The clinical encounter as local moral world: Shifts of assumptions and transformation in relational context

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ABSTRACT

In this study we consider the *process* of the clinical encounter, and present exemplars of how assumptions of both clinicians *and* their patients can shift or transform in the course of a diagnostic interview. We examine the process as it is recalled, and further elaborated, in post-diagnostic interviews as part of a collaborative inquiry during reflections with clinicians and patients in the northeastern United States. Rather than treating assumptions by patients and providers as a fixed attribute of an individual, we treat them as occurring *between* people within a particular social context, the diagnostic interview. We explore the diagnostic interview as a landscape in which assumptions occur (and can shift), navigate the features of this landscape, and suggest that our examination can best be achieved by the systematic comparison of views of the multiple actors in an experience-near manner. We describe what might be gained by this shift in assumptions and how it can make visible what is at stake for clinician and patient in their local moral worlds—for patients, acknowledgment of social suffering, for clinicians how assumptions are a barrier to engagement with minority patients. It is crucial for clinicians to develop this capacity for reflection when navigating the interactions with patients from different cultures, to recognize and transform assumptions, to notice 'surprises', and to elicit what really matters to patients in their care.

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Introduction

Numerous studies have highlighted how providers may hold preconceptions about patients that are predicated on impoverished notions of group membership (van Ryn & Burke, 2000). Literature in social psychology and racial bias primarily focuses on the unconscious application of assumptions that providers make when they see patients in the clinical encounter (Burgess, Fu, & van Ryn, 2004), describing these assumptions as categorizations (such as race, age, sex, socioeconomic status, etc.) that become "over-generalized", e.g., when providers rate Black patients as being less educated than their non-Latino white patients (van Ryn & Burke, 2000). Sometimes assumptions are based on trying to label persons seen from an "out group", such as people who are unpredictable or appear dangerous, and consequently establish social distance (Angermeyer & Matschinger, 2005). In their paper on patient provider communication and health disparities, Cooper and Roter

(2003) identify the critical need to explore how these assumptions can occur, particularly in context of the "reciprocal nature of the patient–physician relationship." They emphasize the importance of recognizing that assumptions can shape the patient and physician relationship particularly in terms of physicians' assumptions about a patient, which has implications for the care they give. This is particularly true in the context of cross-cultural encounters, where providers might be more prone to rely on stereotyped accounts of certain cultural groups in the presence of significant cultural difference (Dysart-Gale, 2006).

In this study, we explore ways in which assumptions are expressed in initial diagnostic interviews, and how they can shift during these interviews and over the course of reflection in post-diagnostic interviews. This in-depth look at the local interview process and how it is co-constructed illuminates how assumptions by clinician and patient may shift moment-by-moment in the clinical encounter. Developing a capacity for reflection is seen as crucial for navigating different cultures (Kleinman, 2006) and for determining what matters to doctors and patients in care (Frankel, Sung, & Hsu, 2005). When invited to articulate and elaborate what they notice, clinicians and researchers alike can make visible what may otherwise pass by unnoticed, which is useful for the analytic research insights it brings, and can be carried over into cross-cultural

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care (Katz & Shotter, 1996). We examine this phenomenon as a process "rooted in social space" and seek to illuminate the *social and relational* aspects of stereotyping, drawing on Kleinman's emphasis on "moral experience, or what is at stake for actors in a local moral world" (Yang, Kleinman, Link, Phelan, Lee, & Good, 2007, p. 1525). Moral experience here refers to that kind of engagement that makes visible "values in ordinary living" (Kleinman, 1999, p. 77), or what matters most in the lives of ordinary people. It is this practical engagement that illuminates what is most important for the actors. Rather than fixed and acontextual, we emphasize assumptions as occurring in a relational process that can shift in interaction and reflection on the lived experience of the participants. We view both the 'one' who makes assumptions, and the 'other' who can be thus objectified, as participants in a process that can be made visible in the course of reflecting upon it.

We expand our exploration of assumptions by patients (as well as by clinicians) with respect to their accounts of being 'marked', a term introduced to describe in interactional terms the experience of someone who is viewed as "deviant, flawed, limited … or generally undesirable" (Jones, Farina, Hastorf, Markus, Miller, & Scott, 1984, p. 6). A person can be 'marked' by his or her appearance, e.g., seen as an indicator of his/her level of education. Domains of assumptions can thus expand beyond gender, race and culture to include appearance, markers of class and education, as well as style of presentation (e.g., aggressive, cold, inarticulate, smart); an individual can be 'marked' by a negative assumption. Following Goffman (1963), being perceived as possessing such an aspect is "deeply discrediting." But he continues, "it should be seen that a language of relationships, not attributes is really needed" (Goffman, 1963, p. 3), for such 'marks' are constructed *within the doctor–patient relationship*. Harré agrees that assumptions "can only be understood when placed in their conversational context" rather than the " widely shared consensus that it is something that is located 'inside' people" (van Langenhove & Harré, 1999, p. 130).

This shift of focus—from influences located in individuals to those located in relationships—opens up the possibility that a shift in a clinician's way of relating to a patient may influence how that patient is seen. If we examine the clinician as anthropologist, we can draw a parallel between the two as they navigate between the different 'moral worlds' of patients, the institutional and professional requirements of the clinical intake, and what is at stake for each in this process. In the event, the clinician necessarily becomes "self-reflexively critical of her own positioning" with its obligations and challenges. This move toward reflection from within a practice—'seeing' herself *in relation to* her patient—arouses a creative tension that "destabilizes stereotypes and clichés and makes her attentive to the original and unexpected possibilities that can (and so often do) emerge in real life" (Kleinman, 1999, p. 77). It is this creative tension that we would like to emphasize as the key to shifting assumptions.

In exploring the lived experience of the clinical encounter in safety net clinics, (clinics that provide a disproportionate share of healthcare to uninsured, Medicaid, poor and other vulnerable patients), we seek to describe how stereotypes occur in naturalistic settings. Research on these issues "may help us understand how basic social processes, rather than simply poor training or clinician prejudice, contribute to problems of assessment associated with class and ethnicity" (Good, 1997, p. 240).

Methods

Sample

The sample in the current study is part of a larger Patient–Provider Encounter Study (PPES) (Alegria, Nakash, Lapatin, Oddo, Gao, Lin, & Norman, 2008) composed of both providers and patients in intake sessions conducted in 2006–2008. All patient participants were seen for initial evaluation by a group of 47 providers who agreed to participate in the study from eight clinics in the Northeast of the US. Most clinics were safety net or served low income populations, and all of which offer services for many uninsured patients, working families, and recent immigrants, with approximately 55% of the outpatient service volume attributed to Medicaid or uninsured patients. The clinicians provide mental health services to adult populations in outpatient and language specialty clinics; interviews are conducted in English or Spanish based on patient preference.

We targeted those providers who offer mental health services to multicultural populations in general outpatient clinics as well as clinics that specialize in substance abuse treatment, representing a diverse disciplinary background and a varied level of experience: about 28% were psychiatrists, 26% psychologists, 38% social workers and 6% nurses or others. Approximately, 66% were females, and 70% had six years or more of experience in practice. In the study, 53% of clinicians self-identified as non-Latino whites, 36% as Latino, 9% as non-Latino black (African American or Afro-Caribbean); and 2% as Asian. In 64% of the cases, the patient and provider were matched on ethnicity/race.

One hundred and twenty-nine patients from adult mental health outpatient clinics participated in the PPES study from diverse backgrounds: approximately 50% Latino, 12% Black (African American or Caribbean) and 39% non-Latino White. Ages ranged from 18 to 65 years, with 80% of them between 18 and 49. Approximately 60% were females and 65% had completed high school. More than 64% had a household income of less that $15,000, and approximately half of the patient sample was unemployed or out of the labor force. The Institutional Review Boards at each site approved the study prior to data collection, obtaining written informed consent from all participants. Capacity to consent was established using a 10-item screening measure based on four legal standards of demonstrating capacity (understanding, appreciation, reasoning, and voluntarism) (Zayas, Cabassa, & Perez, 2005).

Procedure

The PPES study consisted of three components (#1–3 in Fig. 1.) Diagnostic intake interviews (#1) were videotaped. Subsequent research interviews were conducted separately with patients and clinicians using a semi-structured interview guide, lasting approximately 30 min and focused on understanding patients' and providers' experience during the initial clinical interview. Provider
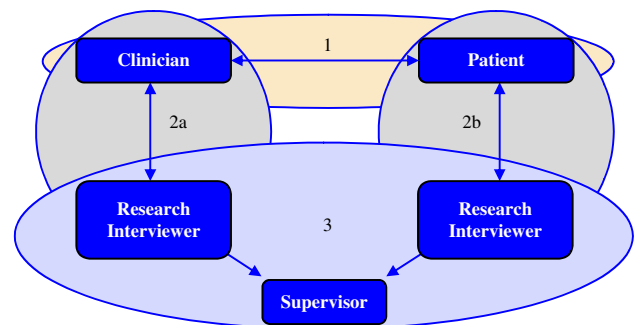

Fig. 1. The reflecting process: (1) a *diagnostic interview* between clinician and patient; (2) pairs of *post-diagnostic interviews* between (a) research interviewer and clinician and (b) research interviewer and patient; (3) a *joint follow-up interview* between the research interviewers and their supervisor, the first author.