi-item agenda with goals that include (a) self-health, (b) family-health, (c) pharmaceutical needs, and (d) advice on bureaucratic problems with the system. Women who do have jobs rarely have paid sick leaves/days. As a result, they must carefully plan when to miss work and lose pay that is already too low to meet their needs. Further, IHS clinics are spread around the states with high Indian populations, necessitating long drives for many people who do not have safe and reliable transportation. Additionally, paid childcare is usually impossible, but restrictions are posted on children accompanying their mothers and grandmothers to the clinic. Native Americans tend to rely on family for childcare, not outsiders (Shaver, 1997). However, the Native American family living in urban areas will often not have friends or family on which they can relay. Rather than building relationships among neighbors, they often spend each weekend "back home."

All of these factors contribute to the Native American woman's need to have a multi-item agenda. The conflict between the doctor trying to see the patients allowed by the budget and the woman attempting to meet all of their own needs and their family's needs in the often postponed and waited-for visit is very clearly delineated in the talk between the two.

Discussion

Presumptions about the role of women in society and the assumptions about the status of health providers rest in the perspectives of the participants. Their interactions reveal points of conflict between the worldviews of the participants.

Rorty (1991) discusses the implications of the domination of bureaucratic organizations by positivistic (i.e., scientific dogma). From Rorty's (1991) point of view, the notions of "science," "rationality," "objectivity," and "truth" [are] bound up with one another. Science is thought of as offering "hard," "objective" truth: truth as correspondence to reality, the only sort of truth worthy of the name (p.35). According to Rorty, the tendency to use methodical, rational, scientific, and objective as synonyms are representative of a culture in which "scientist" replaces the priest. The reliance on technology as the verification of cognitive knowledge blurs the reality of human interaction.

Language analysis as informed by the insights of semiotics and rhetoric allows further areas of conflict to emerge, presenting opportunities for both patient and doctor to become empowered by the knowledge of their own cultural systems rather than being constrained by their respective pre-judgments with respect to the therapeutic encounter.

This study extends health communication research by examining Native American women patients who are culturally and socioeconomically different from their doctor. The findings include the stages of the doctor-patient visit that provide a framework of analysis wherein conflict between patient and doctor emerges. These findings support other research that notes that societal perceptions about the roles of women, particularly indigent women of color, are barriers to good health care.

Further, stereotypical assumptions by health providers and researchers about women, their roles in society, and their so-called normal states of wellness and illness are detrimental to successful health diagnosis and care. Using the stages of the health visit as a framework of analysis, researchers should conduct additional studies that include women of various ethnic groups.

**This paper is part of my dissertation (Glenn, 1990/1991) and portions have been presented at conferences at the National Communication Association and the International Communication Association in the Health Communication Divisions.*

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