

ORIGINAL ARTICLE

From oppression towards empowerment in clinical practice – offering doctors a model for reflection¹

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Abstract

Objectives: This article aims to present an Oppression Model describing how and explaining why doctors sometimes take up the role of oppressor in clinical practice, and to furthermore create change by proposing alternatives. The model is intended to increase awareness of power issues in medical practitioners, thus creating an urge for empowering practices. **Design:** The Oppression Model is constructed by theoretical reasoning, inspired by empirical findings of doctor-as-oppressor from a Norwegian research project with users of psychiatric services. The model is composed of the chosen theoretical elements, assembled as a staircase model. The model is intended to give descriptions and explanations and foster change relevant to oppressive processes in clinical practice, and is mainly relevant when meeting patients from vulnerable or stigmatized groups. An Empowerment Track is conceptualized in a similar way by theoretical reasoning. **Results:** The Oppression Model describes a staircase built on a foundation of objectifying, proceeding by steps of stereotypes, prejudice, and discrimination up to the final step of institutionalized oppression. An Empowerment Track is proposed, built on a foundation of acknowledgement, proceeding by steps of diversity, positive regard, and solidarity towards empowerment. It represents, however, only one of several possible ways of proceeding in developing empowering practices. **Conclusion:** Keeping the Oppression Model in mind during patient encounters may help the busy clinician to counteract oppressive attitudes and actions.

Key Words: *Communication, consultation, empowerment, family medicine, general practice, oppression, physician-patient relations, psychiatric services, stigma, theoretical model*

Measuring the coping power of poor people against what I thought I could have managed myself, with the same history, in the same circumstances, they never failed to amaze me. (Julian Tudor Hart)

Background

Regarding myself as a patient-centred general practitioner, I believed that the majority of my patients appreciated my consultation behaviour. However, while doing a study of the experience of users of psychiatric services (in this article called “the Experience Study”); I learnt some hard lessons that never left my professional mind. The users described dehumanizing experiences of being reclassified as the stigmatized “other” [1]. They presented convincing and harsh experiences of

oppression, lack of love, and lack of a life of one’s own – mainly in their encounter with people in their local community, but also in the health and social services. My findings suggested that the dominating person in a human encounter sometimes stigmatizes and harasses the other, and that doctors are no exception.

Why did doctors like me take up the role of oppressor in medical encounters? Was it mainly due to personal shortcomings, or was the reason more structural? How could the oppressive process be described? If I accepted that I sometimes acted as an oppressor of my patients, how could I change? And why had these power issues been predominantly invisible to me in the past?

In order to enable myself and other medical practitioners to counteract oppressive behaviour I

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¹ This paper has been independently peer-reviewed according to the usual Scand J Public Health practice and accepted as an original article.

decided to visualize such processes in a model. Just as an unpleasant snapshot of oneself as disgustingly overweight can make people go on a diet, the snapshot offered by the model was intended to reveal a picture of reality in order to foster change. Most intimidations are unintended – even unrecognized – by the oppressor. By acknowledging that oppressive practices are taking place in medical practice it should be possible to develop strategies for counteracting dehumanizing oppressive behaviour, and to stimulate patient empowerment in the clinical context.

Aims

The aims of this article are to present an Oppression Model describing how and explaining why doctors take up the role of oppressor in clinical practice, and furthermore to create change by offering alternatives. The model is intended to increase awareness of power issues in medical practitioners, thus creating an urge to develop change.

Material and methods

The model is inspired by empirical findings from the Experience Study where users of psychiatric services in six Norwegian rural communities were participants and informants [1]. The Experience Study describes stigmatization and oppression of psychiatric patients but it does not explain how and why people, including doctors who have chosen a helping profession, take up the role of oppressor. The model is a result of exploring academic literature looking for theories that could possibly account for this phenomenon, while constantly weaving back and forth between data from the Experience Study, my professional knowledge as a general practitioner, and my personal knowledge from being in positions both as oppressor and sometimes even as oppressed. From this process some theories have been rejected, and some have been accepted as providing answers to my research questions and adequate explanations of the phenomena observed. The Oppression Model is composed of the chosen theoretical elements from this process of theoretical reasoning, assembled as a staircase model.

The choice of a staircase metaphor was inspired by a model developed by WILD (The Women's Institute for Leadership Development, located in Boston, USA). My use of the staircase emphasizes the foundation of the staircase, and how all steps rest heavily on the process of *objectifying* as a point of departure. The Oppression Model is designed to be

simple enough to be kept in mind by the busy medical practitioner – like a snapshot that will remind him/her of important power issues while in clinical action.

Theoretical perspectives

Oppression as the opposite of empowerment

My conceptual point of departure is psychologist Prilleltensky's definition of oppression, both as a state and as a process. "Oppression, as the antithesis of reciprocal empowerment, curtails self-determination, perpetuates social injustice, and suppresses the voice of vulnerable individuals" [2].

Prilleltensky emphasizes the coexistence of political and psychological oppression. Political oppression is understood as what is actually done to people by others in a one-up position. Psychological oppression is about the oppressed person's "internalised view of self as negative and as not deserving more resources or increased participation in societal affairs" [2], also known as self-stigma. This coexistence explains why patients will not always agree to being in an oppressive situation if they are asked, making them even more vulnerable to medical power.

Power issues in medicine

Encountering patients, doctors have a great deal of power and are usually in a one-up position. This is not good or bad in itself, but the crucial question is how this power is used. Speaking from the medical culture, Engel and Emmanuel challenged the strong voice of biomedicine and called for a stronger impact of the patient's voice [3–4]. From the context of general practice, Levenstein et al., Waitzkin, Candib, Fugelli, Malterud, and Hollnagel have explored power issues in medicine [5–10]. But these authors are rare exceptions. Other terms related to power issues are also rare in medical discourse: social stratification, social exclusion, discrimination, stigmatization, racism, sexism, cultural differences, multiculturalism, disempowerment, and other variations on the term power.

There is, however, an extensive literature describing and analysing consequences of oppression in medicine from the outside, mainly in the social sciences. Feminist critiques, critical psychology, consumer and disability movements, gay/lesbian/bisexual theorists, anti-racist movements, and organizations for HIV-infected individuals have criticized medicine as an instrument of more general oppressive practices in society.

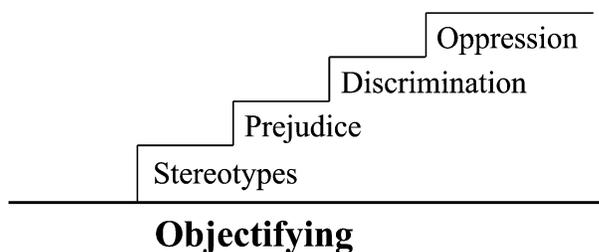


Figure 1. The Oppression Model. For legend, see text.

Empowerment in medical discourse

The term *empowerment* is becoming increasingly popular in the medical discourse. However, empowerment for the purpose of lifestyle modification and health promotion appears to be more related to patient education in achieving goals medical people have set for patients, than of reversing the processes and products of oppressive practices in society [11]. The kind of oppression described in the Experience Study [1] calls for a more radical interpretation of the empowerment concept, concerning fundamental issues of human rights more than influencing disease by modifying lifestyle. I therefore return to Prilleltensky's definition – *empowerment* as the opposite of *oppression* – as an adequate conceptual frame of reference for the model I want to propose.

Objectifying – a foundation for oppression

Philosopher Skjervheim [12] has written extensively on the phenomenon of objectifying. He describes how a person can make another person an object of study instead of meeting him/her as a fellow individual, sharing the human condition. Skjervheim distinguishes subject–subject – or the intersubjective relationship, from subject–object relations – or the relationship that predominates in natural sciences. He offers an example: Two people talk, and A states: “The cost of living will increase even more.” B then has two choices: He can either engage in the issue and discuss the statement with A in a subject–subject relation, together discussing a third issue. Or B can ignore the issue, refrain from engaging in the discussion, and rather focus on the fact that A declares this, as in a subject–object relation. If we change the example to a conversation where A states that his actions are controlled by external forces by way of radiation, the chances of B relating to A in a subject–object relation instead of in a subject–subject relation will usually increase.

The foundation of the Oppression Model is formed by Skjervheim's important distinction

between meeting the other as a subject, a fellow individual, as opposed to meeting him/her as an object to be studied, a thing representing a category, something to be reasoned about but not a person to be engaged with.

The Oppression Model

The Oppression Model is summarized in Figure 1.

The model describes a staircase built on a foundation of *objectifying*, illustrating the danger of being swept up to the final step of *oppression* once the process of objectifying begins. The staircase steps illustrate how stereotypes can lead to prejudice (negative, or stigmatized stereotypes), which leads to discrimination (unjust allocation of resources, voice, and democratic participation on the basis of group membership – such as disability, gender, class), which leads to systemic or institutionalized oppression (discriminating practices built into the very structure of society). Below, each of the steps of the Oppression Model will be elaborated further.

The process starts by the *objectifying* process of categorizing the person. Clinicians cannot avoid categorizing the patient's pattern of symptoms and signs in order to reach diagnosis and treatment. On the other hand, to counteract the automatic categorizing and objectifying of *the patient as a person* it is of paramount importance to recognize him/her as a fellow human being, and thus in staying human ourselves. In objectifying the person diversity is blurred, and cultural stigmatizing attitudes towards marginalized groups are abundant and easy to take up.

The notion of objectifying that proceeds towards oppression embodies the whole person, not only his/her symptoms and signs. Staying within the Oppression Model, I can see Mrs Smith only as the problematic and ever-returning somatizing neurotic patient without any real pain, or Mr Simpson only as the promiscuous gay guy who deserves his HIV infection.

Patients from stigmatized groups are especially at risk of becoming “the other” when seeing the doctor. Goffman describes a stigma as “an attribute

that is deeply discrediting, but ... a language of relationships, not attributes, is really needed" [13]. This is because a stigma is "a special kind of relationship between attribute and stereotype". In this way, Goffman points to the role and responsibility of the one stigmatizing the other. Or, he points to my attitudes towards women with medically unexplained disorders represented by Mrs Smith, or towards gay men represented by Mr Simpson.

The consequences of the next steps of *stereotyping and prejudice* are harassment and intimidation. Social psychologist Ås described what happens in encounters between people from a dominating and an oppressed group before any actual power is required [14]. Ås, who studied gendered interaction in national politics, describes the harassment of women by men in "the five master suppression techniques": making someone invisible, ridiculing, withholding information, blaming and shaming, and no way to win (damned if you do, and damned if you don't). Familiar examples from general practice consultations could be: Assuming that Ms Thompson, the middle-aged woman in front of me, is heterosexual, making it invisible that the death of her friend Jane actually equals being widowed after 20 years of a committed relationship. Ridiculing Mrs Smith's fear of a brain tumour that kept her awake for the last five nights. Withholding the fact that the psychiatric medication I want Mr Stevens to take is likely to cause impotence or diabetes. And so on.

Philosopher Young describes the consequences of the last steps of *discrimination and oppression* as "the five faces of oppression". These are: exploitation, marginalization, powerlessness, cultural imperialism, and violence [16]. In this position of institutionalized oppression the consequences for patients are exclusion, unjust distribution of resources, limited democratic participation, limited self-determination, and limited voice and choice.

The story of Bill from the Experience Study serves as an illustration of powerlessness: Bill did not want the work that a well-intended psychiatric nurse had found for him. This was hard to understand until he told us that he had to get up very early, spend more than two hours daily on the bus to get to work and back, and had to pay more for the bus tickets than he earned for a full day's work.

Above, I have presented the foundation and steps of the Oppression Model. The staircase as metaphor illustrates the progressive temporal and structural relationship between objectifying stereotypes and institutional oppression – from private images of "the other" towards structural and institutionalized

oppression requiring power. The steps are presented as distinct entities for didactic purposes, but in real life the processes can take place simultaneously. An important shift occurs between the steps of prejudice and discrimination: some sort of institutional power is required in order to discriminate and oppress but not to prejudice and stereotype. Prejudice and stereotypes are private constructs that can give themselves away in the doctor's body language and clinical decisions in consultations with low-hierarchy patients. But some sort of societal power is needed to legitimize the skewed distribution of resources and unjust practices that hits vulnerable and oppressed groups.

Alternatives to oppression

This article is neither about how patients can change their role as oppressed, nor about how authorities can change doctors' behaviours towards non-oppressive actions. It is about how doctors, on seeing their own role as oppressors, can choose to become allies of empowerment processes in patients instead. Theorizing is not enough; alternative modes of behaviour in clinical practice need to be tried out and to be validated in carefully designed research projects. Participatory action research designs will probably be best suited for this task.

The Oppression Model is a disturbing and negative description of how some doctors can function some of the time. It is important not to leave doctors who recognize this snapshot in a state of dismay and passivity. I therefore propose a possible alternative strategy in the form of an Empowerment Track. I consistently probed for the relevant opposites of the foundation and different steps of the Oppression Model as a guiding star in proposing an Empowerment Track.

What are the counterparts of objectifying, stereotyping, and discriminating that can be applied by the practitioner to counteract oppression? Taken literally, this could be a dangerous way of proceeding, suggesting that there are only two opposing roads, and that dichotomy is what is needed. On the contrary, I want to remind the reader that empowerment is a highly context-dependent concept and thus many different ways can be right ways of contributing in empowerment processes.

A proposed Empowerment Track

The Empowerment Track (Figure 2) starts by the step of acknowledgement, understood as a fundamental respect for the experiences of "the

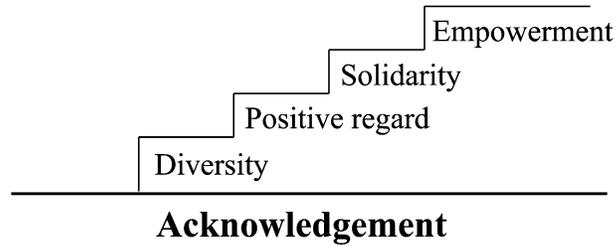


Figure 2. An Empowerment Track. For legend, see text.

other” in a subject–subject relation. Then follow the steps of recognizing diversity and a stance of positive regard. The consequences of this are for the doctor to focus on resources and identify strengths. Finally come the steps of solidarity and empowerment, asserting that the patient in front of us, as a fellow human being, should have the same resources and rights as we have ourselves. Below, each of these possible steps will be elaborated further.

The Empowerment Track is founded not on *objectifying* but on *acknowledgement* as described by psychologist Schibbye. She explicated acknowledgement as being heard and seen as the person one is, as being understood, as being met with respect, and as being recognized in ways that acknowledge uniquely personal experiences [17]. Although the patient needs the doctor to sort out her/his symptoms, the cool objectifying, medical gaze is not sufficient to acknowledge her/him as a person. She/he needs to meet a healer too, another human being, someone to trust, someone to engage with.

It can be argued that the opposite of objectifying should be subjectifying, not acknowledgement. However, as a foundation for an Empowerment Track it is not enough to recognize the other as someone different from yourself: she/he needs to be recognized as someone uniquely human and as worthy of respect as yourself.

On the Empowerment Track, I might see Mrs Smith’s despair at not being able to fulfil her role as a teacher and mother in ways I can relate to and work with, and Mr Simpson as the guy struggling to cope with medication side effects, a committed relationship to John, and being a loving and present father to his sons from his first heterosexual marriage.

The next steps of the Empowerment Track, founded on the attitude of acknowledgement, emphasize the patient’s *resources*. On these steps, diversity replaces stereotypes, and positive regard is attributed to the patient and her/his qualities, instead of prejudice and stigma. At these steps, the doctor opens up to the positive expectation, a strong belief that the patient has strengths and solutions

to contribute. Antonovsky’s concept of salutogenesis captures people’s own contributions to staying well in spite of being exposed to pathogenetic agents [18]. Hollnagel & Malterud elaborated the salutogenesis concept with a patient-centred model, drawing attention to patients’ self-assessed health resources [10]. For example, signalling in various ways to Ms Thompson that I do not assume heterosexuality could create space for her to talk about the loss of the love of her life. Listening carefully around Mrs Smith’s fear of a brain tumour could reveal good as well as not-so-good reasons for her fear, and teach me about her coping strategies when in panic. And so on.

The final steps of the Empowerment Track are *solidarity and empowerment*, as opposed to discrimination and oppression. In this context, solidarity means to convey to the patient that she/he deserves and should receive the same resources and rights that we have. It captures the meaning of Prilleltensky’s concept “reciprocal empowerment” [2], where solidarity in practice can be listed as the actions and power to give to self and others equal ability to define identity, equal and sufficient resources, and an equal voice in society.

Discussion

Limitations and weaknesses of the model

Although the Oppression Model has been developed for a specific purpose and context – the clinical consultation – the underlying foundations are not original and have been articulated by other authors. An example is philosopher Honneth, who describes similar processes in his book “The struggle for recognition” [19].

Models can be dangerous. They can lock the mind and blind people to the unexpected, to what is different, to new developments, to what does not follow the rule of the model. Another danger in using the Oppression Model is the misunderstanding that objectifying, categorizing, diagnosing etc. necessarily are bad practices that are to be avoided. An

example illustrates this point: failing to diagnose anaemia, depression, or hypothyroidism in a formerly dismissed woman misdiagnosed as having chronic fatigue is just as detrimental to patient health as stereotyping and stigmatizing patients with conditions like chronic fatigue, liver cirrhosis, fibromyalgia, or HIV infection.

The Oppression Model is most relevant when meeting low-status patients from vulnerable and marginalized groups who regularly experience oppression, of which psychiatric patients serve as an example.

Finally, even when we take acknowledgement as a starting point and keep our minds set on positive expectations, there still are patients who are very hard to like, and some who even want illegal or immoral services from us. In my experience, they are very few. How to behave in such situations is beyond the scope of this article.

Consequences of accepting the Oppression Model as a valid description

When being accused of oppressive professional behaviour most doctors would probably reject the claims and say that some (other) doctors may behave badly, or that the patients are difficult or have misunderstood.

I have presented the Oppression Model to facilitate awareness of the forces at play by highlighting the double-edged sword of objectifying and categorizing: on one hand an invaluable tool in diagnosis, on the other hand the point of departure for stigmatizing behaviour. The Oppression Model presents clinicians with the unpleasant fact of how, in some medical meetings, the doctor can act and be perceived as an oppressor. Acknowledging this, the clinician can choose to accept the state of affairs with various justifications. Or, he can choose to take up the professional challenge of trying out various Empowerment Tracks. Clinicians might choose the empowerment tracks the more closely the patient resembles themselves or people they admire. The Oppression Track predominates when patients belong to stigmatized groups low in medical and societal hierarchies. Hunter reminds us that moral knowing is not separable from clinical judgment [20].

By being aware of these mechanisms, we as clinicians have more freedom to choose who we want to be in medical encounters, and thus stay human ourselves [21,22].

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