ANALYSIS OF EXPLANATORY MODELS AND THERAPEUTIC CHOICES UNDER PATIENT-PROVIDER POWER RELATION CONTEXT

Miss Kornkaew Chanthapasa

สถาบันวิทยบริการ
จุฬาลงกรณ์มหาวิทยาลัย

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การวิเคราะห์ตัวแบบการอธิบายความเจ็บป่วยและทางเลือกในการรักษาภายใต้บริบท
ของความสัมพันธ์เชิงอำนาจระหว่างผู้ป่วยและผู้ให้บริการ

นางสาวกรแก้ว จันทภาษา

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จุฬาลงกรณ์มหาวิทยาลัย

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กรแก้ว จันทภาษา : การวิเคราะห์ตัวแบบการอธิบายความเจ็บป่วยและทางเลือกในการรักษาภายใต้บริบทของความสัมพันธ์เชิงอำนาจระหว่างผู้ป่วยและผู้ให้บริการ. (ANALYSIS OF EXPLANATORY MODELS AND THERAPEUTIC CHOICES UNDER PATIENT-PROVIDER POWER RELATION CONTEXT). อาจารย์ที่ปรึกษา : ผศ.ดร.รุ่งเพ็ชร สกุลบำรุงศิลป์, อาจารย์ที่ปรึกษาร่วม : รศ.ดร.ลือชัย ศรีเงินยวง 184 หน้า. ISBN 974-17-6956-3.

การศึกษาครั้งนี้มีวัตถุประสงค์ที่จะอธิบายและวิเคราะห์ตัวแบบการอธิบายความเจ็บป่วย (Explanatory Model) และทางเลือกในการรักษาภายใต้บริบทของความสัมพันธ์เชิงอำนาจระหว่างผู้ป่วยและผู้ให้บริการ โดยทำการศึกษาที่กลุ่มงานผู้ป่วยนอกและกลุ่มงานอายุรกรรมของโรงพยาบาลขนาดใหญ่แห่งหนึ่งในภาคตะวันออกเฉียงเหนือ ระหว่างเดือนธันวาคม 2546-เดือนมกราคม 2547 ใช้วิธีการเก็บข้อมูล 2 วิธีคือ การสังเกตพฤติกรรมการให้และรับบริการของแพทย์และผู้ป่วยจำนวน 455 ครั้ง จากแพทย์ 8 คน และผู้ป่วย 452 คน ประกอบกับการสัมภาษณ์เจาะลึกแพทย์ทั้ง 8 คน และผู้ป่วยจำนวน 18 คน ที่เลือกจากการสังเกตพฤติกรรม จากการศึกษาพบว่าในระหว่างการตรวจรักษาแพทย์เป็นผู้ที่มีอำนาจควบคุมการสนทนา การตัดสินใจสั่งการรักษา ขณะที่ผู้ป่วยส่วนใหญ่มีบทบาทเพียงเป็นผู้ให้ข้อมูลความเจ็บป่วยของตนตามที่แพทย์ต้องการทราบเท่านั้น ผลการศึกษาชี้ให้เห็นว่าลักษณะความสัมพันธ์ระหว่างแพทย์และผู้ป่วยเป็นปัจจัยสำคัญที่มีผลต่อการแลกเปลี่ยนตัวแบบการอธิบายความเจ็บป่วยในมุมมองของผู้ป่วย ในระหว่างการตรวจรักษาหากแพทย์มีอำนาจมากกว่าผู้ป่วยมากเท่าใด แพทย์ก็จะได้ข้อมูลที่เกี่ยวกับการอธิบายความเจ็บป่วยในมุมมองของผู้ป่วยน้อยลงเท่านั้น ในทางตรงกันข้าม หากแพทย์ใช้อำนาจควบคุมการตรวจรักษาน้อยลง ผู้ป่วยก็จะแลกเปลี่ยนข้อมูลความเจ็บป่วยในมุมมองของตนเองมากขึ้น การศึกษาครั้งนี้ได้เสนอ แบบจำลอง "ฐานการแบ่งปันอำนาจ" (The Chamber of Power Sharing Model) เพื่อใช้อธิบายการแลกเปลี่ยนตัวแบบในการอธิบายความเจ็บป่วยระหว่างแพทย์และผู้ป่วยในระหว่างการตรวจรักษา โดย "ฐานการแบ่งปันอำนาจ" ได้อธิบายความสัมพันธ์ซึ่งแพทย์เป็นผู้มีอำนาจว่าเกิดจากการที่ฐานนี้ถูกยึดครองด้วยตัวแบบของการอธิบายความเจ็บป่วยของแพทย์เป็นส่วนใหญ่และไม่เกิดการแบ่งปันอำนาจระหว่างแพทย์และผู้ป่วยในลักษณะที่เหมาะสม แบบจำลอง "การแบ่งปันอำนาจ" เสนอมุมมองใหม่ในการอธิบายพฤติกรรมการไม่ให้ความร่วมมือในการรักษา โดยเฉพาะพฤติกรรมการตระเวนรักษาของผู้ป่วย ว่าเกิดจากการที่ผู้ป่วยพยายามชดเชยอำนาจที่สูญเสียในระหว่างการตรวจรักษา โดยการแสวงหาสถานพยาบาลแห่งใหม่ที่เปิดโอกาสให้ตนมีโอกาสเลือกวิธีการรักษาตามตัวแบบการอธิบายความเจ็บป่วยในมุมมองของตน ผลการศึกษานี้ชี้ให้เห็นว่าผู้ป่วยคือผู้ทรงอำนาจที่แท้จริงในการดูแลรักษาความเจ็บป่วยของตน คุณภาพการรักษาพยาบาลจะเกิดขึ้นในรูปแบบของความสัมพันธ์เชิงอำนาจที่มีความเท่าเทียมกันระหว่างแพทย์และผู้ป่วย

สาขาวิชาเภสัชศาสตร์สังคมและบริหาร(นานาชาติ) ลายมือชื่อนิสิต.......................................

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ลายมือชื่ออาจารย์ที่ปรึกษาร่วม.................................

##4376966233: MAJOR SOCIAL AND ADMINISTRATIVE PHARMACY

KEY WORD : EXPLANATORY MODEL / PHYSICIAN-PATIENT RELATION / POWER

KORNKAEW CHANTHAPASA: (ANALYSIS OF EXPLANATORY MODELS AND THERAPEUTIC CHOICES UNDER PATIENT-PROVIDER POWER RELATION CONTEXT). THESIS ADVISOR : ASST.PROF. RUNGPETCH SAKULBUMRUNGSIL, PH.D. THESIS COADVISOR : ASSOC.PROF. LUECHAI SRI-NGERNYUANG, PH.D. 184 pp. ISBN 974-17-6956-3.

Both physicians and patients have their own explanatory model, "the notion about an episode of sickness and its treatment that is employed by all those engaged in the clinical process". The difference of explanatory models between physicians and patients is the significant factor causing negative relationship and unsuccessful therapeutic outcomes in the long run. The purpose of this study was to examine and contextualize explanatory models and therapeutic choices under patient-provider power relationship. A field study was conducted at the out-patient service of the general practice and the medicine departments in one of tertiary hospitals in the Northeast region of Thailand during December 2003 till January 2004. In the process of data collection, the research took the participant-as-observer role to observe 455 medical consultations from 8 physicians and 452 patients, and then 18 selected patients were followed for in-depth interview. The result showed that during medical consultations physicians' power dominated that of patients. This study has conceptualized *"the chamber of power sharing"* model to describe the exchange of explanatory models between patients and physicians in each relation. The model pointed out that during the consultation session, a chamber of power sharing was formed. In case of the physicians' power relation, this chamber was mostly filled with the physician's explanatory models, since it was used as the significant source of power and prescription was written out of this explanatory model with limited input or exchange from the patient's explanatory model. Patients then equalized the imbalanced explanatory model in the chamber of power sharing by exercising their explanatory models after medical consultation on therapeutic choices by not following what physicians ordered. The results suggested that patients would find their ways to utilize their power in practicing illness behaviors. The effective exchange of explanatory models under the proper role and relation between patients and providers was concluded as the solution to achieve better quality of care.

Field of study Social and Administrative Pharmacy. Student's signature…………………...

Academic year 2004 Advisor's signature……………………

Co-advisor's signature......................

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Much of this dissertation is about “Power”; it is the impression that this word implicated that encouraged me to complete my dissertation. There are many people who powered me. My “Acknowledgements” underline on these powers: they are not only a record of heartfelt thanks, but an admission of deep indebtedness. So who is behind this dissertation?

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LIST OF THAI TERMS

Ak-Seb	Inflammation from Both the Infection and Non-Infection
Hai Jai Bau Im	Short of Breath
Kin Kao Bau Sab	Loss of Appetite
Mai Tuuk Kub Ya	Incompatible with Medicine
Mor Yai	The Specialist
Mot Luuk Ak-Seb	Low Abdominal Pain
Non Bau Lub	Insomnia
Pa-Yad Tua Jeed	Trichina
Roke Pod	Abnormal Lung, or Tuberculosis
Roke Tai	Abnormal Kidney
Tong Deard	The Stomach was in Turmoil
Tuuk Kub Ya	Compatible with Medicines

สถาบันวิทยบริการ
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CHAPTER I

INTRODUCTION

1. Rationale and Statement of the Problem

Physician–patient relationship is increasingly viewed as a crucial aspect of therapeutic outcome. A number of researches documented that good therapeutic outcome was the result of good relationship between physicians and patients (Heszen and Lapinska, 1984; Sleath, 1996; Harris and Shearer, 2001; The et al., 2003). Most researches in this area studied this relationship through the communication process during medical consultation sessions. Several studies revealed that problematic communication between physicians and patients influenced therapeutic outcomes such as satisfaction, compliance, and etc (Helman, 1985; The et al., 2003). Wright and Morgan (1990) proposed the useful framework, the macro-level approach, to analyze the problematic interactions between physicians and patients. This approach suggested that an understanding of the structure of care, of power dynamics within the physician-patient relationship and of the assertion of medical over individual values should be useful in such an analysis.

As far as the power dynamics within the physician-patient relationship is concerned, several studies revealed that interactions between physicians and patients involved participants who had unequal power and possibly different interests (Boesch, 1972; Shapiro et al., 1983; Arborelius and Timpka, 1991; Reeler, 1996). Generally in the medical consultation, physicians have more power than their patients. Wright and Morgan (1990) pointed out that physicians used their responsibility on patients' health to justify physicians' power. Biomedical knowledge is a powerful source which supports physicians' responsibility on patients. Substantial political, financial, and social powers also allow physicians to have more power than patients both as individuals and as a profession. Such powers are symbolized in the physician-patient interaction by asymmetrical rules regarding touching, initiation of conversation, expression of

perceptions of the illness, and determination of the content of the discussion. Lang, Floyd, and Beine (2000) revealed that only a minority of patients spontaneously disclosed or "offered" their ideas, concerns, and expectations. Patients often suggested or implied their ideas through "clues". It is suggested that asymmetrical relations between physicians and patients may affect the exchange of information particularly on patients' side. Effective exchange of information requires appropriate relation during consultation. To our knowledge, a few studies have determined this issue. To achieve the best possible quality of care, the proper role of providers and clients during their interaction should be taken into consideration. It is very valuable to conduct an in-depth study on the power relation between patients and physicians.

Understand the power in the physician-patient relationships is a key to understand the sources of power. In any physician-patient interaction, power can be originated from three key sources, i.e., legal and social authority, material wealth, and information and knowledge exchange (Goodyear and Buetow, 2001). Although information and knowledge exchange are the significant sources of power in physician-patient interaction, both physicians and patients use these powers in different ways. Physicians use their knowledge as the crucial source of power. It is usually the effective source. Most patients did not use their knowledge as the effective source of power. Patients' knowledge is viewed as an ineffective source of power particularly during the usual consultation. However, physicians' power is still far from complete. Patients use behavior as a mean to assert control, commonly by violating physicians' order (Wright and Morgan, 1990).

Several studies pointed out that physicians and patients had different ideas of ill health (Boesch; 1972, Mathews; 1983, van Dulmen; 2002, The et al., 2003). The significant reasons which caused these differences were the dissimilar worlds between physicians and patients, different systems of thinking and belief, different social values and languages used (Boesch, 1972). The recent study showed that physicians and patients had different roles (health care seeker VS health care provider), languages (medical jargon VS lay talk), expectations (more diagnosis tests VS wait and see) and

perspectives of the complaints (biomedical VS psychosocial attributions) (van Dulmen, 2002). Mathews (1983) stated that incompatible frames of reference between two parties in consultation, sociolinguistic differences, the degree of shared knowledge, and the social distance influenced problematic areas in physician-patient communication. Therefore, a meeting between a patient and a physician is a meeting between two extremes.

From these differences, Helman (2000) proposed that disease and illness were the meaningful differences. Disease is the basic concept of biomedical knowledge which rules on scientific rationality, and is universally valid. The clinical fact must be counted, tested, and tangible. Illness is the concept of lay knowledge on ill health which is generated from the pattern of activities reinforced by ways of life. Illness is the subjective response of an individual for sickly being. It is a result of culture and social structure. Disease and illness are very different premises. They use different systems of evaluation on causes, efficacy of treatment, and others. The differences of diseases and illness are the root of the different Explanatory Models between physicians and patients. Kleinman (1980) stated that Explanatory Model is “the notion about an episode of sickness and its treatment that is employed by all those engaged in the clinical process”. Both physicians and patients have their own explanatory models but different on five aspects of illness: etiology of the condition, onset of symptoms, pathophysiological processes involved, natural and severity of the illness, and appropriate treatments for the conditions. For example, significant differences have been described between physicians’ and patients’ interpretations of the location and function of bodily organs (Boyle, 1970), the nature of ‘germs’ and ‘virus’ (Helman, 1978), and what a ‘drug’ is and is not (Jones, 1979). A recent ethnographic study of terminal patients with small cell lung cancer indicated that false optimism about recovery, preventing appropriate end of life care, is the result of the different perspectives between physicians and patients (The et al., 2003).

During the medical consultation, besides patient's ill health, both physicians and patients bring their own explanatory models to exchange with each other. Kleinman (1980) proposed that the consultation was a transaction between physicians and patients explanatory models of a particular illness. He suggested the important key for reaching successful diagnosis and treatment i.e., the understanding of patients' explanatory model. Physicians should be aware of and learn about patients' explanatory models in order to improve the quality of the therapeutic encounter. This finding was supported by Barsky et al., (1980), and Garrity (1981). Understand patients' explanatory model in the consultation is an important responsibility of physicians. However, Kleinman (1980) found that in practical physicians tried to fit the patients' explanatory models into biomedical models, rather than allowing patients' perspective on illness to be involved. Most physicians did not concern about patients' explanatory models.

Reeler (1996) proposed a different view. She stated that it was not important to negotiate explanatory models in the consultation especially on Thai setting as explanatory model was not the main interest for each party. Physicians are expected to know about diseases and choose appropriate medicines, while patients are expected to get the prescriptions to relieve their symptom immediately. In addition, she pointed out that the different explanatory models between physicians and patients did not have negative effect on their relations or the patients' perception of the outcome of the encounter. These findings clashed both the argument of Kleinman and the new concept of physician-patient relationships: patients' centered, adherence, and concordance that concerned on lay perspective. Reeler's findings were inconsistent with other studies. In other studies, it was found that the difference of explanatory models between physicians and patients was the significant factor which caused negative relationship and unsuccessful therapeutic outcomes in the long run (Wright and Morgan, 1990; Cohen et al., 1994). For instance, to analyze the problematic interactions between physicians and patients, Wright and Morgan (1990) proposed the patient belief approach. In this

approach the 'problem' patients are the result of the divergent beliefs on the explanatory models between physicians and patients. Recent studies documented that "at least one third of the patients in most studies failed to comply with physicians' orders", and one third of the studies reported more than 50% of noncompliance rate (Svarstad and Bultman, 2000). The key reason of failed therapeutic outcomes was the patient's explanatory model. Mull, Nguyen, and Mull (2001) showed that the belief that insulin injection was a strong aversion caused non-compliance. About thirty percent patients brought back half of their monthly unused insulin. The finding was supported by the study of van Dulmen (2002) which stated that the differences of explanatory models might cause a lot of problems such as dissatisfaction, seeking for a second opinion, and incorrect medication use. It means that patients seem to have more therapeutic choices, for example, deciding whether to follow or not follow physicians' order, seeking for other providers, and many other non-compliant actions. As mentioned above, the influence of the exchange of explanatory model on the therapeutic choices and patients' outcomes is still controversy particularly in Thai context. Therefore, it seems clear that the study on the negotiation or exchange of explanatory model and therapeutic choices is very important and should be thoroughly investigated in order to improve the quality of care.

Generally, physicians' explanatory model is generated from biomedical knowledge. Society values it as the scientific rationality. It is believed to be universally valid. Patients' explanatory model or lay knowledge, on the other hand, seems to be a mistaken knowledge which influences their irrational behaviors such as non-compliance. Biomedicine views patients' explanatory model as an incorrect knowledge. Actually, from patients' sight, explanatory model may be as rational as biomedical knowledge. Therefore, patients' explanatory model could be considered as a source of patients' power. Irrational behavior in biomedical view may, in fact, be the powerful expression of patients. A study on patients' explanatory model in the optimistic view may provide more understanding about patients' behavior. Furthermore, a number of studies on the outcomes of providers and patients encounter often focus on physician-patient

relationship. Few studies have examined the usefulness of the concept of power and its capacity to provide more understanding about the outcome of these interactions. This issue is very interesting since it proposes the new viewpoint of patients' explanatory models beneath their context and it has never been explored. The significant goal of this study is to analyze the explanatory models under patient-provider power relation context.

Despite of the fact that explanatory models are the significant factor which influences the outcomes of provider and patient encounter, there are still considerable gaps of knowledge. From the previous works, especially in Thailand, these gaps have never been explored. There is an urgent need to examine the influences of explanatory model on the outcomes of medical consultation since understanding this issue may influence the quality of care. The main purposes of this study were then to examine explanatory models, therapeutic choices and contextualize explanatory models and therapeutic choices under patient-provider power relationship.

2. Objectives

1. To examine explanatory models and therapeutic choices.
2. To contextualize explanatory models as well as therapeutic choices under patient-provider power relationship.

3. Expected Contributions

1. Knowing the potential of explanatory models in physician-patient relations will gain the understanding on the patterns of therapeutic choices from the perspective of lay. It will also help develop the effective intervention to improve patients' drug use behavior.
2. Understanding the physician-patient power relationships, including the way they exercise their power will provide a direction of an appropriate relationship

required during their encounter to support the rational use of drug for both patients and physicians.

4. Research Questions

1. The explanatory model
    a. What are the differences of explanatory models and therapeutic choices between physicians and patients?
    b. What are the factors that influence these differences?

2. The physician-patient power relation
    a. What are the patterns of power exercising between physicians and patients during the medical consultations?
    b. How does the pattern of physician-patient power relation influence the exchange of explanatory model?
    c. What are the significant factors that influence the pattern of physician-patient power relation and the exchange of explanatory model?
    d. Who are the powerful persons during medical consultation?
    e. How do they have these powers?
    f. What are the sources of power that they used?

3. The quality of care
    a. How does the pattern of physician-patient power relation impact the quality of care?
    b. How does the symmetric power relation between physicians and patients or the patient-centred approach provided high quality of care?

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CHAPTER II

LITERATURE REVIEW

Power is an inevitable aspect of all interpersonal relationships (Goodyear and Buetow, 2001) including the physician-patient relationship. Studies on physician-patient relationship usually converge on the imbalance of power. In fact, inequality of power is a common situation in any interaction. Imbalance relationship may take place over time. Moreover, the imbalance of power is definitely indicated by social movements such as the change of economic, technology, politic, and culture. People may be powerful in one situation but not another. The study on physician-patient relationship is an obvious picture for this notion. To have more understanding on power in medical relationships, the review literature were structured into 7 parts, first was the power in physician-patient relationship, followed with sources of power, the explanatory models, communication between physicians and patients, therapeutic outcomes, quality of care, and finally the conceptual framework of the study was delineated.

1. Power in Physician-Patient Relationship

The physician–patient relationship has been investigated more than two decades throughout the Western. Earliest the relationship was clearly asymmetrical one between a patient seeking help or care and a medical expert. The physicians' diagnostic evaluations were more or less indisputable and whose decisions should silently be complied by the patient. Up till recently, explanation of this relationship fit with the paternalistic model which assumed that physicians took the dominant role, while patients embraced the passive role. As the dominant role, physicians had a number of professional authorities. First, for most illnesses, a single best treatment existed and physicians were generally well versed in the most current and valid clinical thinking. Second, physicians not only knew the best treatments available but also consistently applied this information when selecting treatments for their own patients. Third,

because of their expertise and experience, physicians were in the best position to evaluate tradeoffs among different treatments then make the treatment decision. Fourth, because of their professional concern for the welfare of their patients, physicians have a legitimate investment in each treatment decision. All of these assumptions lead both physicians and patients to expect a dominant role for physicians in treatment decision-making. In addition, status differences between physicians and patients in terms of education, income, and gender contribute to larger power gaps between them in the medical consultation.

Starting from the period of 1980s, the credibility of the above assumptions began to be questioned. There were a number of dissatisfied patients who had not taken prescriptions or attended subsequent appointments, and practiced several other non-compliant actions. Several studies showed that the physician–patient relationship has changed dramatically during recent years. Physicians are becoming less authoritative and patients are more autonomous (Lupton, 1995; Lupton, 1997; Goodyear and Buetow, 2001; Falkum and Forde, 2001). Some physicians have proposed a more active and autonomous role for the patient in medical decision making. In addition, advocacy by some physicians on greater patient control at the same time reduced physician dominance has been evidenced. These practices shape legislative changes concerning patient rights and physician obligations as well as patient and physician expectations in the relationship.

To explain the shift of power in the relationship between physicians and patients in this decade, there are a number of models illustrating these relations. The famous one is proposed by Emanuel and Emanuel (1992). They presented four models of the physician–patient relationship, i.e. paternalistic model, informative or consumer model, interpretive model, and deliberative model. These models indicate the treatment decision-making including role of physicians and patients. Paternalistic model is the extreme model which assumes that a set of objective criteria to determine what is best does exist. Consequently, physicians can decide what is in patient’s interest without or

almost without patient participation. If there is a conflict between patient's autonomy and his health, the paternalistic physicians emphasize health without hesitation. The informative or consumer model locates at the other extreme of the patient-physician power scale. In this model, patients autonomously decide which medical intervention should be made, regardless of the physicians' opinions and values. The physicians' task is simply to provide the patient with all relevant information, i.e. the mean to exercise control. The model seems to presuppose that individual values are fixed and known, and restrict the physician-patient relationship to the exchange of factual information. The careful exploration by physicians on patients' views, values, needs and feelings is thereby excluded from the interactive process. Hence, both models rather detached portrait of the physician from its rationalistic vision of the patient's autonomy. The autonomy of patients seems to be distorted and in poor accordance with what really goes on between physicians and patients.

In between these two extremes, there are the interpretive model and deliberative model. The main aims of the physician-patient interaction in interpretive model are to elucidate embedded, inchoate or unclear needs and values of patients, and to help patients determine what medical interventions are most likely to realize these needs and values. Physicians act in the role of counselors or advisors who help patients increase self-understanding and thereby the autonomy of the patient. The emphasis of the interpretive model is the emotional aspects of the clinical consultation. The last model is the deliberative model. The physicians' aim is to help the patient determine the best health-related values which can be realized in the clinical situation. They provide factual information, elucidate values which embodied in the different options, clearly indicate why certain health-related values are more worthy than others, and try to persuade patients to make the right choice. Physicians act like teachers who aim to cultivate students' moral self-development through dialogue and deliberation.

According to the last two models, there is quite similarly on the patient's and the physician's roles, so it may be difficult to differentiate these two models. For example,

the role of physicians in interpretive model is a counselor or advisor, while in deliberative model physicians are teachers, these two roles are very close. It may be difficult to separate one from the other. Besides, there is a risk that the interpretive physician and deliberative physician become paternalistic. However, the proposal of Emanuel and Emanuel is a very useful study. It provides several keys to express the power in physician-patient relationships. These keys are:

1. who sets the agenda and goals of the visit (physicians, physicians and patients in negotiation, or patients);
2. the role of patients' values (assumed by physicians to be consistent with their own, jointly explored by patients and physicians, or unexamined);
3. the functional role assumed by the physician (guardian, advisor, or consultant)

Roter (2000) applied these keys to varieties of power relations between physicians and patients to present power of both sides. In each side she arranged power in two levels, high and low power, then classified the four prototypes of the physician–patient relationship, i.e. mutuality, paternalism, consumerism, and default (Table 2.1). These relationships presented both the powers of physicians and patients. The models of Roter provided clearer picture than Emanuel and Emanuel's models particularly on the mutuality and default relationship. Power in the mutuality relationship is balanced, and then goals, agenda, and decisions related to the visit are the results of negotiation between partners. Both patients and physicians become part of a joint venture while the medical dialogue conveys patient values. Physicians act as counselors or advisors throughout this process. This relationship is relevant to a patient-centered approach. The default relation has been characterized as unclear or contested common goals, obscured or unclear examination of patient values, as well as an uncertain physician role. It is here where medical management may be least effective with neither the patient nor the physician sensing progress or direction. At the paternalism and consumerism, Roter (2000) pointed out more description than the

proposal of Emanuel and Emanuel. Physician's role in the paternalism is the guardian who acts in the patient's best interest regardless of patient preferences, while physician's role in the consumerism is limited to technical consultant with the obligation to provide information and services contingently on patient preferences (and within professional norms). Consumerism redefines the medical consultation as a marketplace transaction.

Table 2.1 Prototypes of the Physician–Patient Relationship

Patient power	Physician power	
	High physician power	Low physician power
- High patient power	*Mutuality*	*Consumerism*
- Goal and agenda	Negotiated	Patient set
- Patient values	Jointly examined	Unexamined
- Physician's role	Advisor	Technical consultant
- Low patient power	*Paternalism*	*Default*
- Goal and agenda	Physician set	Unclear
- Patient values	Assumed	Unclear
- Physician's role	Guardian	Unclear

Source: Roter (2000)

The physician and patient relationships in both Emanuel and Emanuel's, and Roter's are illustrated through treatment decision-making models. Both models look at three significant elements, i.e. who makes decision in this treatment, who sets the agenda and goals of the visit, and what roles taken by patients and what functional roles assumed by the physician. These three elements are the meaningful factor expressing the power in physician-patient relationship. There was the other study in the previous period that described various pictures of physician and patient roles: the physician-patient role models of Sparr et al., (1988). Sparr et al., (1988) developed six role models of physician to explain the physician-patient relationship (Table 2.2). The role model of

Sparr et al., (1988) has more explanation on the role of both physicians and patients than the model of Emanuel and Emanuel as well as that of Roter. For example, the paternalism model of Emanuel and Emanuel and Roter may be illustrated in the model of Sparr et al., (1988) as the model no.1 (scientist), no.2 (expert resource), and no.5 (parent). Physicians in paternalism model may assume a role of scientist, expert resource, or parent, while patients may assume a role of research subject, active cooperative participant, or child.

The roles model of Sparr et al., (1988) presented the very interesting roles of both physicians and patients, since these models detailed a variety of roles of both physicians and patients. They indicated that there were five roles of physicians as scientist, expert resource, clerk or paper work processor, parent, and unskilled or inexpert resource. While patients had six roles as research subject, active cooperative participant, non-cooperative obstructionist, subscriber, child, and unsuspecting victim. Although, Sparr et al., (1988) had not directly explained the relation between physicians and patients of each model, the role of physicians and patients in each model implied the physician-patient relation. For instance, in model no.4, physician acts as clerk or paper work processor, while patient acts as subscriber, these roles may present the problematic relationships that the physician shifts the focus from interaction with the patient towards reading or writing medical records (Ruusuvuori, 2001).

Table 2.2 Physician-Patient Role Models

Model	Role of the physician	Role of the patient
- Model no.1	Scientist	Research subject
- Model no.2	Expert resource	Active cooperative participant
- Model no.3	Expert resource	Non-cooperative obstructionist
- Model no.4	Clerk, paper work processor	Subscriber, seeker of eligibility
- Model no.5	Parent	Child
- Model no.6	Unskilled, inexpert resource	Unsuspecting victim

Source: Sparr et al. (1988)

The studies by Sparr et al.,(1988), Emanuel and Emanuel (1992), and Roter (2000) provided more understanding on physician and patient relationships particularly the factors that explicit the power in these relationships and the role of physicians and patients in each relationship. In addition, the study by Phillips (1996) revealed that physician and patient relationships could be presented in terms of 'medical professional dominance'. Medical professional dominance in this study consisted of three elements:-

1. Professionalism: The ability of a profession to control all aspects of functioning including the selection of recruits, the setting of standards for curriculum and training, the determination of client and the specific types of activity;
2. Controlling over other professions: The extent of influence of the profession over other professions in dictating the parameters of their functioning, this control may be sanctioned by law;
3. Social control: This element involves the legal power of a profession to define what may otherwise be understood to be 'social problems' as 'illnesses'. The profession thus directly or indirectly influences the decisions made in other professions as well as in wider areas of social life.

These three elements stated that medical professional dominance was the consequence of social context, therefore studying on physician and patient relationship should take social context into account. This finding was consistent with the argument of Pendleton et al., (2003) the power relation between patients and doctors were profoundly influenced by the social and cultural context in which they took place. They pointed out that values and norms were two significant social influences on medical encounters (Pendleton et al., 2003). Values are relatively abstract and shared beliefs. Norms are more concrete way of thinking; feeling and acting that derive from values. Both values and norms are learned from, and sustained by, membership of social group. Furthermore, Phillips (1996) identified the expression of dominance in the physician-patient relationship through both verbal and non-verbal communication as detailed later in this chapter.

The Situation of Physician-Patient Relationships in Thailand

There are very few studies exploring the physician and patient relation in Thailand (Boesch, 1972; Kanittanan, 1985; Reeler, 1996; Sirima Chiengchowvai, 2000). Two studies emphasized on the linguistic properties between physicians and patients (Kanittanan, 1985; Sirima Chiengchowvai, 2000). It was found that there were unequally relation between physicians and patients. Physicians' status was regarded higher than their patients. The other two relevant studies on the physician and patient relation were conducted by Boecsh (1972), and by Reeler (1996). The first study was conducted in the early seventies (Boecsh, 1972). It showed that there was a significant difference between the status of physicians and that of patients in consultation. Physicians behaved as superior and patients were inferior. This study was carried out data in 1970-1971 or nearly thirty-five years ago. However the findings still represented the portrait of relationship between physicians and patients in Thailand nowadays.

The second study showed a completion of power negotiations in the therapeutic consultation by Reeler (1996). She proposed that health seeking behavior of sick persons was based on their power relation with providers. Sick patients classified their status as friends, patients, or customers in relation to providers. The power negotiations of sick persons in the therapeutic consultation with providers depended on their status. According to the type of social relations in each consultation, the therapeutic outcome was varying. Reeler's study presented a different perspective of provider-patient relationship from other studies (Boecsh, 1972; Sparr et al., 1988; Emanuel and Emanuel,1992; and Roter,2000). While others looked at the relationship as two-way interaction, she reflected this relationship only from the patient perspective as friends, patients, and customers. As well, other studies would try to explore roles and functions, values, and needs of both patients and physicians. Although, she classified doctor-patient relation differently from Emanuel and Emanuel (1992) and Roter (2000), this relation presented the current trend which moved from paternalism to consumerism as found in Emanuel and Emanuel's and Roter's studies.

Despite of the fact that the physician-patient relationship moves from paternalism to consumerism, there are still considerable gaps of knowledge especially on the proper role of health care providers and clients. To achieve the best possible quality of care, the proper role of health care providers and clients should be taken into consideration. It is very valuable to conduct an in-depth investigation on the pattern of power relation between health care providers particularly on physicians and patients in medical setting.

The review of literature in this part both in the section of research studies and the situation of Thailand indicated the significant points on power in physician-patient relationship. Firstly, the trend of physician-patient relationship, that currently shirts from paternalism towards consumerism, was recapped. Secondly, the three elements expressing the power in physician-patient relationship, including agenda and goal setter, role of patients', values, and functional role of physicians, was illustrated and the last was a various roles of both physicians and patients. To have more comprehension on power in physician-patient relationship, sources of power was reviewed as below.

2. Sources of Power

The sources of power should be taken into consideration to help understand the power in the physician-patient relationship. In any physician-patient interaction, power can be seen to originate from three key sources i.e. legal & social authority, material wealth, and information & knowledge exchange (Goodyear and Buetow, 2001). Both physicians and patients have these three types of power (Table 2.3). However, these powers are derived from different sources. For example, physicians derive legal & social authority power from social authority and status, while patients gain this power from social standings and legal rights such as consumers' rights. While physicians usually exercise their material wealth power thru the use of the available medical resources, e.g. medicine, medical equipment, patients employ financial resources as the source of their material wealth power. As for Information & knowledge exchange,

the last type of power, physicians commonly utilize their knowledge as the crucial source of power. On the other hand, patients' knowledge seems to be an ineffective source of power since it is considered to be inaccurate from biomedical point of view. Most patients are usually perceived as the persons who lack of biomedical knowledge. Lang, Floyd, and Beine (2000) revealed that only a minority of patients spontaneously disclosed or "offered" their ideas, concerns, and expectations. Patients often suggested or implied their ideas through "clues". It is suggested that asymmetrical relations between doctors and patients may affect the exchange of information particularly on patients' side. Effective exchange of information requires appropriate relation during consultation.

Table 2.3 Sources of Power in the Physician-Patient Relationship

Type of power	Physician's source of power	Patient's source of power
Legal & social authority 'Muscle'	Social authority & status	Social standing & legal rights
Material wealth 'Money'	Available medical resources	Financial resources to pay for medical care (includes insurance or state subsidy)
Information & knowledge exchange 'Mind'	Medical knowledge & skills	Self knowledge; beliefs values about own health problems

Source: Goodyear and Buetow (2001)

Goodyear and Buetow (2001) pointed out that both physicians and patients needed power. Physicians needed power to maintain their own professional completeness and to promote the healing of patients as persons, while patients needed power to have their health needs met and to meet their own responsibilities. Furthermore, they indicated that the concept of use and misuse of power was the significant point that illustrated physician-patient relationships. Power could be used or

misused in these relationships. There were several aspects of personal qualities, such as trust, ethics, communication skills, assertiveness, and the sense of confidence within the interaction, which influence the power use in the relationship between physicians and patients. Although, several studies revealed that there were unequal power or asymmetrical relation in the consultation. These findings do not point out on the use or misuse of power (Shapiro et al., 1983; Arborelius and Timpka, 1991; Reeler, 1996). Moreover, they stated that physicians and patients may also misuse their powers through their misuse of social authority, material resources, and knowledge as detailed in table 2.4

Table 2.4 Examples of the Misuse of Power in the Physician-Patient Relationship

Type of power	Misuse by physicians	Misuse by patients
Social authority	✎ 'Playing God', e.g. using selective euthanasia or abortion to create an improved human population	✎ Using high social standing to obtain unfair access to medical resources, e.g. jump waiting-list queue
Material Resources	✎ Making decisions about investigative or management resources influenced by personal monetary gain	✎ Failing to pay for services received (excluding cases of genuine indigent) ✎ Engaging in unscrupulous lawsuits against physicians for the primary motive of making money
Information & Knowledge	✎ Withholding medical information from patients to maintain position of superiority ✎ Continuing treatments even physician's knowledge & skills are inadequate ✎ Controlling or punishing patients because patients do not follow advice or are disliked ✎ Making decisions not for patient's best interest but based on physician's own beliefs & values	✎ Withholding information, e.g. denying or minimizing alcohol or tobacco use ✎ Providing the physician with misinformation, e.g. falsely claiming compliance with physician's treatment; ✎ Consciously or unconsciously manipulate physicians to initiate examinations, investigations or treatments which the physician may regret ✎ Sabotaging physician's diagnosis & treatment.

Source: Goodyear and Buetow (2001)

Regarding on each dimension in turn, as the information & knowledge source, patients abuse their power by providing the physician with misinformation, manipulating physicians to initiate examinations, investigations, or treatment. In fact, these misuses of power may be the positive power when looking from patients point of view, since these misinformation may be the correctly information from patients' perspective. There were many studies that indicated that both patients and physicians had their own notion about an episode of sickness and its treatment (Kleinman, 1980; Helman, 1985; Helman, 2000). Several studies documented that patients' knowledge differed strikingly from the medical knowledge (Kavanagh and Broom, 1997a; Kernick, Reinhold, and Mitchell, 1999; Nations and Nuto, 2002; Karasz and Anderson, 2003). Kleinman (1980) defined this notion about an episode of sickness and its treatment as *"The Explanatory Model"*. Thus, the explanatory model is considered the information & knowledge source of power. The review of literature on the explanatory model presented in the next section would provide more understanding.

3. The Explanatory Models

Every society has collections of beliefs about an episode of illness and its treatment which is called explanatory model (Kleinman, 1980). This concept is theoretically grounded in cognitive anthropology and based on the premise of the social construction of reality. Explanatory models offer explanations of sickness and treatment, guide choices among available therapies and therapists, and give social meaning to the experience of sickness. Since explanatory models are learned through the process of socialization, people in different societies may have different beliefs about what causes illness and how it should be treated. Physicians as well as patients have their own explanatory models which are different on five aspects of illness i.e. etiology of the condition, onset of symptoms, pathophysiological processes involved, natural and severity of the illness, and appropriate treatments for the conditions (Helman, 2000).

A number of studies stated that the explanatory models held by patients differed sharply from those held by physicians (Gregg and Curry, 1994; Johansson, et al.,1996; Kavanagh and Broom, 1997; Gesler, 1999; Nations and Nuto, 2002; Karasz and Anderson, 2003). For example, most women do not understand the specific meanings of technical terms such as wart virus or pre-cancer. They often assume that they have cancer because they do not know that smear tests detected precancerous lesions (Kavanagh and Broom, 1997). This example suggests that there are meaningful points about diseases which are not covered by biomedical knowledge. Patients usually interpret and explain their illnesses in the context of their everyday lives. For example, women diagnosed with vaginitis experience the role of vaginal symptoms and treatment in the communicating distress, anger, and gender conflict particularly on sexual functioning (Karasz and Anderson, 2003). Another example, women who experience pains would perceive the consequences of pain as the negative consequences of their everyday life (Kavanagh and Broom, 1997). In contrast, physicians' narratives about health and illness center around diseases and cure through the application of scientific medicine (Rothschild, 1998; Kernick et al., 1999). The other example explains patients' culturally constructed explanatory model of teeth rotted (estraga) by "tooth worms" (lagartas). This explanation is substantively different from dentists' model of dental decay which is proved to cause by Streptococcus mutants (Nations and Nuto, 2002). These differences came from the distinct premises of the systems of evaluation on causes, efficacy of treatments, and etc (Helman, 2000).

Owing to the different perspectives, physician's explanatory model rules on the scientific rationality, so it is believed to be universally valid. Physician's explanatory model is usually based on "single causal trains of scientific logic", while lay's explanatory model generates from the pattern of activities reinforced by the ways of life. The later model tends to be 'idiosyncratic and changeable'. Hunt, Jordan, and Irwin (1989) pointed out that lays developed their explanatory model by the significant prior histories, ongoing experiences and social worlds. Illness explanation is an interactive process. It is a dynamic entity whose adequacy is determined by its usefulness within

the extra-medical social environment. Ill health in lays' perspectives often comes with the explanation of their suffering in the everyday life.

The different perspectives toward illness between physicians and patients negatively correlate with patient outcome variables such as compliance, satisfaction, subsequent use of health care facilities, treatment response and reporting of untoward side-effects of treatment (Kleinman, 1980; Anstett, 1980; Greenfield, Borkan, and Yodfat, 1987; Cohen et al., 1994; Johansson, et al.,1996; Pollock, 2001). For example, Anstett (1980) indicated that some physicians defined some patients as difficult patients. The failure of relationships between physicians and patients lead to dissatisfactory outcomes at last. The notable reason for the failure relationship is the incongruent between physician's and patient's explanatory models. Then the explanatory models of both physicians and patients are the important source of power that both of them used to manage ill health. Generally, physicians fail to recognize the symbolic or phenomenological aspects of their patients' illnesses. They also fail to perceive needs and expectations of patients.

Explaining the outcome of health care service by the concept of power may be the new approach which obviously brings comprehension on physicians' and patients' behaviors. In this approach, the negative outcomes, such as non-compliance, shopping around, and etc, are the result of the power exercised by patients. In addition, these negative outcomes are the consequence of physicians' power during medical consultation. Since several studies point out that physicians usually lack awareness and understanding of patients' explanatory model (Klienman, 1980, Pollock, 2001), they use only their explanatory. The negative outcomes are the result of the power exercise by both physicians and patients, correcting these outcomes should be the responsibility of both physicians and patients (Podell and Gary, 1976; Trostle, 1988; Rothschild, 1998).

Lay and medical explanatory models are not separate systems. Several studies reveal that lay explanatory model incorporate with medical understanding (Cohen et al.,

1994; Curry et al., 2002). For instance, the study of parent's belief about childhood ear infections (Curry et al., 2002) reveals that physicians are the important source of information about otitis media. Parent's beliefs about risks, symptoms, and causes of otitis media are similar to the current biomedical model of the illness. This finding agrees with previous study which found that patients' views about treatment and severity were similar with health staff's views (Cohen et al., 1994). The findings are also consistent with the appearance of explanatory model which proposed by Kleinman (1980). Explanatory models tend to be 'idiosyncratic and changeable' and are heavily influenced by context e.g. personality, cultural factors, and biomedical knowledge. Although explanatory models draw from general belief system, they are not the same as general beliefs about sickness and health care. Explanatory model is a response to a particular episode of illness, chronic or acute. It is not static. It reflects beliefs held at a particular time (Cohen et al., 1994). Explanatory model is an interactive process, drawing significantly on the prior histories, ongoing experiences and social worlds (Hunt et al., 1989). However, there are no formal studies on how lay knowledge could influence medical decision and behaviors.

The very soundness of Klienman's model is that explanatory models reflect differences between knowledge and beliefs of physicians and those of lay people. The different definitions of the illness which was resulted from different explanatory models serve as one of patient's major weapons in the struggle of control (Wright and Morgan, 1990). Since the explanatory model is an important source of power, its meaning should be identified. Kleinman (1980) has identified five components of explanatory models. These include (a) etiology, (b) onset of symptoms, (c) pathophysiology, (d) course of sickness and (e) treatment. Cobb and Hamera (1986) argued that the terms "etiology" and "pathophysiology" were not clear when they were used in lay context. These two terms are distinctly biomedical phraseology. In addition, Cobb and Hamera (1986) pointed out that Kleinman's model excluded the prevention and evaluation of treatment which are the considerable concepts. The evaluation of treatment is an important part of the explanatory models as it directs both patients and professionals in their selections

(or rejection) of ongoing therapies. Cobb and Hamera (1986) identified the components of explanatory model as (a) ideas of causation, (b) recognition of symptoms, (c) course of the illness experience, (d) therapies, including professional, popular, and folk and (e) evaluation of therapies. Comparing Kleinman's model with Cobb's and Hamera's model, the later had more evident identification.

This study employs components from Cobb's and Hamera's model to describe the explanatory models. However, in therapies component, the therapy expectation i.e. etiquette, treatment style, and therapeutic objectives (Reeler, 1996) are also added. Reeler (1996) mentioned that expectations varied according to the type of social relations and these expectations were greater different between physicians and patients. She classified expectations into (a) etiquette or the manner expectation such as formal, polite, etc., (b) treatment style or the expectation on the medical equipment or technology, and (c) therapeutic objectives or the recovery, biomedical cure, and patient satisfaction. The therapy expectation is as notable as the evaluation component part in the explanatory models especially on patients' explanatory model because it influences the ongoing therapies. It may be the criteria of the evaluation component as well.

To complete the understanding on explanatory model, the perception of medicine must be considered, since it has direct effect on behavior and the use of multiple therapy sources especially among lay persons (Nichter, 1980; Reeler, 1996). Nichter (1980:228-229) discussed a very attractive point on the power of medicine that villagers considered medicine as both the inherent power and the ability of patients to accommodate with it. He pointed out that in villagers' perception, power of medicine depended on the physical characteristics. For example, tablet was considered a weaker dose of medication than injection, and a single injection was a weaker dose of medication than a double injection. Powerful medicine was desired by those whose bodies could stand the "shock", it was an inherent power of medicine. In addition, villagers used medicines to enhance the power of their medication against the

instruction of practitioners by adjusted their medication themselves. If one tablet did not yield satisfactory result, two or three tablets were taken simultaneously.

Furthermore, Reeler (1996) pointed out that the prescription of many unknown drugs and injections seemed to be the expectation of sick person. In Thai culture, drugs were the negotiated outcome where both physicians and patients had a sort of power in the medical consultation. Medicines were having more value than just the substances to cure disease. Medicines were the forceful power influencing on lay's behavior. Because the perception of medicines on explanatory model is significant, this study includes it as one component of explanatory model.

As mentioned above, the explanatory models were the significant source of power that both of physicians and patients use to exchange or exercise their power during the medical consultation. The explanatory models were the potential source of power that patients used to evaluate the treatment after medical consultation as well. Then, these following components were used to discussing the explanatory models in this study:

(a) ideas of causation;

(b) recognition of symptoms;

(c) courses of the illness experience;

(d) therapies, including professional, popular, and folk

- therapy expectation
- etiquette: manner such as formal, polite, etc.
- treatment style: medical equipment or technology
- therapeutic objectives: recovery, biomedical cure, patient satisfaction

(e) evaluation of therapies

(f) perception of medicines

- physical characteristics
- value

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To analyze power between physicians and patients in other aspect, several researches in this area studied this relationship through the communication process during medical consultation sessions (Boesch, 1972; Kanithana 1985; Ong et al., 1995; Chiengchowvai 2000). It was found that verbal and non-verbal behaviors in the communication process conveyed the power use of physicians and patients, these behaviors were the most certainly behaviors that presented power. To put this study in context, some of the literature on the communication between physicians and patients are reviewed on the next section.

4. Communication between Physicians and Patients

Based on the concept of "the medical professional dominance" the power of physicians could be expressed through the communication both verbal and non-verbal (Phillips, 1996). Phillips (1996) identified the expression of dominance in the physician-patient relationship by "the outcome variables" as:

1. meaningful communication initiated by the physician;
2. expressed willingness to give information to the patient related to his/her condition and care;
3. evasion of direct questions of the patient by the physician;
4. use of medical jargon in discussions with the patient

In addition, the study "Physician-Patient Communication: A Review of The Literature"(Ong et al., 1995) addressed two topics related to power between physicians and patients: different purposes of medical communication and specific communicative behaviors. Three different purposes of communication were identified, namely: (a) creating a good inter-personal relationship; (b) exchanging information; and (c) making treatment-related decisions. These purposes implied the power use of both physicians and patients. They also showed the idea of patient-centered or physician-centered approaches. On patient-centered approach, physicians placed more concern on

patients, therefore, the power use of each physician and patient may equal or be the mutuality power.

In term of specific communicative behaviors, there are several communicative behaviors that convey the power use of physicians and patients. These include three communicative behaviors: verbal vs non-verbal behavior, privacy behavior, and high vs low controlling behaviors. Verbal and non-verbal behaviors may be the most certain behavior that presented power. According to verbal behavior, power can be communicated by language including medical or everyday language vocabularies, and use of second personal pronoun and polite expression articles at the end of sentences. This assumption is confirmed by the findings from studies by Boesch (1972), Kanithana (1985), and Chiengchowvai (2000). Boecsh (1972) found that physicians used second personal pronouns and polite articles at the end of sentences to express and differentiate their status from patients. This result was similar to results from linguistic studies which patients showed respect to their physicians thru the use second personal pronouns and polite articles at the end of sentences too (Kanithanan, 1985). Kanithana (1985) mentioned that one consequence of the different status between physician and patient is the uncomfortable manner of patients to their physicians. Patients feeled uneasy and very polite, while their physicians, concerning themselves as a super-ordinate role, did not worry on their appearance. Sirima Chiengchowvai's result (2000) on the politeness of patient was consistent with previous studies. This study found that patients used the question sentences instead the ordering sentences when they wanted to suggest treatment or examination in order to be more informative than requirement. They used interrogative forms for politeness and pre-request for information. As mentioned above, language, using second personal pronouns and polite articles at the end of sentences including manner and interrogative forms, are the significant findings that both parties used to communicate the different status.

According to Sirima Chiengchowvai's findings, from pediatrists' point of view, parents seemed not to give sufficient information. This finding was similar to results from

previous investigations by Boecsh (1972), and Kanithana (1985). Kanithana (1985) proposed that this problem might come from the different ideas between physicians and patients. Physician's content in the conversation followed by the step in diagnosis process. Another word, physicians had a frame in the conversation. On the other hand, without the conversation frame, patients' contents came from their illness experience influenced by education, income, and etc. The expressions of power through non-verbal were tone of voice, gaze, posture, laughter, facial expressions, touch, and physical distance (Ong et al., 1995).

For the second specific communicative behavior, privacy behaviors, there were four sorts of privacy: informational, psychological, social, and physical privacy. Some of these behaviors may be one element of verbal or non-verbal communication. Parrott, Burgoon, and LePoire (1989) defined psychological privacy as “it is the patient's ability to control affective and cognitive inputs and outputs, and ability to think and form attitudes, beliefs or values and right to determine with whom and under what circumstances [the patient] will share thoughts and feelings or reveal intimate information”. In addition, social privacy was described as “the patient's ability and effort to control social contacts in order to manage interactions or maintain status divisions”, while information and physical privacy was defined as “the extent to which a patient is informed or physically accessible to others". According to the definition of each behavior, psychological and social privacy were the abstract behavior, therefore they were very difficult to categorize. This study involved only in information and physical privacy because they were more apparent to classify and they could communicate power in the consultation.

The other practice of power expression in physician-patient relationship exists on a spectrum of high and low control behavior. There are several studies using controlling behavior to categorize physician-patient relationships. Kaplan, Greenfield, and Ware (1989) used control as one of three categories to classify physician-patient communication as 'physician direction' (questions, interruptions, etc. by the physician),

'patient direction' (questions, interruptions by the patient), and 'affect/opinion exchange'. The first two patterns include controlling behaviors. In addition, controlling behavior may be very useful to explain the physician-patient relationship model in general approach: physician and patient centered. Control is one common style displayed by physicians during consultation. Paternalism model, for example, if physician has high control (and patient has low control), physician will be dominant in the relationship meaning that the physician will make decisions in what he perceives to be the patient's best interest. Buller and Buller (1987 cited in Ong et al., 1995) pointed out that controlling could be exhibited through both verbal and non-verbal, behaviors, dominated conversations, verbal exaggeration to emphasize a point, dramatization, constant gesture making when communicating. This result was consistent with the linguistic studies (Kanittanan, 1985; Sirima Chiengchowvai, 2000) that physicians, in consultation, had more control than their patients. Doctors generated or changed topics, controlled length of consultation. Patients had a passive role such as providing information that their physician asked, complying with their physician's order. Furthermore, the difference in control in medical communication could depend on the patient's limited understanding of medical problems and treatment, heightened uncertainty, physicians' control on medical information, and the institutionalized roles prescribed for the physician and the patient (Ben-Sira, 1980; Hall, Roter, and Rand, 1981).

In case of Thailand, Reeler's study (1996) showed obvious picture of actual communication between physicians and patients during in medical consultation as described below:

A Consultation at the Public Hospital

The physician is seated in a small consultation room behind a desk. A middle-aged woman enters and greets the physician respectfully. The physician gestures her to sit down in a chair next to the desk. The woman sits, slightly hunches, and looks

anxious. The physician asks her name, age, and compliant. She answers briefly. He listens, looks at her face and then he starts writing the prescription. The interaction lasts less than two minutes, most of which is spent on writing the prescription. The physician hands the prescription to the woman and she thanks him and leaves for prescription filling at the hospital pharmacy.

This picture introduced at least three considerable issues of the communication between physicians and patients: nature of physician-patient relationship, information giving and asking during the consultation, and the length of the consultation. Firstly, between physician and patient relationship, there was no personal relationship or purchasing power in the consultation. The negotiation was between an expert and a layman. The patient had a weak bargaining position. The relationship was asymmetrical in terms of power. This picture was consistent with previous studies by Boecsh (1972) and linguistic studies (Kanittanan, 1985; Sirima Chiengchowvai, 2000) as mentioned above.

Secondly, as stated by the information giving and asking during consultation, the picture mentioned above represented that the physician spent no time to discuss about diagnosis and the prescription, while the patient did not ask any question during the consultation (Reeler 1996: 110). Similar to results from Boecsh's study (1972), the study pointed out that physicians focused on the actual disease and patient history more than the personal and social situation of patients, while patients seemed to be willing to accept and cooperate with circumstances. Patients provide more information, but their information is often incomplete, inconsistent, and imprecise. Information giving and asking during consultation is one of several points that explain power of physicians, as well as control of the information during communication process in medical consultation.

The last issue is the length of the consultation. Reeler (1996) reported that though patients waited several hours to see the physician, the actual consultation with the physician was very short. This finding was similar to the result from previous

investigation by Boecsh (1972) which found that the length of consultation on the average was too short to organize close contact, or to diagnose and advise with adequate precision, clarity, and tact. Furthermore, Reeler pointed out that the length of consultation seemed to express much more on the attitude of the physician than on the number of waiting patients. Besides, this study showed that many physicians avoid problems by shortening interaction with their patients and by adopting a style of communication which increases difficulties of contact. The other study related with physician and patient relation in Thailand is the study on "the Problems and Suffering Experienced by Patient Obtaining Services at Health Care Facilities" (Yotin Sawangdee, Pimonporn Isarabhakdi, Malee Sanpuwan, 2000). The study concluded that communication between physicians and patients, such as bad manner of health care providers, and limited time of visitation by physicians, are important factors causing patients' distress.

5. Therapeutic Outcomes

"Outcome" used in health care studies can be defined as "an observable consequence of prior activity occurring after a consultation, or some portion of the consultation, is completed" (Beckham, 1994; Kaplan et al.,1995). There were five factors which influenced patient outcomes namely: some characteristics of the physician-patient interaction including physicians' directiveness, physicians' attitude towards the patient, patients' activity, patients' partnership status (Falvo, Woehlke, and Deichmann, 1980; Heszen-Klemens and Lapinska, 1984; Harris and Shearer, 2001), the different cultures between physicians and patients (Rothschild, 1998; Pollock, 2001), the congruence of the patients and health care providers' explanatory model (Greenfield et al., 1987; Pollock, 2001), the lack of professional awareness and understanding of patients' explanatory model (Pollock, 2001), and the affective quality of the consultation (Ong et al., 2000).

The dissimilar culture between physicians and patients may be the consequential factor influencing patient outcomes. Rothschild (1998) reviewed the role of culture in primary care medicine and the effect of health beliefs on decisions to seek care. Rothschild (1998) pointed out that although health care had been increasingly guided by scientific and evidence-based models; individual patients were increasingly seeking health care that addressed their personal beliefs and needs. If physicians focus only on a narrowly defined biomedical approach to the treatment of disease, they will often misunderstand their patients, miss valuable diagnostic cues, and experience higher rates of patient non-compliance with therapies. Such miscommunication will also result in greater patient dissatisfaction and more malpractice suits. Therefore physicians must develop the knowledge and the skills to engage patients from different cultures and to understand the beliefs and the values of those cultures. Rothschild's findings pointed out the very useful argument that the distinctive culture between physicians and patients addressed the incongruent explanatory models between physicians and patients and this incongruence indicated patient outcomes which might be the negative outcomes such as non-compliance in biomedical view. This argument was consistent with several studies particularly the study by Klienman (1980).

As mentioned, both physicians and patients have power but for different need. Physicians need power to maintain their own professional completeness, while patients need power to have their health need met. Both physicians and patients try to exercise their power, therefore, the power may be balanced or imbalanced depending on their sources in each situation. Ordinarily, there is the imbalance of power during medical consultation, with power shifted to the physician's side. Non-compliance may be the behavior that patients try to exercise their power in order to balance power. After visiting a physician, patients may exercise their power by choosing to behave in a way that conforms with their beliefs and values to counterbalance the loss of power during the medical consultation.

Many different patient outcomes have been identified such as compliance/adherence to treatment, satisfaction, recall and understanding of information, subsequent use of health care facilities, treatment response and reporting of untoward side-effects of treatment, and health status/psychiatric morbidity (Kleinman, 1980). As far as the time that outcomes occur is concerned, it can be categorized in two groups: short-term or intermediate outcomes, and long-term outcomes. Short-term and intermediate outcomes are the compliance / adherence to treatment, satisfaction, recall and understanding of information, subsequent use of health care facilities, treatment response and reporting of untoward side-effects of treatment. Long-term outcomes are health status, and psychiatric morbidity. However, several researches that studied the impact of the different explanatory models between physicians and patients on the negative outcomes by and large referred to non-compliance behavior (Jones, 1979; Greenfield et al., 1987; Cohen et al., 1994; Johansson et al., 1996; Pollock, 2001). In this study, short-term outcomes particularly the compliance/adherence behavior are emphasized as the result of the power use between physicians and patients.

6. The Quality of Care

Campbell, Roland, and Buetow (2000) pointed out that the interaction of physicians and patients was the significant domain that several studies used to describe the definition of quality of care specifically on the process of care dimension. Since medical consultation represented the relationship of trust, the understanding and empathy, humanism, sensitivity and responsiveness it included the management of the social and psychological interaction between physicians and patients. That meant the medical consultation could reflect the approach of care employed by physicians to contact with their patients. Therefore, the two pictures, the picture of power relation between physicians and patients and the picture of the quality of care were connected. The study hypothesized that there was the association between the physician-patient power relation and the quality of care. This hypothesis was supported by the study of

Campbell et al. (2000), in that high quality of care took place in the symmetrical power relation between physicians and patients. They pointed out that a symmetrical power relation was the key concept of the *"patient-centered"* approach. This approach promoted the idea of an egalitarian physician-patient relationship where power and responsibility were shared. It was increasingly regarded as a crucial factor that contributed to the quality of care (Mead and Bower, 2000).

This study defined the quality of care individual patients as proposed by Campbell and colleagues (2000: 1614):

"Whether individuals can access the health structures and processes of care which they need and whether the care received is effective".

To describe how access and effectiveness were related to health care structures, to processes of care and outcomes, Campbell et al. (2000) developed the *"Dimensions of quality of care for individual patients"* by applying the concepts of access and effectiveness to the Donabedian's systems based model of care (structure, process and outcome) (Table 2.5).

Table 2.5 Dimensions of Quality of Care for Individual Patients

Quality	Care		
	Health Care System (Structure)	Patient-Centred care (Process)	Consequences of Care (Outcomes)
Accessibility	↳ Geographic / physical access ↳ Affordability ↳ - Availability	↳ Affordability ↳ Availability	↳ Health status ↳ User evaluation
Effectiveness		↳ Effectiveness of Clinical care ↳ Effectiveness of Inter-personal care	↳ Health status ↳ User evaluation

Source: Campbell et al., (2000)

Based on the systems based model of care (structure, process and outcome), the study applied the framework of "Dimensions of Quality of Care for Individual Patients" developed by Campbell et al., (2000) to the context of this study. According to this framework, the physical and staff characteristics were classified under the structure dimension. While the process dimension of quality of care for individual patients was described by the *"patient-centered"* care. However, the patient-centered care under the process dimension was modified using five conceptual dimensions of patient-centeredness proposed by Mead and Bower (2000). These five conceptual dimensions included biopsychosocial perspective, patient-as-person, sharing power and responsibility, therapeutic alliance, and physician-as-person. The consequence of care in this study focused only on the user evaluation particularly on the future decisions about their prescriptions and accessing care.

7. The Conceptual Framework

This literature review pointed out the very significant issue, power between physicians and patients are profoundly influenced by social and cultural context. Two significant social influences on medical relationship are values and norms, since they are the basis of the construction of power between physicians and patients. They provide the power structure: pattern of power relation between physicians and patients and power use: the way to use or exercise power in each relation. That was the core conceptual framework of this study. To put this research in context, this conceptual framework of this study emphasized the power exercise and considered patient compliance as the significant variable resulted from the power use between physicians and patients. Along with other sources of power, legal and social authority as well as the material resources, this study concentrated on the explanatory model as the significant source of power that both physicians and patients used in exercising their power.

The Conceptual framework

Social Context

Power structure

- Social relation

Power use

- *Legal & social authority*
    - Social authority & status
- *Material wealth*
    - Medicine
    - Medical equipment
    - Money
- *Information & knowledge exchange*
    - Explanatory model
        - ideas of causation
        - recognition of symptoms
        - course of the illness experience
        - therapies, including professional, popular, and folk
            - therapy expectation
                - etiquette: manner such as formal, polite
                - treatment style: medical equipment or technology
                - therapeutic objectives: recovery, biomedical cure, patient satisfaction
        - evaluation of therapies
        - perception of medicines
        - physical characteristics, value
- *Therapeutic choices*

Results - Adherence

Figure 2.1 The Conceptual Framework

To have more identification on power in physician-patient relationship, this study tried to identify the purposes of communication during the medical consultation sessions, since these purposes implied the power relation between physicians and patients. They also provided the idea of patient-centered or physician-centered approaches. Several studies revealed that problematic relation between doctors and patients influenced therapeutic outcomes such as satisfaction, compliance, as well as other outcomes along the same line. (Helman, 1985; The et al., 2003). On the other aspect, a number of researches documented that good therapeutic outcome is the result of good relationship between physicians and patients (Heszen-Klemens and Lapinska, 1984; Sleath, 1996; Harris and Shearer, 2001; The et al., 2003). Then, there were some relation between physician-patients relationship and therapeutic outcomes. The next section reviewed some of the study on this relationship.

For the communication aspect, this study selected all of three communicative behaviors (verbal and non-verbal behavior, privacy behavior, and high vs low controlling behavior) to compose the conceptual framework. Concerning on the limitation of time and budget, this study picked up the most definite behaviors in each communicative behavior to present power between physicians and patients. The communicative behaviors that this study used to compose the conceptual framework were:

1. Verbal behavior
    - medical or everyday language vocabularies
    - second person pronoun used
    - polite particles at the end of sentences
2. Privacy behavior
    - information privacy
    - physical privacy
3. High and low control behavior
    - physician direction
    - patient direction

The literature review provided the potential analytical guideline for this study. The conceptual framework indicated the key variables that used to describe power between physicians and patients. Within the context of the study, the medical consultation session, three communicative behaviors: the verbal behavior, the privacy behavior, and the high and low control behavior were key variables used in identifying power. In term of verbal behavior, power could be communicated by language including medical or lay language vocabularies, and the use of second personal pronoun and polite articles at the end of sentences. For the privacy behavior, this study selected only the information and physical privacy to explain power during the consultation. As high and low control behavior, this study used the elements of Emanuel and Emanuel (1992) to identify the direction of medical consultation. These elements were who made the decision in this treatment, who set the agenda and goals of the visit. If the physicians made the decision in the treatment or set the agenda and goals, it was then considered the physician direction. On the contrary, if the treatment or the goals of the visit was directed by patient, it was the patient direction. In addition, this study analyzed the expression of power through non-verbal as tone of voice, gaze, posture, laughter, facial expression, and touch.

The other potential variable that this study used to discover power in physician-patient relationship was the purposes of communication during the medical consultation sessions, since these purposes implied the power relation between physicians and patients. Three purposes of communication were identified, including: (a) creating a good inter-personal relationship, (b) exchanging information, and (c) making treatment-related decisions.

According to the conceptual framework which concentrated on the exchange of explanatory model, the pattern of power relations was determined. This study used Roter's model: "the four prototypes of the physician–patient relationship" i.e. mutuality, paternalism, consumerism, and default model to structure the pattern of power relation, since this model provides more explanation of power between physicians and patients

particularly in Thai context. In line with the pattern of power relation, the roles of both physicians and patients and the approach of care were identified. For the role model, this study arranged the framework of the roles model of physicians and patients from the role model of Sparr et al. and Roter, and then there were a variety of role of both physicians and patients that were identified. As the approach of care, the pattern of power relation also provided the idea of patient-centered or physician-centered approaches.

In addition, the study followed this same approach in investigating the medical consultation based on the two related pictures, the relationship between physicians and patients and the quality of care. To reinforce and strengthen the analysis of the observations, the framework which was founded on *"Dimensions of quality of care for individual patients"* was proposed as the frame of reference. Following the key concepts of the study, the concepts of power and source of power used in examining the power relation between physicians and patients were, hence, integrated into the conceptual framework of the study.

CHAPTER III

METHODOLOGY

The aim of this study emphasized on the socially constructed nature of reality of medical consultation phenomena that was not experimentally examined or measured in terms of quantity, amount, intensity, or frequency. This study explored the meanings, concepts, definitions, characteristics, symbols, variations, and perceptual experiences of explanatory model on medical consultation. Qualitative research methodologies were the valuable tools to find out this knowledge. Qualitative methods were used to uncover and understand what laid behind this phenomenon which little was yet known. This study focused on the power relation between physicians and patients both during medical consultation and after medical consultation. At medical consultation, data were collected by observation, audiotape recordings. Factors that both physicians and patients used to exercise their power and their behaviors, particularly those related to their explanatory models, were explored after medical consultation. In-depth interview was employed to elicit this information. More detailed of these methodologies are explained as following:

1. Research Design

The qualitative research design was used to uncover and understand what laid behind the relationship between health care providers and patients. This design tried to find out the meanings, concepts, definitions, characteristics, symbols, variations, and perceptual experiences of explanatory model on medical consultation. To strengthen this study design, triangulation and the combination of methodologies in the study of the same phenomena were used. This study used triangulation through the combination of methods and a variety of data sources to discover what was actually going on by integrating information from one method with another to reach the needed information. The combination of method was the participation observation, and in-depth interview. The variety of data sources were physicians, patients, and written notes and files.

Triangulation allowed the study to develop a complex picture of the phenomenon being studied, which might otherwise be unavailable if only one method was utilized.

2. The Research Setting

Establishing the research setting as exactly where, when, and with whom the phenomena took place was very important task of this research. According to the notion of qualitative research, the goal was to go deep into a definable setting in which phenomena were placed meaningfully within a specific social environment. The setting should connect closely to the research question in that it provided an environment in which the questions were addressed. According to the research questions, the setting of this study was the health care organizations where the interaction between physicians and patients in the consultation took place. Exploring the interaction between physicians and patients in clinical setting was the sensitive issue in Thai society, so it was very difficult to gather data in this setting. Therefore, the most important criteria to select the research setting in this study were data accessibility. The researcher participated in whatever role possible to collect data. With regard to this point, this study was conducted at the out-patient service of the general practice and the medicine departments in one of tertiary hospitals in the Northeast region of Thailand where the researcher was allowed to observe the medical consultation during December 2003-January 2004.

3. Participants

There were two groups of participants in this study. The first one was a group of physicians and the second was a group of patients. Since exploring the interaction between physicians and patients in clinical setting was the sensitive issue in Thai society, it was very difficult to gather this data particular from the physicians' side. The purposive sampling was then decided in identifying and recruiting the physicians who were the information-rich cases. This allowed those physicians who were interested in the study, and wanted to contribute to join the research as the volunteer samples. As

well, taking into account the time frame, and the available resources on manpower and budget, the study used the purposive sampling to select patients for observation. According to the objectives of the study that focused on the power relation between physicians and patients, the study observed only the medical consultation that patients visited the physicians by themselves without the relatives. At post consultation, the 18 chosen patients were followed up for in-depth interview. These patients were purposively chosen from the selected samples at the consultation session by selecting extreme cases. The significant criterion that the study used to identify the extreme cases was the exchanging behavior on explanatory model of the patients. Then, there were two kinds of extreme cases, the first were the group of patients who tired to exchange their explanatory model to physicians by asking for high technology such as x-ray, ultrasound. The last were the group of un-exchange patients. The chosen patients pointed out the different patterns of power relation between patients and physicians. As far as the number of sample size was concerned, theoretical saturation was used in this study. The sampling was terminated when no new information was forthcoming from new sampled units. For the observation, there were 455 medical consultations, and 18 patients for in-depth interview method.

4. Data Collection

This study used triangulation through the combination of data collection methods and a variety of data sources to discover what was actually going on by comparing one method with another to reach the needed information. The combination of methods was the participation observation and in-depth interview. While the variety of data sources were physicians, patients, and the interaction during the medical consultation between two parties. In the process of data collection, the implied consent was used to assure the participation of both physicians and patients. Both physicians and patients were assured of confidentiality. The protocol of this study had been approved by the ethical committee of Faculty of Pharmaceutical Sciences from Chulalongkorn University on September 26, 2003.

According to the context of the study, the data collection was separated into two parts: at medical consultation and after medical consultation.

4.1 At Medical Consultation

During the consultation, the researcher took the participant-as-observer role to observe 455 medical consultations from 8 physicians and 452 patients. This study was integrated both verbal and nonverbal behaviors of physicians and patients to determine social relation between them and their exchange of the explanatory models as the power use of each party. This study selected all of three communicative behaviors (verbal and non-verbal behavior, privacy behavior, and high vs low controlling behavior) to compose the observation guideline. Concerning on the limitation of time and budget, this study picked up the most definite behaviors in each communicative behavior to present power between physicians and patients. The communicative behaviors that this study used to compose the observation guideline were:

1. Verbal behavior
    - medical or everyday language vocabularies
    - second person pronoun used
    - polite particles at the end of sentences
2. Privacy behavior
    - information privacy
    - physical privacy
3. High and low control behavior
    - physician direction
    - patient direction

In term of verbal behavior, power could be communicated by language including medical or lay language vocabularies, and the use of second personal pronoun and polite articles at the end of sentences. For the privacy behavior, this study

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The other potential variable that this study used to discover power in physician-patient relationship was the purposes of communication during the medical consultation sessions, since these purposes implied the power relation between physicians and patients. Three purposes of communication were identified, including: (a) creating a good inter-personal relationship, (b) exchanging information, and (c) making treatment-related decisions.

Then this study observed the medical consultation both in verbal and nonverbal behaviors by systematically watching and recording physicians and patients' verbal behavior on the audiotape. In addition, this study also observed the general context of setting especially on the context which influenced the power exercising both of physicians and patients. To confirm that researcher's function as an observer did not interfere or disturb the setting, the researcher tried to find the ways to fit into the organization and tried to establish rapport. The researcher spent three days in each setting to get acquainted with the setting and fully developed the habits and skills of accurate recording of observations prior to actual data collection began. The study collected data by observation in the real situation in parallel with recording the situation onto audiotape. The decision of whether to use an audiotape recording depended on the permission of both physicians and patients in each setting.

4.2 After Medical Consultation

This study chose in-depth interview as the data collection tool to discover narrative understandings about explanatory model of each party. The creative depth interview was an entranceway to narrative understanding. It opened the way to understanding how particular individuals arrived at the cognitions, emotions, and values on the context of that understanding. Designing an in-depth interview study began by developing a sampling strategy. There were two groups of participants in this section. The first group was a number of physicians from the former part, whereas the second group was patients. For the physicians, all of them (8 physicians) were individually in-depth interviewed on their perceptions and narrative understandings about their explanatory model and therapeutic choices they made. The interviews were held in the consulting room, or in the physician's office or in the cafeteria of the hospital, depending on the convenience of physicians. Each physician was interviewed once and each interview took approximately one hour. However, some part of interview was held immediately after the physician finished the medical encounter particularly in case of the conflict encounter.

As for the patients, 18 patients were followed for in-depth interview on how they exercised their power, evaluated their treatments and their therapeutic choices particularly related to their explanatory models. Patients were purposively chosen from the selected samples at the consultation session. The extreme or deviant case sampling was used to select these patients. The interviews were held in the hospital, usually in front of the pharmacy department while the patients were waiting for their prescriptions. Each patient was interviewed once and the interview took approximately thirty minutes to one hour, depending on the participant. The interviewed information was note taken by researcher and audiotape recorded. Information transcribed from audiotape recording was used to fill out missing details and cross check with note taking by the researcher in order to attain accuracy of information.

5. Data Analysis

As the result of triangulation methods, this study had two sets of raw data from audiotapes, and filed notes. The recorded medical consultation and interview were transcribed verbatim into the language of the interview. For audiotapes, the complete interview-to-transcription process was a series of carefully designed steps. These raw data were edited, corrected, and made more readable before they were organized and indexed. The initial process of analysis involved observing both physicians and patients' behaviors during the consultation, listening to tapes, reading and re-reading transcripts, making notes on the transcripts and writing down ideas concerning interpretations of the data and analytical categories. Categories were checked against new cases to see whether they remained relevant or whether they had to be adapted or modified. The process of data analysis was conducted in parallel to the data collection process, in order to collect and interpret data, and identify emerging themes for further analysis (Strauss and Corbin, 1990). In addition, this study verified these conclusions in two points: assuring that they were real and not merely wishful thinking on the part of the researcher, and all of the procedures used to arrive at the eventual conclusions had been clearly articulated. Qualitative data analysis began at the beginning of the study. It was part of the research design, part of the literature review, part of the theory formation, part of data collection, part of data ordering, filing and reading, and part of the writing. By design, this study did not attempt quantitative measures of behaviors, beliefs, or demographics.

The data was analyzed using a thematic analysis method guided by phenomenology (Liamputtong Rice and Ezzy, 1999). The interview transcripts were used to interpret how physicians and patients exercised their power through their explanatory models under their power relation both during and after medical consultation sessions. Their narratives were then organized into coherent themes (Liamputtong Rice and Ezzy, 1999), as presented in the following sections. Physicians

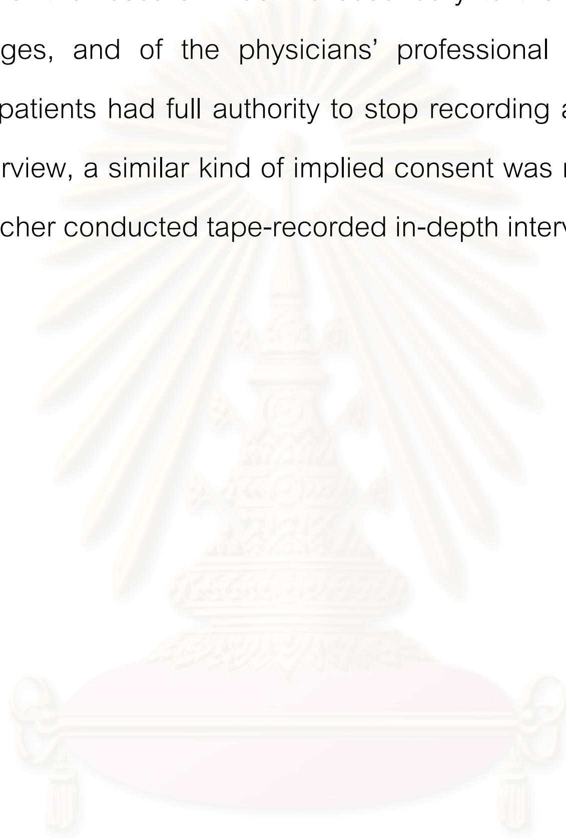
and patients' discourses concerning their power relation through their explanatory models were presented and their names had been changed for confidentiality.

6. Ethical Consideration

The final step in the designing phase was accounting for core ethical consideration, including informed consent and issues of confidentiality. Because the major objective in this study was to investigate the social relation and power use of physicians and patients, informing all of the goals particularly on this point might affect the participants' behavior, and as a consequence would yield little meaningful understanding. In order to tackle this problem while taking ethical issue into consideration, all of participants both physicians and patients were made known of the general goals and nature of the study but were not informed specifically on their social relation and power use. This study tried to ensure that all aspects of the study were handled in a way which was respectful to the human rights and needs of the participant. Moreover, this study and its results did not place the participant at risk of civil liability, nor was it damage participants' financial standing, or reputation.

Passive or implied consent was used in this study. Passive or implied consent was usually based on the assumption that participants did not decline after being informed about the study's purpose. In addition, the passive or implied consent in this study was indicated by the participant taking the time to interview. The most important reason that this study decided to apply implied consent was to avoid excluding relevant study subjects. The active consent style was not appropriate for the context of this study, since the patients in the rural area of Thailand were unfamiliar to sign their names, as a formal written permission on the informed consent slips and were likely to refuse to participate if so used in this study. The following steps were taken in order to affirm to the ethical issues.

The general purposes, potential risks and benefits of the study were explained to patients before the consultation. Patients were assured that nonparticipation would not affect their care before being asked to participate. Implied consent was used at this step. This study made every effort to protect clients' personal privacy during audiotape recording. The audiotape recording was made anonymous by deleting proper names. The importance of the research was the secondary to the protection of the patients' words and images, and of the physicians' professional outstanding and respect. Physicians and patients had full authority to stop recording at any time they wish. For the in-depth interview, a similar kind of implied consent was replaced a signed consent slip when researcher conducted tape-recorded in-depth interviews.



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CHAPTER IV

RESULTS

In order to examine explanatory models and therapeutic choices under patient-physician relationship, this study was conducted at the out-patient service in one of the largest hospitals in the Northeast of Thailand during December 2003-January 2004. The participants of the study included patients and physicians from the out-patient service at general practice department and medicine department. The qualitative methods especially the observation and in-depth interview were used for data collection. The study protocol was approved by the ethical committee of the Faculty of Pharmaceutical Sciences, Chulalongkorn University. The results of this study were structured into 3 parts. The first part detailed the context of the study; the second part included the explanatory model of physicians and patients, and the last part followed with the physician-patient power relation and the quality of care.

1. The Context of the Study

This first part briefly provided the portrait of the research setting where the cases were observed. The characteristics of participants, both physicians and patients, were descriptively explained. Finally, the nature of the cases and encounters was qualitatively delineated so that what happened during medical consultation sessions could be visualized.

The out-patient service of one of the largest hospitals in the North-Eastern of Thailand was selected as the research site for data collection conducted during December 2003-January 2004. Like other large public hospitals, the service system of this setting was separated into three major sections: out-patient, in-patient, and emergency services. The out-patient service was classified by biomedical specialties into 9 departments: general practice department, surgery department, orthopedics department, obstetrics and gynecology department, medicine department, pediatrics department, ophthalmology department, ear, nose & throat department, and

dermatology department. Two out-patient departments, general practice and medicine departments were selected for data collection sites.

The participants of the study consisted of 452 patients (contributing to 455 observations with one patient having two continuing medical consultations and the other having 3 continuing medical consultations) and 8 physicians from both out-patient departments. Physicians purposively recruited into this study from these 2 departments included 3 staffs, 4 interns, and one retiree. Staffs were specialist physicians and employees of the hospital. They usually worked at the specialized clinic or department. Interns were physicians who recently graduated from the university. They were on the apprentice roll at this hospital for 1 year. All of interns were required a three month rotation to each department. The retiree was a specialist who had, by age, retired but was on contract to work for the hospital with the major responsibility on the outpatient services. The data showed that the main workforce that provided services at the general practice department were the retiree and interns. The major assignment of the retiree was to provide services at the general practice department while interns were on their rotation. The retiree had office hours from Monday till Thursday at 9.00-11.00 am., while interns worked from Monday till Friday at 9.00-12.00 am. and 13.00-16.00 pm. Staffs, on the other hand, provided the service at the general practice department on the voluntary basis for one to two days a week either during the morning or afternoon period. Patients visited the medicine department were treated by staffs only.

Most of physicians in this study (7 of 8 physicians) were men. Nearly 90% of the medical consultations were, thus, treated by male physicians. Except one specialist recruited from the medicine department, 7 physicians including one retiree, 4 interns, and 2 specialists, were selected from the general practice department. Most of medical consultations (92.18%) observed in this study were, by proportion, collected from the general practice department, while the rest of medical consultations (7.82%) were treated by the specialist from the medicine department. Descriptive data showed that

nearly 60% of the medical consultations observed at the general practice department were treated by the retiree, almost 30% by interns, and only 15% by staffs.

For the patients, nearly 60 percents of patients were women, most of them (84.68%) were older than 30 years of age, and a half of the patients in this study (51.28%) used Thai Language during the medical consultation. Most of the patients (nearly 84%) went into the consulting room without their relatives. The conversations in 86 percents of the observed medical consultations were opened by physicians. They usually greeted patients with *"How are you?" or "How about your symptoms?"* In nearly 72% of the observations, physicians ended up the consultation session by making treatment decision based on the information that they got during their encounters, while 28% arranged patients to have further medical care such as 47% of this group had more investigation, 30% were referred to specialists. For therapeutic decision, prescribing medications was the significant treatment alternative that most of physicians used to end up their consultation sessions. The data presented that 70% of the medical consultations were concluded with prescriptions.

The main objective of this study was to examine the explanatory model and therapeutic choices under power relation between physicians and patients. It was hypothesized that the explanatory model was the significant source of power that both of physicians and patients used in exchanging or exercising their power during the medical consultation. The study found that medical consultation was the meaningful event that illustrated 2 significant interests of the explanatory model. The first was the differences of explanatory model between physicians and patients. The second was the exchange of explanatory model between physicians and patients. The contextualization of the differences of explanatory model and the exchange of explanatory model between physicians and patients were, thus, detailed in the next section.

2. The Explanatory Model of Physicians and Patients

This part used the observed data to present how the elements of explanatory models were different between two perspectives. The evidences on how patients constructed new idea on explanatory model were descriptively integrated. Following the difference explanatory model between physicians and patients, the source of these differences and the exchange of explanatory model in medical consultation were described. The second part of the result then ended with the analysis of the factors influencing the exchange of explanatory model.

2.1 The Differences of Explanatory Model between Physicians and Patients

Six components, including ideas of causation, recognition of symptoms, courses of the illness experience, therapies, evaluation of therapies, and perception of medicines, were used in this study to refer to the explanatory model. The results confirmed that these patients' explanatory model was significantly different from the physicians' explanatory model. These differences were mainly found in the components as the recognition of symptoms, the causation of the symptoms and the evaluation of therapies.

2.1.1 Recognition of Symptom

For the recognition of symptom, the same symptom was named differently between patients and physicians. Most of patients explained their symptoms using the term and language from their viewpoint which usually reflected the feature of their signs and symptoms. They had their own languages for some symptoms which were different from the biomedical point of view. These were usually indigenous illness. The observation revealed a number of the indigenous illnesses that some patients recognized namely *"Roke Tai", "Roke Pod", "Mot Luuk Ak-Seb" and "Hai Jai Bau Im"*. The patients who had *"Roke Tai"* were the patients who had chronic low back pain,

some of them may had the strong yellow urine, while *"Roke Pod"* was the symptom of the patients who had chronic cough. The *"Mot Luuk Ak-Seb"* symptom was the sign of the women who had low abdominal pain. And the last indigenous illness was the *"Hai Jai Bau Im"* symptom which was the short of breath. The patients (cases 227,242,250,322,359) tried to explain *"Hai Jai Bau Im"* as the tried and exhausted symptom. In addition, the patients who had *"Hai Jai Bau Im"* symptom usually had other symptoms as *"Kin Kao Bau Sab"* (loss of appetite), and *"Non Bau Lub"* (insomnia). These symptoms were the set of symptoms of the indigenous illness: *"Hai Jai Bau Im"* (short of breath), *"Kin Kao Bau Sab"* (loss of appetite), *"Non Bau Lub"* (insomnia) which usually occurred together.

As well, physicians used their own explanatory model explaining patients' illness however their explanatory model was based on different set of knowledge on biomedicine. They described patients' symptoms using the term and language from biomedical point of view. Their explanation on patients' sign and symptom was the universal description which was indicated by the framework of biomedical. Within this concept, their explanation was the result of the investigation of the abnormal organ like the patients' explanation. However, it was found that there was the different explanation between physicians and patients. For example, in case of patients who had chronic low back pain, patients explained this symptom as the significant sign of *"Roke Tai"*, while physicians described as the sign of inflammatory muscle. For the low abdominal pain, most of women perceived that was the sign of *"Mot Luuk Ak-Seb"*, while physicians recognized as the inflammatory muscle as well. The study found that *"Hai Jai Bau Im"* symptom was the obvious example that presented the difference of the recognition of symptom between physicians and patients, since patients explained *"Hai Jai Bau Im"* as the tried and exhausted symptom, physicians clarified this symptom as the psychic problem.

2.1.2 Causation of Symptom

The idea of the causation was the important explanatory model that was found to be dissimilar between patients' perspective and physicians' perspective particularly on the indigenous illness. There were many examples of these differences. For instance, most of patients who had *"Roke Tai"* symptom perceived that they had the abnormal kidney, since they believed that the low back pain was caused by the abnormal kidney, while the low back pain from the physicians' perspective was caused by the inflammation of the muscle, and was not tied to the kidney. The other example of the differences on the idea of causation was observed in the case of a patient who perceived that her cough at the time of this study was the consequence of the bonefish in her throat (case 240), while cough in this case from the physicians' perspective was sign of a cold with fever and was not related to the bonefish. Or in another patient who understood that her high blood pressure was caused by the ask shell of the genus Arca (396), the physician perceived that the patient's high blood pressure was the result of her eating behavior and her weight. The results pointed out these patients' explanatory model originated from their direct experiences. Then, their explanatory model might be dynamic along with the experiences they got. On the contrary, the physicians' explanatory model was centered around the biomedical knowledge.

2.1.3 Evaluation of Therapies

The other significant component of explanatory model often found to be exchanged during the consultation session was the evaluation of therapies. The study found that patients evaluated their treatment with a new set of idea on their explanatory model. The significant explanatory model that most of patients used to construct a new set of idea were the evaluation of therapies, the recognition of symptoms and the idea of causation. The results pointed out that patients used a new set of explanatory model as the main reason for non-compliance, touring for other treatment alternatives and therapy expectation.

The data revealed that most of patients would construct a new set of the explanatory model through their treatment experiences gained and quite often it lead them to non-compliance, and/or touring for other treatment alternatives. They constructed a new set of the explanatory model which related to the perception of medicines, the evaluation of therapies, and the therapeutic choices. Most of patients used the perception on medicine, locally expressed as whether a person or a disease was "compatible with medicines" *(Tuuk Kub Ya)* to evaluate their prescription drugs. If they were not compatible with the medicine, their symptom would not be relieved by the particular medicine. Therefore the medicine was considered an ineffective medication, and they would stop taking the drug. The patients linked the un-recovery of illness with the compatible with medicines concept and then used it as the main reason for non-compliance behaviors as not taking medications as directed or touring for other treatment alternatives. For example, in case of the patient who had cough (case 249), before she visited this hospital, she was prescribed a prescription for her cough from the health center. After taking the prescription for one day, her symptom was not relieved and her cough continued bothering her. She, then, concluded that she was not compatible with the prescription from the health center and decided to stop taking that drug. In this case, she evaluated the prescription with the set of idea by linking the recognition of symptom with the perception of medicine or the concept of "compatible with medicines".

The patients relied on the perception of medicines in the process of self-evaluation on the treatment. This study revealed that *"compatible with medicine" (Tuuk Kub Ya)* was the crucial concept of explanatory model channeling patients to adhere with medicines and/or shop around for other treatment alternatives. From patients' perspective, *"compatible with medicine"* would result in the relief of their symptoms or, in another word, the medicine was effective. On the contrary, the ineffectiveness of the medicine was perceived as *"incompatible with medicine" or "Mai Tuuk Kub Ya". "Compatible with medicine"* for each patient depended on the physical characteristics of medicine such as color and shape. The same generic drug with different colors and

shapes was then perceived as having different potency for treatment. Each individual could also have variation in response to medicines. Patients with the same symptom might be compatible with different medicines. Patients related the un-recovery of illness with *"incompatible with medicines"* which was considered as the major reason for patient non-adherence and seeking for other health services. For example, in case of the patient who had hemorrhoids (case 391), the compatible medicine in her perspective was the medicine that could stop bleeding. Besides the relief of symptoms, the compatible medicine might, as well, strengthen the body. As in the case of the patient who had chronic low back pain (case 244), he decided to non-adhere with the prescription since he perceived that the medicine did not strengthen his body. He was *"incompatible with medicine* ".

The other example of the patients' construction of a new set of the perception of medicines was the set of idea which related with the value of medicines and the perception of health services and the value of medicines. They perceived that the quality of services and medicines was depended on the size of hospital, the larger the hospital, the higher the quality, and the smaller the hospital, the lower the quality. They perceived that large hospitals had experts and effective medicines. They valued medicines from large hospitals as the effective medicine although this medicine was, in fact, the same generic name as small hospitals had. The data showed that a lot of patients who stayed in the remote area tried to visit this studied hospital. For example, in case of the tuberculosis patient (case 182), this patient and his relatives traveled from the other province, approximately at least 300 kilometers far from this hospital, they hired a pickup and traveled since 3.00 a.m. in order to visit the physician at 10 a.m. He said: *"My friend told me this hospital had the best treatment for tuberculosis. It is the large hospital, so it has good medicines. This symptom will certainly disappear by this medicine, so we hired pickup to come here. All of us are very drowsy, but we want to visit the physician here."*

In the physicians' perspective, medicines were only substances that used to relieve patients' symptom. The potential of medicines were not relied on the physical characteristics of medicine such as color and shape. The different colors and shapes of medicines did not represent the potency for treatment. The same medicine would produce the same effect to each individual patient. Patients with the same symptom might get the same prescriptions. Most of physicians did not understand nor concern on the patients' perception of medicines. When the patients asked for the specific characteristic of medicines such as color, shape, they usually said *"It was the same medicines since it was the same generic name. Don't be mislead".*

The other significant component of explanatory model often found to be exchanged in the consultation because of some discrepancies among them was about therapies particularly on the therapy expectation or the treatment options. The result showed that some patients tried to exchange their explanatory model by asking for the x-ray, ultrasound, or other examinations such as blood and urine examination. In fact, the expectation on this medical technology was the consequence of the three important components of explanatory model: the evaluation of therapies, the recognition of symptoms and the idea of causation. This result indicated that the patients linked these three components and created a new set of idea on therapeutic expectation and tried to exchange these sets of idea to physicians during they had the medical encounter. For example, in case of patients who had *"Roke Tai",* most of them tried to ask for the x-ray after they took the prescription drugs for a while, but their symptom was not relieved. They created a new set of idea from the evaluation of treatment with the current symptom and linked the result of this evaluation with the idea of causation they perceived. In these cases they concerned that their kidney might have the abnormality causing their symptom. They would then like to examine their kidney using the technology, like the x-ray. Most of them usually said: *"The physician only touches my back. How could they possibly know my illness just by touching? I want to know the exact cause of my disease".*

For physicians, they determined patients' symptom by a standard protocol which was indicated by biomedical knowledge. The abnormality of organ was confirmed by the result of laboratory investigation. When they did not find the abnormality, their mission had completed even though patients still insisted on illness existence. The symptoms complained were deemed as insignificant and thus disregarded.

To fully illustrate the difference of explanatory model between physicians and patients, two significant symptoms: the abdominal pain and the indigenous illness were described as examples. It was found that these significant symptoms pointed out the obviously different explanatory models between physicians and patients in every aspect of explanatory model from the ideas of causation, recognition of symptoms, courses of the illness experience, therapies, evaluation of therapies, and the perception of medicines. It revealed that physicians and patients interpreted the same symptom in the difference way.

The Abdominal Pain Symptom

In case of the abdominal pain symptom, some patient (case 276) perceived that his symptom was genetically passed on since his father also had this symptom. According to the idea of causation that he perceived, this patient concluded that his symptom could not be completely relieved therefore he did not try to have continuity of treatment. Instead he took medicines only when he had this symptom. He did not have any concern on the eating behavior or the appropriate time for his meals. He kept on eating habit of having his meals when he was hungry. After he had suffered from chronic abdominal pain for 5 years and had shopped for many private clinics and hospitals, he said *"I try to find the compatible medicine which could relieve my symptom for a while. I knew I could not be fully recovered from this symptom."* In this case, the patient had his own explanatory model. He constructed a new set of idea and used it in evaluating his treatment particularly on the medicines. The new set of idea was related with the 3 components of explanatory model: the perception of medicines,

the evaluation of therapies, and the therapeutic choices. He used the perception on medicine, the *"compatible with medicines" (Tuuk Kub Ya)* to evaluation their prescription drugs. When he was not compatible with the medicine, his symptom would not be relieved by the particular medicine. Therefore the medicine was considered an ineffective medication, and he would stop to take the drug. He linked the un-recovery of illness with the compatible with medicines concept and seemed reasonable not to continue what was considered not effective. Then the touring for other treatment alternatives was another way to search for the compatible medication. In addition, this patient had the different explanation on the recognition of symptom; he explained his symptoms using the term and language from his viewpoint which conceptually reflected the feature of his sign and symptom. For example, he explained his symptom as *"Tong Deard"* (the stomach was in turmoil). This explanation was very different from the biomedical point of view. The other different explanatory model that this patient had was the perception of the medical technology: the x-ray and the ultrasound. He perceived that the x-ray and the ultrasound were the method for treating his illness. He understood that the ultrasound was a more efficient treatment than the x-ray, since the ultrasound could relieve his symptoms at least for a while. That was the reason he asked for the ultrasound during his physician visit.

In this case, the physician's explanatory model was based on the biomedical knowledge, he had dissimilar explanatory model in every aspect. Firstly, on idea of causation, the abdominal pain in physician's perspective was caused by the inappropriate eating behavior. The physician recognized this symptom using the term and language from biomedical point of view such as *"burning pain"*, or *"bowel cramps"*. He did not understand on the patient's word as *"Tong Deard"*. The other different explanatory model was the perception of medicines and the perception of the medical technology. In the physician's perspective, medicines was only the substances that used to relieve patient's symptom. Each individual could also have similarly response to medicines. Patients with the same symptom might get the same prescriptions. The physician did not realize or understand the patient's concept on *"compatible with*

medicines" (Tuuk Kub Ya). Furthermore, he had negative attitude on this concept. He said *"Tuuk Kub Ya is a foolish idea"*. As for the perception of medical technology: the x-ray and ultrasound, it was the very obvious component that presented the difference of explanatory model between physicians and patients. The x-ray and ultrasound in physician's perspective were the tools used for investigation of internal organs. They were not the method for treating patient's illness.

The Indigenous Illness

"Roke Tai"

The significant indigenous illness that evidently presented these differences was *"Roke Tai"* and *"Hai Jai Bau Im"*. The study found that most of patients who had *"Roke Tai"* were male in the middle age. Most of them had heavy work such as laborers. The major symptom of the patients who had *"Roke Tai"* was the chronic low back pain. The other recognized symptom was the strong yellow urine. The low back pain and strong yellow urine symptom were linked to the abnormal kidney since they perceived that the area of low back pain was the site of kidney and the strong yellow urine was the result of the abnormal kidney. According to the perception on the recognition of symptoms and the idea of causation, most of patients wanted to investigate their kidney. The result revealed that they tried to ask for the x-ray after they took the prescription drugs for a while, but their symptom was not relieved. They then created a new set of idea from the evaluation of treatment with the current symptom and linked the result of this evaluation with the idea of causation they perceived, which was the concern that their kidney might be the abnormal organ causing their symptom. The physician had prescribed medicines which were not for their kidney and could not relieve their symptoms. They would then like to confirm their belief by having their kidney examined by using the technology, like the x-ray.

Along with the difference explanatory model between physicians and patients, the physicians did not recognize *"Roke Tai"* symptom as the patients. In general, low

back pain in physicians' perspective was the inflammatory muscle which normally caused by the heavy weight lifting or exercise. The low back pain was not related to the kidney, if it had not the positive result of urine examination or the x-ray. Some physicians said that *"There were only 20% of patients who perceived they had "Roke Tai" had the actual abnormal kidney. Most of them had only the chronic low back pain from their hard work. It was an inflammatory muscle."*

"Hai Jai Bau Im"

The other significant indigenous illness was *"Hai Jai Bau Im"* symptom. The result revealed that most of patients who had *"Hai Jai Bau Im"* symptom were the older patients. The main sign of *"Hai Jai Bau Im"* was the short of breath, tried and exhausted. Some of them often had other symptoms as *"Kin Kao Bau Sab"* (loss of appetite), and *"Non Bau Lub"* (insomnia). Most of the patients who had *"Hai Jai Bau Im"* symptom did not have the idea of causation. However, some of them perceived that this symptom was the common symptom happened to the elderly; it was the result of age. In this case, all of them wanted the medicines particular vitamins for strengthening their health so that the exhaustiveness would disappear. Most of them took this prescription as the routine. The perception of medicines especially the *"compatible with medicine" (Tuuk Kub Ya)* was the crucial concept of explanatory model that the patients used to ask for the prescription. It was found that they tried to ask for the compatible medicine which could relieve their symptoms, or strengthen their body as well. Although, they did not know the generic name of medicines, the patients requested their compatible medicine by the physical characteristics of medicine such as color and shape.

As *"Roke Tai"*, the physicians were not familiar with *"Hai Jai Bau Im"*, since this indigenous illness was not the type of symptom that they learned from the biomedical knowledge or anywhere. The results pointed out that there were different explanatory models between the groups of physicians. The idea of causation and the recognition of

symptom were the crucial explanatory model that indicated the difference of explanatory model among physicians. The physicians, who perceived that *"Hai Jai Bau Im"* was the result of age and the common symptom among the elderly, would prescribe the prescriptions without the other investigation. While the other group of physicians perceived that *"Hai Jai Bau Im"* was the psychosomatic symptom since the physicians could not detect this symptom or unable to explain from biomedical technology, the patients were physically healthy, had normal vital sign, normal blood pressure, etc. In this case, some physicians had negative attitude on *"Hai Jai Bau Im"* and stigmatized these patients as psychosomatic patients. It was found that most of physicians concluded the consultation with the belief that patients were perfectly healthy although patients still insisted on their illness. The decision to follow was then depended on the situation and other factors such as physicians' emotion, etc. They sometimes did not prescribe any medication, and another time would follow what patients asked for or referred patients to another specialist.

2.2 Patients' Explanatory Model: The Mistaken Knowledge in Physicians' Perspective

In general, physicians perceived patients' explanatory model as the mistaken or incorrect knowledge which guided their therapeutic behaviors, such as non-compliance, shopping around. Physicians viewed these therapeutic behaviors as the irrational behaviors. Both parties had different concepts of explanatory model. Whereas physicians' explanatory models were based on the biomedical knowledge which centered on the disease pathophysiology, the basic concept of patients' explanatory model was the illness, which was developed from the pattern of activities reinforced by ways of life. Believing that the patients' explanatory model was erroneous, some physicians ignored the patients' explanatory model. For example, in case of the patient who had chronic abdominal pain (case 434), after she tried to explain her symptom, the only question the physician asked was *"Where were you treated?"* and then he said: *"Those hospitals provided the good treatment."* When the patient said: *"I still had this*

symptom". The physician cut the conversation by referring the patient to a surgeon. The patient's problem was not solved at the time and very unlikely the next time. In this case, the physician disregarded the patients' explanatory model, since he stigmatized the patient with a psychic problem. He said after finished this consultation: *"She had the psychic problem. Her symptom was not the biomedical issue. Let her go to the specialist".*

2.3 Source of the Difference Explanatory Model between Physicians and Patients

The study found that most patients developed their own explanatory model from their direct experiences. The data depicted that by having an impression on their previous symptom, some patients used it as the criteria to evaluate the current one. When their symptom showed similar sign like the previous one, they perceived that they were having the same cause and illness they once had. For example, in case of the patient who had an itching-swell rash (case 190), he perceived that his symptom was caused by the intestinal worm, specifically *"Trichina" ("Pa-Yad Tua Jeed")*, since his symptom was similarly to the prior experience occurred 10 years ago. He, then, concluded that he had the *"Trichina" ("Pa-Yad Tua Jeed")* like in the past.

By the same token, through direct experiences, patients often constructed a new set of idea on their explanatory model. For example, even if patients became aware of the x-ray or the ultrasound from physicians especially from physicians working in private clinics, however by their means of learning they built their own pieces of knowledge about these equipments. In fact, they could not tell the differences between the x-ray and the ultrasound. For them, both equipments were just only the high technology used for investigation of internal organs. This study found that some patients constructed the new knowledge on the x-ray and the ultrasound as the kind of treatment. The patient (case 276) perceived that the x-ray and the ultrasound were the method for treating his illness. He understood that the ultrasound was more efficient treatment than the x-ray,

since the ultrasound could relieve his symptoms at least for a while. That was the reason he asked for the ultrasound during his physician visit. In this case, the new idea on the explanatory model was learned from his directly experience.

For physicians, their explanatory model was based on biomedical knowledge; most of them often asked their patients with the questions guided by biomedical knowledge. Their questions were the series of pathological events/episodes happening in the patient such as *"How about your symptoms? What is the main symptom?, How long did you get it?".* The results confirmed that physicians' explanatory model followed the biomedical model, while patients developed their own explanatory model from their direct experiences. The differences of explanatory model affected both parties in the medical consultation particularly on the conceptualization of the health problem. The physicians saw a disease while patients experienced an illness. Disease is an objective biological phenomenon, involving malfunction of some part of the body, and can be identified and measured by indicators or signs observed during a physical examination, and by diagnostic tools such as laboratory tests. According to this concept, it was not surprising that physicians' attention was only drawn to the investigation of the abnormal organ. When they did not find the abnormality, their mission had completed even though patients insisted on illness existence. Their practices presented the strong support of biomedical knowledge as *"treat on disease, not treat on illness"*. The obvious example was the cases of the psychosomatic patients.

Whereas the biomedical approach assumes illness to be an objective state, Waxler (1981, cited in Weiss and Lonnquist, 1996: 132) proposed the labeling theory to offer the definition of illness. Labeling theory views illness as a subjective matter worked out in particular cultural contexts and within particular physician-patient encounters. Every society has its own particular norms for identifying the behaviors and conditions that are defined and treated as illnesses. A person experiencing symptoms noticing some departure from the normal may ignore these signals or perhaps feel some anxiety about their possible meaning. It was found that there were some indigenous symptoms

that patients used to label their illness, for example, *"Roke Tai", "Roke Pod", "Mot Luk Ar-seb" and "Har Jai Boi Im"*. These indigenous symptoms were far from the biomedical knowledge, for example, *"Har Jai Boi Im"* symptom was not anywhere explained in the biomedical textbook or taught in medical school.

2.4 The Exchange of Explanatory Model in Medical Consultation

This section used the observed data to present how physicians and patients exchanged their explanatory model in medical consultation. It was found that the exchange of explanatory model in almost all consultations was a superficial interaction. Following some cases on superficial exchanges of explanatory model, the nature of the exchange of explanatory models was portrayed in 2 subsections: the consultation with exchanges and consultation with no exchange.

2.4.1 The Superficial Exchange of Explanatory Model: The Way of the Ineffective Consultation

This study revealed that out of these six components of the explanatory model, the recognition of symptoms, therapies, evaluation of therapies, and the perception of medicines were elements that patients commonly exchanged with their physicians. The data portrayed that the exchange of explanatory model in almost all consultations was superficial and could lead to the ineffective consultation. These exchanges did not reflect the system of thinking on the patients' illness which significantly influenced how patients exercised their power. For example, in case of the patient who had severe pain from his bottom onto the whole leg (case 22), he came from the other province with the serious concern on his symptom since he was afraid that his symptom was caused by the bone cancer. He wanted to examine his leg using x-ray. In the consulting room, after the physician reviewed the patient's medical record, the conversation between physician and patient was…..

Physician : *Do you come from Roi-Ed province?, Why do you come here?*

Patient : *The physician here is better than Roi-Ed.*

Physician : *The treatment at your province was the same pattern like this hospital will prescribe you. It is the same prescription. Visiting here, it just wasted your time and money. You could have saved your gasoline expense. Have you tried to treat at Roi-Ed hospital?*

Patient : --- *(Don't say anything)*

The physician investigated his leg and continued…...

Physician : *Your symptom is the muscle pain.*

Patient : *Is it necessary to have the x-ray?*

Physician : *No.*

After that, the physician wrote something on the patient's medical record and the prescription and then handed it back to the patient. That meant the consultation was over.

This conversation was the obvious picture that revealed a very interesting issue on the exchange of the explanatory model. The exchanged explanatory model in this medical consultation was very superficial. It was an ineffective exchange, because the physician could not recognize the patient's expectation on this treatment. They could not find what laid behind the patient's mind. In addition, there were differences between what was observed from the exchange of the explanatory model during medical consultation and what the patient's explanatory model actually was and had never been exchanged with the physicians. This patient came from the other province which was the main issue that the physician exchanged during the consultation, the physician tried to correct the patient's explanatory model on the perception of health service. Both of them had a little exchange on the symptom before they finished the consultation with the prescription. Actually, this patient had the expectation on the x-ray; he wanted to examine his leg. The significant explanatory model that forced the patient to visit this

hospital was the set of idea between the idea of causation and the recognition of symptom. This patient had 2 considerable ideas of causation, the first one was the pressed nerve from bone, and the second was the bone cancer. He was very concerned if he had the bone cancer. He was afraid that his symptom was caused by the bone cancer. In addition, this patient had the criteria for classifying his symptom from the muscle pain. He thought that his symptom was not the muscle pain, since he did not carry or lift heavy things. This significant explanatory model was not exchanged with the physician. The exchanged explanatory model in the medical consultation was very superficial. It was an ineffective exchange, both physicians and patients did not exchange on the significant explanatory model influencing the patient to visit this hospital. The exchanged explanatory model that the physician used in making treatment decision treatment was definitely dissimilar from the patient's explanatory model which resulted in different therapeutic choices. The physician decided to give him prescriptions for muscle pain while the expected therapeutic choice of the patient was the examination of his bone using the x-ray. From the ineffective exchange of the explanatory model, this patient did not get the therapeutic choice that he wanted.

Furthermore, the in-depth interview revealed some other interesting explanatory models the patients did not exchange with their physicians. In case of the patient with peptic ulcer (case 276), he perceived that his symptom was genetically passed on. He said *"My symptom came from the lineage, since my father had the peptic ulcer as well".* Other cases on women who had *"Mot Luuk Ak-Seb"* (low abdominal pain) reflected how different explanatory models between two parties were not profoundly communicated. These women perceived that *"Mot Luuk Ak-Seb"* was the result of the excessive weight lifting work such as carrying the heavy thing, or weaving cloth. The *"Mot Luuk Ak-Seb"* from the physicians' perspective was the microbial infection in the uterus which was a completely different causation. Most of rural patients did not concern about germs, since they could not see germs by the ordinary vision. Then, the inflammation from germ infection was not real from patients' comprehension. The term "inflammation" *or "Ak-Seb"* had created some confusion on its meaning. In the

biomedical term, "inflammation" or *"Ak-Seb"* could refer to either the inflammation from the infection, like having abscess, or the inflammation not related to the infection, such as the muscle sprain. From the patient context, *"Ak-Seb"* was concerned with the later meaning of the inflammation, which was not caused by infection. *"Mot Luuk Ak-Seb"* was, thus, the muscle pain in the patients' perspective. All of these observations confirmed the hypothesis of minimal exchange or in another word ineffective explanatory model sharing among both counterparts.

The ineffective exchange included all aspects of explanatory with no exception. The perception of medicine was included. The results indicated the very important concept concerning the perception of medicine which was not exchanged during the medical consultation session, the trial period of the prescription. It was found that almost all of patients spent 3 days to 7 days to try out their prescriptions. In the process of prescription trial, these patients selectively took only medications prescribed by the specific physician. Patients arranged their own experiment by trying one prescription medication at a time. One of them said: *"I did not combine the prescription. I just try only one prescription from one physician, not all the prescriptions that I have. I try one by one, since I want to find out which one is the effective medicine, and whether I am compatible with medicine of mine. If you combined the prescriptions you could not know that."*

However, some patients had a shorter period of the prescription trial. They said: *"The effective medicine is the medicine that produces the immediate effect on their symptom. If you take the compatible medicine, your symptom is relieved in a minute. That means you "Tuuk Kub Ya"".* Most of patients who perceived that they *"Mai Tuuk Kub Ya"* (incompatible with the medicines) decided to non-adhere with the prescription since they perceived that the medicine did not benefit their health or strengthen their body. One of them (case 387) said: *"Taking the incompatible medicine is likes taking some flour, it is not necessary to take."* The perception of medicine was the significant

explanatory model that strongly signified the consequence of care, in particular on the patients' adherence behavior.

The results pointed out that most of patients did not have the effective exchange on their perception of medicine because they did not have a chance to explain their explanatory model. Physicians did not concern, thus paid no attention on this matter. There were no conversation or explanation for *"Tuuk Kub Ya"* or *"Mai Tuuk Kub Ya"*. Most of physicians did not have the further exchange regarding this point. As a result, they did not have any understanding on the patient concept on *"Tuuk Kub Ya"* or *"Mai Tuuk Kub Ya"*. Some physicians said: *"I don't understand why most of patients have the concept of "Tuuk Kub Ya" or "Mai Tuuk Kub Ya". It makes no sense."* The exchange of the perception of medicine was just the superficial exchange like the other part of the explanatory model.

The other example of the ineffective exchange explanatory model was in case of patients who created a new set of idea on therapeutic expectation. The data revealed that some patient would construct a new set of the explanatory model through their treatment experiences gained leading to a search for new expectation in the next treatment episode. However, the process of this model construction was not fully communicated or exchanged with their physicians. The empirical example observed in the study was in the case of the abdominal pain patient (case 436). During the medical consultation session, she tried to exchange just only her present symptom and her expectation on the gastro-endoscope. She did not exchange the whole picture of her explanatory model particularly on the evaluation of the past treatment although it was the very important part of her explanatory model influencing her expectation of the new medical technology, specifically the gastro-endoscope. The in-depth interview pointed out that this patient had suffered from abdominal pain for 7 years, she had shopped for private clinics and hospitals around the district she resided, districts in the vicinity, the province she resided, nearby provinces and remote provinces. She had plentiful of x-rays and ultrasounds till she lost count of times she had been examined. She

evaluated the x-ray and the ultrasound and concluded that these technologies could not detect her illness, since her symptom was not relieved. She still had the abdominal pain. After exchanging her explanatory model with her friend, she had formed a new expectation on the new technology: gastro-endoscope. She used the recognition of symptom to evaluate the effectiveness of the x-ray and the ultrasound, and then generated the new expectation on the new technology.

The study suggested that the characteristics and the magnitude of exchange between physicians and patients on their explanatory models was the very important factor determining patient behaviors both during medical encounter and afterward. The un-exchange explanatory model illustrated the picture of the ineffective medical consultation as well. In order to fully delineate the detail of how they exchanged the study divided the result of this part into the exchange consultation and the no exchange consultation. Most of the medical consultations were the exchange consultation. To some extent, either physicians or patients or both of them tried to share their explanatory models. A few observations were classified as medical encounters without explanatory model exchange.

2.4.1.1 The Consultation with Exchanges

This study found that most of the medical consultations (93%, 424 from 455 observations) were considered the exchange consultation. At least one party of the two counterparts tried to exchange their explanatory models to the other. The characteristics of exchange could be categorized into three levels, high, moderate, and low levels of exchanges, depended on the number of the explanatory model components that they discussed during the consultation sessions.

The high exchange type of consultation was the consultation that both of physicians and patients tried to exchange their explanatory models to each other. The observation showed that at this level patients tried to answer physicians' questions,

asked about their symptoms, or requested some special investigation or the specific medicine for their treatment, while the physicians tried to explain to patients about their symptom as well as the treatment method. Like patients, most of physicians attempted to exchange their explanatory models by putting more effort to correct the misconception of patients' explanatory model. The obviously example that presented the high exchange type of consultation, was in case of the patient who was in a daze (case 190), he had a groggy and numb symptom on the head.

After the physician reviewed the patient's medical record, the conversation between physician and patient was…..

Physician : *You took the anti-dizziness medicine, is it effective?*

Patient : *No, I had x-ray at Sarakam.*

Physician : *How much?*

Patient : *Four thousands.*

Physician : *Do you have more groggy symptoms?*

Patient : *Not much.*

The patient handed the x-ray film to the physician, the physician examined this film and said……

Physician : *Your x-ray result was normally, but there was the trace of tapeworm in your brain.*

Patient : *Can I make sure whether the result of x-ray is valid?*

Physician : *If it has, I would see.*

Patient : *Why am I not relieved from this symptom?*

Physician : *It would not disappear immediately, you body will adapt by Itself. It was the result of the trace of tapeworm, but it has already died. Don't eat uncooked food.*

Patient : *The private physician told me like this. He said that I could not be recovered completely from this symptom.*

Physician : *I will prescribe the anti-dizziness medicine and some vitamins for you.*

Patient : *Do I need to repeat the x-ray?*

Physician : *The x-ray did not treat your symptom. Don't go to repeat the x-ray.*

Patient : *Why do I have a chronic indigestion?*

Physician : *Don't go to repeat the x-ray.*

The physician concluded the consultation by handing the patient's medical record back to the patient. However, the patient tried to ask some questions to the physician as…….

Patient : *I would like to know if I still have a groggy and numb symptom on my head, I will die in shortly, won't I?.*

Physician : *Who tell you?*

Patient : *If I have a hard work, I will get ill, won't I?*

Physician : *Your disease has been disappeared, but you may have a chance of convulsion. That's all.*

This example illustrated the differences between the explanatory model exchanged during the medical consultation and the real explanatory model of patients. This patient wanted to double check the explanation of the private physician; he wanted the second opinion. He did not wholly believe the exchanged explanatory model given by the private physician. The private physician told him that this symptom was the result of the trace of tapeworm in his brain and it would not be disappeared completely as a result the symptom could be permanent. In addition, this patient was not sure that the parasite was completely dead, although they finished the prescription both the injection and the oral dosage form. To make sure on the death of the parasite, the patient wanted to repeat the x-ray. The result indicated that high exchanged explanatory model in the medical consultation was not assured the effectiveness of communication between physicians and patients, since it could not response the patient's expectation. It was the superficial exchange like in other cases. The physician did not try to exchange his

explanatory model, he just asked about the symptom using series of biomedical questions. In addition, he stigmatized on the patients' request which was related to the x-ray using his tone of voice and wording. The patient failed to reach his expectation particularly on the repeated x-ray.

There were several explanations that physicians used in explaining to patients. Some physicians explained that the abnormal sign in patient's perception was the normal physiology. Therefore if the patient did not have those signs they might harm their heath unknowingly. For instance, in case of the patient who had gas bubbles in the stomach (case 78), the physician tried to correct this perception as *"That is the normal sign, if you don't have any gas, it may harm you. Don't see the normal sign as the abnormal."* Or in case of the patient who perceived there was a tumor on her neck (case 35), the physician said: *"Don't see the normal sign as the abnormal. Your shape is not a coin. You did not have any symptom."* In addition, some physicians corrected the patient's explanatory model by comparing the patient's symptom with the physician's own symptom, such as in case of the patient who had concern on his urine (case 372), the physician said: *"You had the urination only 7-8 times. It was less than mine, for mine 15 times. You did not have any disease."*

In the case of consultation with moderate and low exchanges, the result showed that those physicians or patients discussed the explanatory model less extensively than the high exchange of consultation. The attempt to exchange often came from one party either physicians or patients. These exchanges were not mutual. For example, patients in the low level of exchange usually shared their explanatory model along with physicians' questions. They did not offer more exchanges on other elements of explanatory model that physicians did not question. On the contrary, some physicians volunteered the low level of exchange by regularly spending all the time reviewing patient medical record or the result of the patient's examination. They did not initiate any conversation with their patients during the encounter. In this case, physicians exchanged their explanatory model with the patients' medical record.

In general, medical consultation was the significant and only stage that both of physicians and patients could effectively exchange the information to reach the agreement on the appropriate therapy alternatives. However, the results showed that almost all of the consultations even the high level of exchanges had ineffective exchange of information particularly on the explanatory model. Both of them went back with the same explanatory models even after they had exchanged some thoughts. For example, in case of the patient who perceived he had the problem with his kidney (case 441), he wanted to have his urine examined to detect his abnormal kidney. After the physician exchanged her explanatory model on the causes and symptoms of the kidney problem, she concluded that the patient did not have any sign of kidney problem. The patient tried to insist on his symptom, he said: *"I had low back pain for a long time".* Then the physician tried to reason: *"If you had the kidney problem, you cannot work hard like you are doing."* The patient still insisted: *"I could not work hard I must have the problem on my kidney."* The physician said: *"You just only have the muscle pain. It is unnecessary to do urine examination".* The patient tried to insist on his symptom again, he said: *"My urine is yellow color and I have low back pain when I stand for a long time".* In this case, although both of them tried to exchange their explanatory model, it was an ineffective exchange of their conversation. They were having conversation but each was caught in their own frame of reference. Both did not try to cross to the other perspective. Their frame of thinking was not modified and the knowledge was not transferred.

2.4.1.2 The Consultation with No Exchange

The no exchange of consultation was the medical consultation that did not have any exchange on explanatory models. The study found that only 7% of medical consultations (31 from 455 observations) had no exchange between 2 parties. They were usually the silent medical consultations. It was found that no exchange was mostly occurred from physicians' silence. One pattern observed was that physicians spent all times during the encounter reviewing the patient's medical record and/or the result of

patient's examination. In these cases, they finished their treatment with the information that they got from these papers. They did not talk to or interview their patients, so there was no conversation or the exchange of the explanatory model during these encounters. Two therapeutic choices were either prescriptions or patients' referral to a specialist or the next consulting room. Another pattern of consultation with no exchange was the cut short consultation. The physicians usually cut short the consultation without reviewing patients' medical record and/or the result of patients' examination. For example, in some cases (case 102, case 255), after the patients went into the consulting room, the physicians ended up the session by assigning these patients to have the consultation with another physician in the same department. The physicians often said: *"Go to the next room"*.

2.5 The Factors Influencing the Exchange of Explanatory Model

This section outlined some factors projected to influence the content as well as the level of exchange of explanatory model. Among these factors, the patient illness was a significant factor impacted patients' exchange while the information required for treatment decision drove the physician exchanging need. The final thought on how the power relation between physicians and patients affected the exchange and in turn the quality of care rendered to patients was depicted.

2.5.1 The Patients' Illness

The study found that the patients' illness including type of illness as well as stage of blindness in illness was the significant factor influencing the exchange of explanatory model between physicians and patients. The type of illness whether it was acute or chronic was among the first to be observed. Patients with different types of illness had a distinct exchange of explanatory model. For instance, the patients who had acute symptoms such as common cold, headache usually exchanged idea on the recognition of symptom, while chronic patients, such as, diabetes patients, hypertension

patients, exchanged their explanatory model on the perception of medicines especially on the physical characteristics of medicines, i.e., color and shape. Patients used the concept of *"compatible with medicine" (Tuuk Kub Ya)* in the process of treatment evaluation of treatment.

Another factor, influencing how they exchanged their explanatory models, was when patients were in the stage of blindness about their illness. The blindness stage was when patients who had chronic symptom could not find the actual cause of their illness or could not find the "compatible" medicines. Most of patients in the blindness stage, tried to exchange their explanatory model to find out what caused their symptoms what kind of treatment alternatives were "compatible" with them. They tried to find the abnormal organ that was the source of their suffering with medical technologies, such as the x-ray, the ultrasound. From this viewpoint, patients and physicians shared a common drive. Both were searching for the abnormal organ causing patients' illness but from different frames of explanatory model. Whereas the explanatory model of physicians was based on the biomedical principle, the patients' explanatory model was generated from their everyday life particularly on their experiences. Since no causation had yet been identified for patients in this blindness stage, the patients were, then, filled with desire to exchange their explanatory model after they had tried on a period of treatments. Most of them had continued their treatments for some periods. Before they visited this hospital, their illness was treated by other physicians from several places, such as drugstore, private clinic, the district hospital. The important aspect of explanatory model that patients brought into the exchange of explanatory model was a set of idea on the evaluation of treatment and the recognition of symptoms. From this set of idea, they created some expectations on treatment such as need of the x-ray or the ultrasound. Not surprisingly, these expectations encouraged them to exchange their explanatory model by proposing or demanding some treatment alternatives during the consultation. There were some chief complaints that patients usually exchanged their explanatory model, i.e., cough (6 cases), low back pain (13 cases), and abdominal pain (24 cases).

While the illness itself affected the exchange on patients' side, physicians' exchange did not completely rely on the patients' illness but was counted on the information they used in investigating and interpreting within a biomedical framework. The exchange of explanatory model was terminated when physicians had adequate information for diagnosis and selection of therapy alternatives. Most of the information that physicians used in making decision on treatment came from the result of the examination, such as the blood, urine examination, the x-ray film. For example, in case of the low back pain patient who was in the blindness stage (case 8), after the physician finished their questions on his symptom, he reviewed the x-ray film and the patient's medical record for a long time (approximately 5 minutes) before the physician recorded something in the patient medical profile and handed it back to the patient signaling the end of the session. In this case, the exchange was at the low level even if the patient was in the blindness stage. The physician had information enough for making decision on the treatment from the result of the examination. No exchange was deemed necessary from the physician concern. The level of exchange, thus, depended on how much information physicians needed from his patients. Some physicians seemed to give priority to other sources of information, like patient profile or laboratory test report, and so on, over exchanging with his patients.

2.5.2 Power Relation between Physicians and Patients

Besides, the observation pointed out that there was the other considerable factor that influenced the exchange of explanatory model, the power relation between physicians and patients. Power was an unavoidable aspect of all interpersonal relationships including the physician-patient relationships (Goodyear and Buetow, 2001). The expression of each party depended on who had more power in this relation. The results showed that the power relation between physicians and patients had strong impact on the content as well as the level of the exchange of explanatory model. In the relation that physicians dominated the power, the content and level of exchange of explanatory model was of course controlled by physicians. The content of explanatory

model in this relation was founded on the biomedical knowledge and the level of the exchange tended to be moderate or low. On the contrary, in the relation that power was occupied by patients, the exchange of explanatory model both on the content and level was determined by patients. These physician and patient power relation was significantly different from the mutual relation. The mutual relation was the relation that both physicians and patients tried to exchange their explanatory model to each other. The study found that most of the mutual relation comprised the high or the moderate levels of exchanged consultation. These observations fully detailed in part 3 would provide more understanding on the exchange of explanatory model in the context of power relation which was the main focus of this study.

3. The Physician-Patient Power Relation and the Quality of Care

This main part of the study result described the medical consultation based on the two related pictures, the relationship between physicians and patients and the quality of care. To reinforce and strengthen the analysis of the observations, the framework which was founded on *"Dimensions of quality of care for individual patients"* was proposed as the frame of reference. Following the conceptual framework of this study, the concepts of power and source of power used in examining the power relation between physicians and patients were, hence, integrated into this new framework of the quality of care. Before conducting further analysis, the operationalization of the power and the definition on the dimensions of quality of care for individual patients deserved more attention.

3.1 The Operationalization of Power

Along with the definition of power, this section explained how the power relation would be studied. Three key sources of power were clarified as well as the way the power from these sources was exercised. The main purpose of this study was to contextualize explanatory models and therapeutic choices under patient-provider power relationship. The power was, then, needed an operational definition in the context of

physicians and patients relation. According to the Oxford dictionary, power was defined as *"the ability to control people*". The one with more power in the context of this study was, by definition, *"the one who in control of the direction of the relationship".* The relationship between two counterparts did not occur only in the consultation session but extended beyond the face to face encounter. Thus, in the analysis on the power relation between patients and physicians within the context of this study, different stages or patterns of services had been taken into perspective. Three stages or patterns of service provision had been identified as the relationship or the service before medical consultation, during medical consultation and after medical consultation. Each stage encompassed different contexts which impacted sources of power as well as the pattern of power exercised by both patients and physicians. How the power was exercised depended upon the source of the power where it was derived. The conceptual framework had identified three key sources of power, i.e., legal & social authority, material wealth, and information & knowledge exchange.

The legal & social authority established the power in the form of social authority and status for health personnel especially physicians and provided patients the power through social standings and legal rights such as consumer rights. This source of power embedded in the hospital's rules which determined the service system or procedures for provision of care and the role of patients and physicians. The power from material resources facilitated physicians in supplying medical services and supported patients in demanding health care. Physicians usually used the available medical resources, for example medicine, medical equipment as providers' power, while patients utilized financial resources as their power. The information & knowledge exchange was the source of power reflecting explanatory models both physicians and patients possessed and was usually exercised during medical consultation sessions. During a formal interaction like in the hospital setting, physicians' explanatory models seemed to be a dominated source of power, while patients' explanatory models appeared to be ineffective, since it was considered to be an inaccurate source of power from biomedical point of view.

This study was conducted in the public hospital where legal & social authorities as well as material wealth were difficult to change since they were, to some extent, fixed and derived powers. Patients and health personnel exercised powers from these sources through the hospital's rules and organizational structure. These rules and structure were predetermined and would generally not be tailored or customized to serve each individual need. These sources were, in this manner, the external factors that influenced patients' and physicians' power use. On the other hand, the explanatory model was the internal source of power, derived from passed on knowledge and experiences. Patients and physicians could exercise the power from this source independently from the hospital's rules or other organizational procedures. The explanatory model was the potential source of power that reflected the actual picture on the power use between patients and physicians. The emphasis of this study was, thus, placed on how patients and physicians exercised their power through the exchange and communication of their explanatory model.

3.2 The Two Related Pictures: Physician-Patient Power Relation and Quality of Care

Under the concept on quality of care, the study observations reflecting three major dimensions, structure, process, and consequences of care, were detailed along with the data illustrating how the power relation between two counterparts affected the quality of care. The observations on physical and staff characteristics were described in the structure subsection. Under the process dimension, the data on how physicians and patients used their power in each stage of the relationship were presented. The section concluded with the consequences of care detailing the therapeutic alternatives and how patients responded to the treatment received. The result was emphasized on the process dimension with three stages or patterns of service provision, i.e., the service before medical consultation, during medical consultation and after the medical consultation, were separately analyzed.

3.2.1 The Structure: The Hospital System

Campbell et al., (2000) identified two domains of structure: physical characteristics and staff characteristics. They pointed out the physical characteristics consisted of three significant dimensions as resources, organization of resources, and management, while the staff characteristics comprised two dimensions as skill-mix and team working.

For the physical characteristics, it was found that the organization of resources and the management namely the physical environment around the consulting room and the hospital's rules especially on the sequence of services strongly reflected both of the physicians' power and the quality of care. As for the staff characteristics, the type of physicians staged both of the physicians' power and the quality of care.

3.2.1.1 Physical Characteristics

It was found that there were two major physical characteristics: physical environment around the consulting room and the hospital's rules specifically the sequence or steps of services that evidently portrayed both of the physicians' power and the quality of care provided by the hospital. For the physical environment around the consulting room, the study showed that everyday in morning, nurse assistants had daily responsibilities in preparing the physical environment within the consulting room, such as the furniture, office materials, and medical equipments ready for the physicians to provide the medical services to patients. The physicians had the duty only on treatment. They were not responsible for other management aspects. Everything had to be ready before physicians started their jobs. In addition, it was found that the type of furniture in the consulting room particularly chairs for physicians and patients were significantly different. The chair for physicians was a coach-swivel chair and looked more comfortable than the one for patients that was just only the plastic stool. These differences presented the physicians' power and conveyed the sense that they seemed

to be the very important health personnel. This supported the fact that they usually got special things and treatment different from others.

The other physical characteristics that reflected the physicians' power were the hospital's rules particularly regarding the sequence or steps of services. The physicians had only the routine treatment responsibility without other assignments. Everything including patients had to be prepared and prompted to make physicians' job as convenient as possible. Patients' service sequence or steps were arranged by nurses and nurse assistants. Nurses and nurse assistants would review patients' history and queue patients for physician visit. From this context, all of the services and management were centered at the physicians' service. This service system supported physicians' social authority and status over and above other health personnel in the hospital.

Representing the physical characteristics, the hospital's rules, e.g., the sequence or steps of service, created power through the legal & social authority source. This source of power embedded in the hospital's rules which established the service system or procedures for provision of care and the role of patients and physicians. It was indirect power handed to physicians. The physicians did not directly exercise their power through this source. This power was assigned by the hospital's rules and the hospital's system was in control of the direction of the service. The power would be a part of the hospital's system. It did not leave with physicians when they left the hospital. In this context, this hospital's rules were the actual powerful identity.

The results indicated that the structure characteristics on the quality of care particularly the sequence or steps of services had direct impact on quality of care especially on the availability and the effectiveness of care. The data showed that there were some complaints on the referral system from physicians at the general practice department. Some physicians did not know the criteria for referring patients to medicine department, so various patterns had been practiced and observed at the general

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practice department. Some interns said: *"I think this system has some problems. At the general practice department, it is in a mess, you must examine all of those symptoms here, I do not know when I should refer patients to a specialist".* For example, in case of diabetes, there were patients with various stages of diabetes patients from the patients who were at the beginning stage to the patients who were at the severe stage and needed to have insulin injection for a long period of time. Some of these severe patients were not arranged or referred to a specialist.

This situation signified the failure of the referral system in this hospital. The physicians at the general practice department did not take on the gate-keeper role as they were functionally supposed to. In general, the patients who did not have an appointment had to be examined by a physician at the general practice department before they would be referred if necessary. In case that a patient was diagnosed as having severe symptoms, the patient would be referred to a specialist. The general practice department was in theory the screening unit. It was the significant service station that was essential for the health situation with the shortage of specialists like Thailand. This sequence of service was the appropriate system for the Thai context.

The failure of the referral system as presented could affect the quality of care on the aspects of both the accessibility and the effectiveness, since this system could not provide the proper service to the needed. The severe patients could not access the service provided by specialists. In addition, they could probably get an inadequate or ineffective treatment from physicians at the general practice department since their complicated symptoms might be beyond the capability of physicians at the general practice department whose majority were interns.

Furthermore, the unclear referral requirement could cause another problem that impacted the availability and the effectiveness aspects of quality of care. This problem was observed and called the ping-pong situation where patients did not receive the continuity of treatment. They had come and gone among several departments in the

hospital. The ping-pong situation was the result of the unclear referral system among these departments. For instance, in case of the thyroid patient (case 417), she was arranged to the ear, nose & throat department during her first visit, to the medicine department on the second time, and for the third visit she was assigned to the general practice department. This example reflected a problem in the service system especially on the referral system among departments. This come and go situation among departments initiated a question related to the quality of care. The treatment from which department should the patient adhere to if they were contradicted each other. Such question directly signaled the problem on patient compliance and in turn the quality of treatment. Which was the proper department for these cases? Most of patients were not aware or concerned the ping-pong situation. They usually said: *"I don't know. It depends on the physician. I will follow the physician's order."* This acceptance staged the recognition of patients on physician's power. Patients put all of their responsibility on the illness onto their physicians. This patients' practice could yield the significant obstacle that was against the patient-centered care which promoted the sharing of power and responsibility between physicians and patients on patients' illness. Some of physicians at the general practice department had negative attitude on this problem. They thought that physicians at the specialist department disclaimed these patients.

The gate-keeper screening system had raised some problems as well. Since all of new patients were assigned to start their medical care at the general practice department before they could be referred to other specialist departments, patients had to spend more time at the crowded general practice department where patients in general spent at least one hour waiting before their turn of a 2-3 minute consultation would be called. For example in case of the patients with tumor (case 86, 203), according to the sequence of service, these patients had to go through the general practice department, wasted at least one hour waiting for the physician to take a quick glance at their tumor, then referred them to the surgery department. At the surgery department, patients wasted another hour waiting for the specialist. Even it was logical

to set up this sequence of service system for the Thai context, this hospital's rule could create a barrier for accessing the effective care.

3.2.1.2 Staff Characteristics

The study revealed that the type of physicians staged both the physicians' power and the quality of care. This hospital provided health service through three kinds of physicians, i.e., the staff, intern, and retiree. These physicians had different power. The staff and retiree had more power than interns. They were pleased by other health personnel, for example they got a coffee service as they were providing consultation, whilst interns did not get the same prestige. Being the mentor of interns, their status by position was higher. All of interns called them *"The teacher".* Furthermore, when compared with other health personnel such as nurses, physicians still got the very special care above and beyond other personnel. These differences in legal & social authority among physicians and health personnel produced various levels of power authority and status among them.

Although, the hospital's rules dictated social authority and status of physicians and were in control of the direction of the service and the role of physicians, some problems on the physicians' role and behavior were uncontrollable. Staffs' working hours started later and adjourned before the declared service time period. Majority of staffs did not go to the consulting room on time, for example, in the morning they usually went to the consulting room after 9.00 a.m. or nearly 10 a.m. The major labor force treating patients especially at the out-patient services were interns, since all of them were on rotation to all departments. For instance, while three physicians were assigned to provide services at the general practice department during 13.00-16.00 pm., two of them were interns. General observations indicated that interns regularly worked on time while staffs habitually came late, as seen in the afternoon, they often started their job at nearly 14.00 pm. There were some complaints from interns. She said: *"The quality of care is unacceptable, since patients could not access the specialist here. There are a*

few specialists who are doing their jobs, i.e., examining patients. When patients visit this hospital, they want to treat with "Mor Yai" (the specialist), because it is the biggest hospital. In practice, there are only interns here with no staff. I have no confident with my quality."

This situation impacted the quality of care, since patients could not access the physicians that they want to visit. This hospital did not provide the availability. The patients did not meet their need. They did not meet the specialist. That was the over all picture of the out-patient services which related to the hospital's system. This context indicated that physicians especially staffs tended to have more power and higher prestige than other health personnel. Their powers came from the hospital's system as the hospital's rules. They exercised their power through the legal and social authority source. As a whole, structural features of health care provided the opportunity for individuals to receive care, and at the same time it could increase or decrease the quality of care. Structural features not only by itself could affect the quality of care; within a system based model of care they could have an indirect impact on quality through the influences on processes and outcomes as well.

3.2.2 The Process: The Patient-Centered Care

The process of care was the significant step that answered the objectives of the study since it involved interactions between physicians or other health care personnel and patients. The process of care revealed how patients got the care they needed, and whether the care they got was effective. The process was therefore the actual picture of the delivery and the receipt of care. Although, two key processes of care have often been identified: clinical care interventions and interpersonal interactions between patients and physicians (Campbell et al., 2000), the scope of this study covered only the inter-personal interaction. The interactions between health care professionals and patients particularly the exchange of explanatory models and therapeutic choices under physician and patient relationship was the main focus of this analysis. The study

therefore defined the process of care only in terms of interpersonal interaction aspect of care including the definition and communication on problems or needs, diagnoses, their management and co-ordination between patients and physicians.

The five conceptual dimensions including biopsychosocial perspective, patient-as-person, sharing power and responsibility, therapeutic alliance, and physician-as-person were used as the framework for the data analysis. Since the nature of the service was different across different stages of service so was the relationship, dividing the analysis into 3 stages, the service before medical consultation, during medical consultation, and after medical consultation would ease the process in a more comprehensible way. Each stage encompassed different contexts which impacted the power relation between patients and physicians as well as the quality of care in different ways. Furthermore, the good relation between physicians and patients was hypothesized to rely on communication skills, the analytical guideline especially on the communicative behavior and the purposes of communication were hence used to examine the communication between physicians and patients in the process of service. To investigate the exchange of explanatory model under power relation and the quality of care during the process of service, this study used the conceptual framework and the analytical guideline to describe power relation between physicians and patients. As well, the quality of care was considered upon the *"patients' centered"* approach along five conceptual dimensions.

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3.2.2.1 Service before Medical Consultation

Before meeting with a physician in the consulting room, patients had to contact with and received the service from other health personnel starting from the medical record keepers to nurses and nurse assistants. The power exercise occurred with every pair of relationship and contact. The medical recording room represented the first contact point for registration and search for patients' medical record. Medical record keepers also audited patients' financial right under health schemes such as universal

health coverage scheme, social security scheme. The next service patients experienced was the nurse's counter in front of the consulting room, nurses and nurse assistants here had to prepare patients as well as information for treatment. Here, nurses and nurse assistants would review patients' history and queue patients for a physician visit.

At the medical recording room and the nurse's counter in front of the consulting room, patients and health personnel exercised their power through the hospital's rules. It was exercised through the legal & social authority source. The hospital's rule played an important role in assigning the step of care, at the same time handing over the role of patients and health providers. This relation between patients and health personnel followed the hospital's procedures and was thus kept in the formal manner. At the nurse's counter, some nurses exercise their power through the information and knowledge source when they were taking patients' history. During this stage health personnel seemed to have more power over patients through the legitimate power of the organizational and legal and social authority source and patients had the obligation to follow. There were a few patients tried to exercise their power by choosing a specific physician whom they wanted to have a consultation with. Most of them could not reach their request, because nurses or nurse assistants did not grant them their demand. The main reason that nurses gave to patients was: *"It is the system. You cannot select the physician."* All of patients accepted this reason without any hitch. They usually said: *"It is the system. I do not have the right to choose the physician."*

The significant reason that influenced patients asking for the specific physician was the explanatory model in part of the perception of medicines. They perceived that this particular physician would prescribe them the "compatible" medicines. Their past experience together with the desire to recover encouraged them to ask even they knew the answer. For example, in case of the patient with gastric ulcer (case 482), even if she would like to consult the specific physician whom she had experience of prescribing her the "compatible" medicine, she did not try to exercise her power at this service point.

She said: *"At first, I don't want to treat with this physician. I want to treat with Dr. A. He prescribed the effective medicine to me. But the nurse did not let me choose. I cannot choose the physician. It is the system. I do not have the right to choose the physician."*

In this case, the explanatory model was the ineffective source of power, because the patient did not succeed using it or gaining the power through this source. The reason that nurses and nurse assistants informed the patient was against the quality of care particularly on the accessibility. Patients could not access the specific physician whom they wanted to have the consultation with. There was only one patient that could visit the specific physician that she asked for (case 111). She was the health personnel from health center. She exercised her power through her social status not from the explanatory model. In fact, patients had their right to access the physician that they wanted. The reason claimed was just the excuse of these health personnel. There was no written hospital's rule on the patient queuing for physician visit. This process was created by the health personnel to make their job more convenient rather than to facilitate the need of patients. This situation indicated the unconcern of nurses and nurse assistants on their patient needs. They did not act upon patients' best interest. Their services were concentrated on neither the patients nor the patient-centered approach.

This study found that patients were not aware of their rights; all of them accepted the reason informed. They did not exercise their power through their legal and social authority particularly consumer rights. Almost all of patients did not mention about their rights. It could due to the lack of knowledge or understanding on their rights. However, one patient (case 482) who could not choose the physician had a different way to exercise her power; she planned to revisit the hospital on the following week. She said: *"I know he works on Wednesday, I will come back again on next Wednesday to visit him."* From this case, the patient tried to exercise power through the other source of material wealth in the compromise style. She had to get around the hospital's rule by

spending their own resources, both time and money, to revisit this hospital with the hope that she could be lucky and get a chance to see her physician next time. It was the characteristics of Thai on problem solving aspect.

3.2.2.2 Service during Medical Consultation

The period during medical consultation was the crucial stage that represented power exercising using each own explanatory model. In this context, patients and physicians might exchange their explanatory models in order to reach a therapeutic decision that could alleviate or treat patients' illness. Assessing how the power was exercised in this stage took into account the capacity each party had in control of their own explanatory model during the consultation. If physicians' decision on the alternatives of treatment was based on their explanatory models, they were in control of the direction of the consultation and power would be in their hands. It was then considered the physicians' power relation. On the contrary, if physicians based their treatment decision on only patients' explanatory model, patients would have more power to determine the direction of the relation since the consultation and decision would be centralized around their explanatory model or in another word the relation was the patients' power relation. In case that physicians combined both their explanatory models and patients' explanatory model in deciding treatment alternatives for patients' illness, both physicians and patients shared their power to direct the consultation, the power would belong to both parties, patients and physicians, and it was considered as the mutual relation.

However, there were some gray relations that could not clearly identify which party had directed the medical consultation since both physicians and patients were in control of the direction of the consultation. Physicians used both their explanatory models and patients' explanatory model in deciding treatment alternatives for patients' illness as in case of mutual relation, but did not combine or exchange their explanatory

model with their patients. There was no exchange of the explanatory model in the consultation, although the consultation was controlled by both physicians and patients.

The results in table 4.1 showed that nearly 83% (377 observations) of the relations between patients and physicians were the relation of physician's power, about 10% (46 observations) were gray relation, about 4% (19 observations) were mutual relation and a little under 3% or 13 out of 455 consultation sessions were patient's power relation.

Table 4.1 The Power Relation

The Power Relation	Number (Percent)
- Physician's power relation	377 (82.86)
- Gray relation	46 (10.11)
- Mutual relation	19 (4.18)
- Patient's power relation	13 (2.86)

Although, most of the consultations were the physician's power relation, the data showed that almost a half of patients (221 patients) to some extent tried to exert their power by participating in the medical consultation more than what physicians required. They tried to exchange their explanatory model by asking about their symptoms particularly on the ideas of causation. For example, most of patients who had chronic low back pain often asked the physicians about the cause of their low back pain. They doubted that there might be some problems with their kidney, since they perceived that low back pain was caused by the abnormal kidney. They usually exchanged: *"I'm afraid that I got "Roke Tai" (abnormal kidney), since I often "Puad Lunk" (low back pain).*

Furthermore, most of them tried to exercise their power through proposing the treatment alternative which they perceived was effective for their symptoms. The treatment alternative that was the patients' favorite proposal was the use of medical technology for investigation on symptoms such as the x-ray, the ultrasound, or the blood

and urine examination. Besides, many patients tried to ask for the specific medicine that was perceived to be effective for their symptoms. The proposal on treatment alternative and the request on specific medicine implied the patients' expectation on treatment which to a certain extent illustrated patients' power use through their explanatory models. The finding from in-depth interview supported that patients had planned their expectation before going to visit a physician and tried to meet their expectation by exercising their power through proposing or asking for what they had in mind during their encounter in the consultation. However, majority of their requests were not honored by physicians.

The results showed that most of the medical consultations were the ineffective exchange of explanatory model, since physicians still attached with their old explanatory model with the belief that patients' was not theoretically sound. The majority of physicians used only their explanatory model to make decision on the treatment. Then most of power relations were physician dominance. The significant symptoms that patients often tried to exercise their power were chronic back pain and chronic abdominal pain. With the chronic nature of symptoms, most of them had the prolong treatment and needed to adhere to the therapy. Patients had reasonably allowed physicians to play a major role in the treatment decision however after some period of adherence the treatment did not prove the effectiveness or in another way of looking their symptoms were not completely relieved. They therefore had a reason to request that their belief about the causation of symptoms or the treatment alternative should be investigated. That was when they tried to exercise their power using their explanatory about the causation or the therapies. In case of patients with chronic back pain, the abnormal function on kidney was the suspected with the request for confirmation by the x-ray or the ultrasound. For the chronic abdominal pain patients, they wanted to know what happened in their stomachs.

Apart from the patients who expressed their power exercise by participation in the conversation during the consultation session or by proposing or requesting

treatment alternatives, the other half of patients (234 cases) had other styles of power exercising during the consultation. Participation by exchanging explanatory model or request was not the preference of this group. Some of them did not even try to participate in the consultation. The results revealed that these patients had other way to show their expression as a mean to exercise the power from their explanatory model. For instance, some of these patients chose to follow the norms of Thai medical consultation that patients had responsibilities to cooperate and just complied with physicians' order. Most of them (176 cases) just cooperated with the physicians' order by answering only the physicians' question. However, the rest of patients had some different expressions when they interacted with the physicians. There was a variety of means to exercise power for both physicians and patients through these expressions.

In the process of care, physicians and patients even started from different grounds brought into their encounter a comparable power from the explanatory model. Patients mainly relied on this information and knowledge source of power since their other sources were unaware of or deemed inadequate. How patients and physicians exercised or expressed their explanatory model was an appealing aspect and got the attention of this study as the data analysis presented itself. This study therefore contributed a rather extensive analysis on how power exercise was expressed by patients and physicians during their medical encounter. The detail was described in the next two subsections.

3.2.2.2.1 The Expression of Patient's Power

Two major patterns of patient's power exercise according to their exchanging behavior on explanatory model were the exchange and the un-exchange patients. Patients with the same pattern of exchange still had different ways of expression as a means to exert their power during their encounters.

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It was found that the exchange patients had two different styles of expression while having consultation with physicians, super star and participator. A super star was more like a talkative patient. Besides cooperating with the physician's order, the super star often talked about their symptoms and their other stories to the physician. They did not expect to obtain more information. They just wanted to tell some stories to the physician and did not ask or consult the physician even about their symptom. Their conversation was considered as the story telling style. On the other hand, a participator was trying to participate in the consultation. They usually asked physicians about their symptoms. Some of them tried to request for special investigation such as the x-ray, the ultrasound or the specific medicine. The difference between a participator and a super star was the expectation on the treatment. It was found that almost all of the participators had their own expectation on the treatment and these expectations were influenced by some crucial factors. While participating or exchanging with their physicians, participator tried to exercise their power so that their expectation could be reached using either the consulting style or the requesting style.

Then, there were two kinds of the participator. One who exchanged with the physician as an advisee and the other as a requester. A requester seemed to be the participator who was more confident in exercising the power than an advisee. They directly asked or requested what they expected. While an advisee talked in circles around the expectation. For example, in case of the patient who had headache and vomiting (case 424), she actually wanted to have her brain scanned, so she tried to consult the physician: *"I had headache and vomiting. Is it related with the brain? My daughter has told me to ask whether it is necessary to do the brain x-ray."* The difference on the power use between a requester and an advisee was the respect on physicians. The advisee expressed in more polite and reverent manner to the physician than the requester. They were more considerate for physician's feeling. When asked, they often said: *"I am afraid of the physician, so I did not directly ask for the X-ray. I am worried that the physician would think I know more than him."* While the requester

only concentrated on their illness, they said: *"I want to get well, so I ask for the effective method."*

The results indicated that the unexchange patients expressed their power exercise in two different styles as hermit and responder. A hermit was a silent patient who did not talk or did not participate even did not answer when asked by physician during the consultation session. When getting a closer look into situation of hermits, it was found that some were hermits by nature and some were forced by the other counterpart. Natural hermits were hermit by themselves choose not to talk or participate during the consultation although physicians gave their chance. For example, in case of the patient who had tumor (case 306), the physician tried to ask about her symptoms with 3-4 questions: *"How are you?" "Do you have the tumor? Where is it"? "Is it hurt you?"* When the patient did not response, the physician ended the consultation by arranging her to the surgeon. On the contrary a forced hermit was the silent patient imposed by the physician. They were not given any chance to begin their conversation with the physician. There were cases that patients were forced to be hermits just because they visited a physician close to the lunch break or the end of the physicians' office hours. This physician had working hours during 9.00-11.00 am. The first forced hermit visited him at 10.53 am. (case 255) and the second patient visited him at 11.03 am. (case 102), the physician cut short the consultation by assigned these patients to have the consultation with another physician next consulting room. When patients came into his room, he just ordered patients: *"Go to the next room".* The second style of unexchange patients was the responder who cooperated with the physician just only on the physician's order or only answered the physician's question. They did not ask for the other things, although it was legitimate or related to their illness.

This study found that for most of observations (nearly 56%) patients expressed themselves as the exchange patients and 44% as the un-exchangeable patients (Table 4.2). These figures pointed out that in more than a half of observations (56%) patients to some extent tried to participate in the medical consultation or they attempted to exercise

their power. While the rest (44%) were still a part of the Thai norm regarding medical consultation by cooperating with the physician's order.

Table 4.2 The Expression of Patient's Power

The Expression of Patient's Power	Number of observations (%)
- The exchangeable patients	254 (55.82)
- Participator	221 (87.01)
- Super star	33 (12.99)
- The un-exchangeable patients	201 (44.18)
- Responder	176 (87.56)
- Hermit	25 (12.44)

The various expressions by patients reflected different styles of power exercising. The exchange patients especially the participator tended to put more effort in exercising their power than others by negotiating with physicians for their expected services. They used their explanatory models as the vehicle to reach their expectation. The explanatory model was therefore the significant source of power for patients during the process of care. From the other end of expression, hermit, responder, and super star tended to exercise their power in a less assertive manner. They simply followed what their physicians told or ordered. The observations during the consultation sessions led us to believe that these patients were not exercising their power. Their practices were ordered by the physicians. They neither expressed their expectation to their physicians, nor had any negotiation statements during consultation. Majority of patients did not exchange their explanatory model with their physicians. Even super stars that had some chance to speak out, they did not try to request or exchange their expectation instead enjoyed telling their stories. These cases did not fully utilize their explanatory model as the significant source of power. The questions of why hermit, responder, and super star did not exercise their power during consultation or whether the explanatory model was the significant source of power were examined in detailed with how physicians expressed their power exercises.

3.2.2.2.2 The Expression of Physician's Power

Physicians as well had their ways of expression on their power exercises, but with different aim, anticipation, and belief. Physicians did not start the consultation session with a specific expectation like patients. They exercised their power in order to seek information necessary for making decision on treatment.

The same patterns on information exchange were found in the analysis of physicians' behavior as the exchange and the unexchange physicians. In specific, exchange physicians expressed themselves as, what were termed by this study, an expert, an authorized interviewer, or a reinterviewer. These expressions represented different styles of power exercising. An expert was the expression which possessed more professional aspect than the others. Experts tried to exchange their explanatory model with their patients. In this case, the explanatory model was the significant source of power that physicians used to exercise their power. Founded on biomedical framework, experts could logically related patients' symptom, illness, and treatment method requested to their decision. All of the information that they provided to patients was based on biomedical knowledge. Their explanatory model was dominated by biomedical theories. Using the same foundation, authorized interviewers exercised their power by interviewing patients. They used all of the time during the consultation session interviewing their patients. In general, these questions were the series of pathological events/episodes happening with the patient. What authorized Interviewers tried to exchange with their patients was still biomedical knowledge and information. The last group of the exchange physicians was the reinterviewer who exercised power by both reviewing patients' medical record and interviewing patients. They exchanged their explanatory model with their patients like expert and authorized interviewer but using different styles.

The unexchange physicians, on the other hand, expressed themselves as either a medical reviewer or a cut-short. The medical reviewer was the physician who

exercised power through the silent expression. They usually used all of the time reviewing patients' medical record or the results from patient's investigation. They might not talk with their patient during the consultation session. In this case, physicians exchanged their explanatory model with the patients' medical record. The other group of unexchange physicians was the cut-short. In some consultations, the physician would break off the conversation to end the session. It was found that there were two situations when the physician cut short. One was in case of the complicated patient, when the physician considered that the patient had more complicated symptoms, the physician then cut short the consultation by assigning patient to the specialist department. The other situation was when a patient visited the physician during the last minutes of the working schedule. When the time passed his working hour, the physician interrupted and ended the session by sending the patient to the next consulting room.

From the data obtained, it was found that almost all of observations (nearly 93%) physicians expressed themselves as the exchange physicians. Among these less than 48% were the reinterviewer, about 38% expressed as the authorized interviewer, and about 15% behaved as the expert. Only 7% of the observations that physicians were viewed as unexchange physicians with less than 54% being the medical reviewer as shown in Table 4.3.

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Table 4.3 The Expression of Physician's Power

The Expression of Physician's power	Number of observations (%)
- The exchangeable physicians	423 (92.97)
- Reinterviewer	200 (47.28)
- Authorized interviewer	160 (37.83)
- Expert	63 (14.89)
- The un-exchangeable physicians	32 (7.03)
- Medical reviewer	17 (53.13)
- Cut-short	15 (46.88)

This study found that to end the consultation session, physicians had three therapeutic options by prescribing, not prescribing, or referring. For referral, sometimes patients were referred because they needed special care from a specialist, or more investigation, or both but sometimes patients were only cut short and sent to the consulting room next door to see another physician without reasons explained. These therapeutic choices represented how power was exercised in the relationship between physicians and patients as well as the quality of care. These two related pictures, the power relation and the quality of care, were then together explored along with therapeutic choices to provide a better picture of the physician-patient relationship and the results were detailed next.

3.2.2.2.3 The Physicians' Power Relation

Most of medical consultations (nearly 83%) in this study tended to be the relation dominated by physicians' power. This physicians' power relation was no surprised the norms of Thai society, since the physician was valued as a privilege group. They held higher or social status or were accepted as more important than the patient. This status of physician then called for the complete cooperation from the part of patients (Pendleton et al., 2003). The data demonstrated that the majority of the medical consultations in this study were consistent with the Thai norms. The result showed that

during medical consultations physicians' power dominated that of patients. Most of physicians based their treatment decision on only their explanatory model. They rarely took into consideration patients' explanatory model in deciding treatment alternatives for patients' illness. Patients were only information suppliers who provided illness information that physicians needed for treatment decision.

The physicians controlled the consultation from the beginning of the session which started off with greeting. The physician was the one who opened the conversation in majority of observations (86%). They usually greeted patients: *"How are you?" or "How about your symptoms?"* From what had been noticed, most of the times physicians neglected to complete the established initial rapport. They just only greeted patients without demonstrating their interest, concern and respect to what patients would answer though it was important in laying the groundwork for a productive relationship. This neglect could be the result of ignorance on the essence of relationship or the powerful role of physician given by the society. The significant source of power that physicians used in this beginning period was the legal and social authority source. However, this source was less effective for patients not only because the legal and social authority source limited their role but at the same time patients were ignorance on their right. According to the norms of Thai medical consultation, the patients were expected to play the role of cooperation following the physicians' order. If for some reasons, the order was misperceived or disregarded, patients were the first to be blamed and no responsibility was placed on physicians. It was hardly ever questioned whether the source of the problem could be from physicians or the relationship.

Greeting was followed by the information gathering by physicians. They utilized their medical knowledge in exercising their power through the traditional method of history taking and disease diagnosis for underlying pathology. It gradually more concentrated on the individual parts of the body that were malfunctioning. It did not aim at understanding the meaning of illness from the patients' points of view or place it in the

context of their lives. The physicians had been taught to ask specific questions about symptom such as the functioning of a particular organ system. It was the series of pathological events happening with the patient followed by their explanatory model on the biomedical knowledge. They gathered only the information that was needed to make a diagnosis and treatment decision. They usually neglected the patient's explanatory model such as feelings, thoughts, concerns, and impact on the patient's life that was induced by an episode of sickness. In another word, patient-centered or holistic approach was left behind. These pictures were consistent across all observations and types of exchanges or expression. The physicians usually relied only on their explanatory model to make decision on the treatment. Most of the consultations (70%) were ended up with the prescriptions. The medicines seemed to be the crucial tool that supported physicians to manage the consultations and patients. In the period of gathering information, while physicians used their explanatory model and the material source such as the medicine as significant sources of power, patients brought with them only their explanatory model and it was considered inadequate.

Besides, the usual consultation session of which control was determined by physicians other situations happening during this consultation had also pointed in the same direction. Among them nurses' interruption, private calling were some examples. The situation that nurses interrupted consultations was commonly observed. This reflected everyone and his/her matter were important but the patient in the room. Another obvious example that illustrated the physician's power during the consultation was how one handled the private calling. Different behaviors between patients and physicians on this matter were observed. When the physician had the private calling, they replied this call at the same time that they talked to the patient, while the patient cut off the call immediately. Other characteristics that presented the norms of medical consultation were the conversation expressed by both patients and physicians. The manner expressed, tone and wording used were very much different. Almost all of patients had more respect to the physicians, they generally paid respect to physicians regardless of age and despite they were older than physicians. It was found that the

older paid higher respect to physicians than the younger. This respect was represented by the manner, tone of voice and wording. During the medical consultation, most of the patients showed uncomfortable manner. Some of them made themselves small by using the tone of voice and wording presenting they were considerate on the physicians' feeling. For example, when patients wanted to ask for something from the physicians, they said: *"I would like to ask……"*. While the physicians had different expressions, most of them had more comfortable manner and expressions such as sitting with legs crossed or answering the telephone at the same time as they reviewed the medical records. Some physicians used the wording showing their commands, or the tone in a very determined voice to their patients, such as *"Stop….., Do not…., Must do…. "*. For instance, in case of the patient who had liver disease (case 20), the physician commanded: *"Do not take the medicines by yourself. If you had more pain, you cannot take the medicine. Do not buy the medicines. I do not permit you to do that. Stop drinking during the New Year party. I do not allow you to drink. You must eat only vegetable and fish."*

During the exchange, physicians exercised their power by selectively listened only to pathological information, other information that did not fit into the biomedical framework were neglected and considered irrelevant. As in case of the patient who had cough (case 240), she perceived that her cough was the result of the bonefish in her throat or another case that the patient (case 396) believed her high blood pressure was caused by the ask shell of the genus Arca, both physicians in these consultations did not discuss or response their patients on their belief and perception. They skipped these points and focused on the series of pathological events/episodes. After they finished their questions, they prescribed medicines to the patients with clarification on their belief. The patient-centered care concept was not the essence of physicians' services, the quality of care was then questioned. The observations pointed out that patients' illness rarely caught physicians' attention. They did not try to understand the patients from their contexts.

A. "Treat on Disease, Not Treat on Illness": The Common Manner of Physicians' Power

The study found that the practice of physicians in the physicians' power relation presented the strong support of biomedical knowledge as *"treat on disease, not treat on illness"*. Within this concept, physicians' attention was only drawn to the investigation of the abnormal organ. When they did not find the abnormality, their mission had completed even though patients still insisted on illness existence. The case illustrating this point was the patient who perceived he had gall stones (case 434). After the physician reviewed the X-ray, the dialogue between the physician and his patient was:

Physician	:	*You do not have gall stones. Your X-ray is normal. It is very good.*
Patient	:	*I have low back pain, so I must have the gall stones.*
Physician	:	*You do not have any disease. What do you want me to do?.*
Patient	:	*I have gall stones.*
Physician	:	*Go to next room.*

This example presented a very obvious picture that strongly supported the concept of *"treat on disease, not treat on illness"*. The physician finished the consultation with the conclusion that the patient did not have any abnormality although patient still insisted on his illness. This picture also raised other relevant issues as the power relation and the exchange of explanatory model. In this case the consultation was in command of the physician. The physician exercised his power through the expression of the cut-short by cutting off the consultation and arranging the patient to the next consulting room without the concerning on the patient. There was no effort by the physician to exchange or explain his explanatory model to the patient. On the scale of 1 to 10 this exchange would get the score less than 5. It was considered an ineffective exchange of the explanatory model. Both counterparts still had their own explanatory models even if they had already finished their exchanges. The other typical example reflecting the concept of *"treat on disease, not treat on illness"* was in case of

psychosomatic patients or patients who had undetectable symptoms or unable to explain from biomedical technology. They were physically healthy, normal vital sign, normal blood pressure, etc, but had frequent complaints on short of breath, insomnia, and loss of appetite. Some physicians had negative attitude on psychosomatic patients, and stigmatized them. They usually commented: *"There are a lot of patients who perceive they have disease. All of them are actually healthy man".* Observation cases reflecting this incidence were patients who had complaint on short of breath (case 227,242,250,322,359). After the physicians did not find the abnormality on the respiratory tract, they stigmatized these patients as psychosomatic patients. Then the physicians concluded the consultation although patients still insisted on their illness. This picture presented that physicians did not try to understand patients in their context. They investigated just only disease from their perspective and did not cope with patients' illness.

More examples confirming two distinct explanatory models between biomedical knowledge and patients' illness were illustrated. In these cases of patients perceiving they had *"Roke Tai"* (problems on kidney) (case 314,390), the physician cut off the consultation by referring patients to the next consulting room just because patients insisted on having problems which physicians believed they did not have. The physician did not try to exchange or explain their biomedical explanatory model to the patients. There was no effort observed from all of physicians to understand patients' explanatory. They valued the patients' explanatory as the erroneous knowledge. Most of them neglected, or stigmatized this knowledge. Their relations were pictured as the relations of an expert and a lay who was always lack of knowledge.

Some physicians characterized the patient as a case or disease instead of a person to be treated. While less effort of physicians was planted in the exchange of explanatory model they somehow developed the attitude on their patients. Examples illustrated in the case of a low-back pain patient who revisited the physician for the second time after getting the x-ray result (case 8). After the physician finished

questioning patients' symptom, he spent approximately 5 minutes reviewing the patient medical record and x-ray film with no conversation. The physician then wrote something in the medical record and gave it back to the patient as a signal to end of the consultation session. The patient got the medical record back with the confused sense and a question in his mind why the physician did not explain anything to him. After the patient went out from the consulting room, the physician said to the observer: *"Send him to the surgeon. He has some gall stones, but has shopped around every department in the hospital."* This practice pointed out that the physician not only considered the patient as a case, he created a stigma on the patient as the shopping around patient. Although referring to the surgeon might be the proper treatment, the patient neither appreciated the physician nor felt the care was provided. The patient said: *"The physician did not tell me anything. I am very confused why he did not say anything, just only read and read on this paper. I want to know what goes wrong with me."*

B. Quality of Care in Physicians' Power Relation

When these observations were analyzed using dimensions of quality of care, the results showed that entire process of care provided to patients did not conform to the patient-centered approach. According to the first aspect of quality on the biopsychosocial dimension, physicians instead of trying to understand illnesses from patients' perspective, they tried to fit them into conventional disease taxonomies based on the biomedical model. They did not feel responsible for non-medical aspect of problems. More quality problems were observed when taking into account the patient-as-person dimension. These cases were treated as some disease entities. Physicians were not curing or caring "the person" but were treating an organ with abnormality. The less effort in exchanging with their patients by the cut-short physician or the medical reviewer strongly supported this evidence. They ended the consultation with no explanation or information given to patients. If consideration on patients' right to the information was concerned, the practice might be different. Patients' power, particularly from legal and social authority source, was not at all exercised and the result was quality

of care was questioned. This example connected to the third dimension on sharing power and responsibility. Patients were not aware of their right but at the same time physicians also ignored the need to share the power with their patients. Other power sources were also disregarded. It was found that almost all of physicians did not encourage greater patient involvement in the process of care despite many patients tried to be the participator. Physicians had controlled all of the process of their services and made all decisions like paternalistic relationship.

As evidence showed, physicians did not put an aim on power sharing. Their relationship was thus asymmetrical. It was fundamentally very different from the patient-centeredness approach which promoted the idea of an egalitarian physician-patient relationship (Parsons, cited in Mead and Bower, 2000). The quality of care of these observations was as well against the next dimension on the therapeutic alliance. The physician's role in this relation was not a friendly and empathetic manner. There was no evidence in this study supporting that physicians considered patients as their counterpart but some supported the negative attitude of physicians on their patients particularly on the psychosomatic patients. Most of physicians concluded the consultations although patients still insisted on their illness. They perceived that the patients had physically healthy, since they could not detect the symptoms from biomedical technology. This picture presented that physicians hardly took patients' perspective into their decision making. If they considered patients as their alliances, more effort on understanding lay perspective could be expected.

This analysis illustrated that the power relation between physicians and patients and the quality of care were two related pictures and reflected each other. It was found that although physicians had more power than their patients and determined the direction of the medical consultation particularly on the exchange of the explanatory model between them, physicians were not in command of the quality of their care. The quality of care was not unidimensional. Their services did not contain the crucial dimensions of the patient-centered care. The result remarked that the imbalance of the

power relation seemed to be the critical obstacle of the quality of care, since having more power led to less concern on the others. In cases of the physicians' power relation, the results pointed out that the physicians who had more power often had less concern on their patients.

The power relation or how the power was exercised in the relationship between the patients and physicians was partly reflected by the expression between two parties. The analysis so far has been viewed from one party at a time. The data showed that the expression of physicians was the potential factor that impacted the content and the level of the explanatory model exchange, since the physicians' power could to some extent determined how patients exercised theirs. The detail of the interaction between two expressions was then described in pairs as followed. .

C. Unexchange Physicians VS Unexchange Patients

It was found that there were about 6.63% (25 consultations) of medical consultations that were the relation between the unexchange physicians and unexchange patients. Among them, there were 10 relations of the medical reviewer and the hermit, 6 relations of medical reviewer and responder, 4 relations of the cut-short and the hermit, and 5 relations of cut-short and responder. For the hermit, it was found that all of them were the forced hermit, since the unexchange physicians: medical reviewer and cut-short exercised their power by assigned the hermit role to their patients. The relations between these unexchange physicians and the forced hermit indicated the interesting point on the power exercising. These physicians had complete control over their consultation. They did not allow patients to exchange by that they forced patients to be the hermit. The example of the conversation between physician and patient in case 102 was a very clear picture that presented the physicians' power.

When patients came into the consulting room, there was an exceptional short conversation as…….

Physician : *Go to the next room.*

Patient : “--------“

After that, the patient was stunned and hesitated for a while, and then went out from the consulting room.

For the medical reviewer, the results showed that these physicians controlled the consultation by silence, they used all of time reviewing patient’s information on the medical record or/and the result of patient’s examination. Very surprisingly, they decided their treatment by using only the information from the patient medical record without talking or interviewing patients. Thus, there was no conversation observed during the consultation of these relations. For example, in case of the patient who had *“Puad Lunk”* (low back pain) symptom (case 8), after the patient handed his medical record and the film x-ray to the physician, the physician spent the whole consultation period reviewing the medical record and the x-ray film for approximately 5 minutes. The physician then wrote something in the medical record and gave these documents back to the patient without the conversation or the explanation on treatment. As well, this patient was stunned and could not avoid the forced hermit assigned.

This example indicated that the stage of consultation and the stage of illness were the specific factors that determined the expression of the medical reviewer. For the stage of consultation, the patients who revisited the physician after he was sent out for more investigation such as x-ray in this case usually came back with full report of the examination result might be assigned as the forced hermit since the physicians had more information for making decision on treatment. Then, they did not want other information from the patient. For the stage of illness, chronic patients, i.e., diabetes, cancer, might be subject to the expression of the unexchange physicians because most of the chronic patients were treated by the same prescriptions to maintain their symptoms. The consultations in these cases seemed to be the routine work of

physicians. They just reviewed the previous patient's history and then prescribed the same prescriptions with no question asked.

This practice presented two significant issues that were against the patient-centered approach. This practice indicated the complete control of physician over the patients and consultations. The patients did not have a chance to share power and responsibility to manage his illness. It also detected the attitude of the physician on the patient. The patient was treated not as a person but a disease or an abnormal organ. The physician did not respect him as the person. Although the proper treatment was decided and provided for the patient he was not explained about his symptom and the step of care.

However, there were some consultations that the physician expressed as the medical reviewer though it was the first encounter and the patient was not the chronic case. For instance, in case of the patient who had a swollen foot (case 433), after the medical reviewer read the patient medical record, he said without the examining on the swollen foot: *"Go to next room. Let those physicians see your symptom".* Or another case of the patient who had dandruff (case 12), the medical reviewer did not say anything, after he finished reading the patient medical record, he wrote something on the patient medical record and handed it back to the patient without any words from the physician. There was a case of the acute patient with abdominal pain (case 205) that the medical reviewer prescribed the medicine with on the exchange of explanatory model. After they finished reading the patient medical record, the medical reviewer said: *"I prescribed some medicines for you."*, and then gave the patient medical record back to this patient. These patients had flabbergasted mood, all of them failed to avoid the forced hermit expression. They went out from the consultation room without any word but questions on their face.

Regarding on the cut-short, there were two characteristics of the patients that induced the cut-short, the first was in case of the patient visiting the physician during the

last minutes of their working schedule and the case of complicated patients. For the first characteristic, there were examples in cases 102 and 255; both of these cases went into the consulting room close to the lunch break of the physician. The case 102 visited the cut-short at 11.03 a.m., while the case 255 visited the cut-short at 10.53 a.m. Both of them were assigned to the next consulting room. The cut-short just ordered the patients: "*Go to the next room".* As for the complicated cases, the study found that the cut-short ended the consultation after he evaluated the severity of patients' symptom. For instance, in case of the patient with skin disease (case 382), after the cut-short saw this symptom, he said: *"Oh…this is very severe, go to those rooms".*

It was found that some physicians cut short the consultation when they perceived that the patients were the psychosomatic patients, as in case of *"Hai Jai Bau Im"* or short of breath symptom (case 172). In this case, after the physician reviewed the patient medical record, he perceived that this patient was the psychosomatic patient he then cut short the consultation by prescribing the same prescriptions the patient had from the last visit. The physician said: *"I give the oral medicine and ointment to you."* After the patient went out from the consulting room, the physician said to the observer: *"I prescribed these medicines to get around this problem. I wanted to end the consultation."* For this case, although the physician seemed to have more power than the patient, since the consultation was in control of the physician. There was a very interesting point that connected with the power of physician. The medicines the cut-short prescribed in this case were not something the physician could justify based on biomedical knowledge. He prescribed the medicines though they perceived the patients did not have any symptoms. It could be viewed that, the physician might try to satisfy this patient on the one hand; on the other hand he just tried to get around the problem. The significant source of power that pressured this physician was the legal and social authority source: the patient's right. The cut-short usually said: *"Give the prescription to them is the method to get around the problem".*

Comparing the exercising power between the medical reviewer and the cut-short, the cut-short seemed to be in more control than the medical reviewer since the cut-short refused to treat the patients, they did not even review the patient medical record, while the medical reviewer tried to treat the patient by reviewing the patient medical record. The study found that the patients who were in the cut short situation had dumbfounded mood, anyhow they went out from the consulting room as the physician's order without a question asked. This situation pointed out the power of the physicians that they had absolute power from controlling the consultation environment, making decision on treatment or refusing treating patients.

The significant source of power that the physicians used to exercise their power was the explanatory model under the biomedical framework. However, the power from other sources including legal and social authority as well as the material wealth was all fully utilized. The legal and social authority and material sources provided by the hospital's rules and structure that supported power of physicians in term of the physicians' status as a decision maker for all of treatment steps, e.g., the authority to order all laboratory tests and auxiliary services or to prescribe medicines. The study found that physicians also exercised their power through the therapeutic choices. The results showed that most of physicians often exercised their power through the prescriptions even some physicians in this relation exercised his power by ending the consultation with no prescriptions. For example, in case of the patient with chronic low back pain (case 316), after the physician reviewed the results of x-ray, he decided to end the consultation with no prescription since the result from the x-ray indicated that this patient did not have the abnormal symptom. Then, the physician said: *"It's normal. You don't have the serious symptom, you don't need the prescriptions."* The physician finished the consultation by this statement and handed the patient medical record back to this patient. This situation confirmed the physician's power over his patient; however it did not imply or assure the quality of care. From the patient-centered care, the physician completely treated only the disease but not the illness of the patient. From the physician's perspective, nothing else could be done since the physician did not find the

abnormal pathology from the X-ray or another word the patient was treated with the concept of physician-centered approach. The patient went back with the same illness even no disease was diagnosed.

In conclusion this study found that both of the unexchange physicians and patients put less or no effort to exchange their explanatory model. The unexchange patients, both the hermit and the responder, did not try to exercise their power. When they chose to comply with the physician's order, their power from the explanatory model was then an ignored source. From the observation, the medical reviewer exchanged their explanatory model with the patient medical record instead of the patients. The relation of the unexchange between both parties was the very obviously picture that strongly confirmed the concept of *"treat on disease, not treat on illness".* In addition, the quality of care was compromised on all dimensions of the patient-centered care. This relation did not conform to the conceptual dimensions particularly on the biopsychosocial perspective, patient-as-person, sharing power and responsibility and therapeutic alliance.

D. Unexchange Physicians VS Exchange Patients

From the data analysis, it was found that there were only 6 relations between the unexchange physicians and the exchange patients. All of them were the relation between the cut-short and the participator. The participator, by proposing or asking what they expected during the consultations, was exercising power through the exchange of their explanatory model. The aspects of explanatory model used in exchange depended on the stage of illness. Most of them had the chronic symptom such as the chronic low back pain, chronic abdominal pain. Some of them were the psychosomatic patients with symptom of *"Hai Jai Bau Im"* or breathless, tried, and exhausted. They tried to discover this ambiguous symptom by asking for the x-ray or the ultrasound to detect their abnormality organ.

The conversation in case 240 presented power of the physician in the relation that the physician acted as a cut-short man and the patient acted as a participator. The patient in this case had *"Hai Jai Bau Im"* symptom; she had breathless, tried, and exhausted. This patient perceived that there had to be something wrong with her body. She wanted to investigate her internal organ, and tired to exchange her explanatory model as…….

Patient	:	*I am very exhausted; I had "Hai Jai Bau Im".*
Physician	:	"-----" (he read patient's medical record)
Patient	:	*I am very tried, "Kin Kao Bau Sab" (loss of appetite), And "Non Bau Lub" (insomnia) too, Please investigate my body. There is something wrong with my gut. I want to x-ray.*
Physician	:	(handed the patient's medical record to patient and said) *Go to get the medicines.*
Patient	:	"--------".

This example pointed out the physician finished the consultation by the prescriptions though they perceived this patient did not have any symptoms. The study found that most of the cut-short ended the consultation by the prescriptions though they perceived the patients did not have any symptoms (cases 372,376,421,424). The cut-short in these cases compromised their power and could be viewed as being less control than the cut-short with other therapeutic alternatives or other physician's expressions, since their prescribing behavior might to a certain extent be influenced or induced by some forced from the patients. Some cut-short perceived that the prescription was the psychological support tool. Then, they used the prescription to avoid the conflict with patients. In these cases the cut-short tried to reduce patients' disagreement. They did not try to understand patients. They usually said: *"I don't want to waste myself to the patients, the prescription saves me from them."* This reason indicated that this force was not from the patient's explanatory model but it was the

direct impact from acknowledging the patient's right. Although, the patients got the prescription that they wanted, the quality of care was not assured.

These pictures clearly reflected the quality of care in Thai situation. The prescription was the potential source of power that the physicians used to exercise their power. It was the sign indicating the consultation was over. The relations of the unexchange physicians and the exchange patients revealed that the exchange of explanatory model of patients depended on physicians, patients could not participate in the consultation without the physicians' agreement although they intended to participate or share their power and responsibility on the management of their illness.

E. Exchange Physicians VS Unexchange Patients

It was found that nearly a half of the physicians' power relations (45.36%) were the relations between the exchange physicians and the unexchange patients. Majority of these relations (160 relations from 171 relations) were the relations between the exchange physicians and the responder, while the rest of these relations (11 relations from 171 relations) were the relations of the exchangeable physicians and the hermit specifically the natural hermit.

The natural hermit generally did not talk or cooperate in the consultation although the physicians gave them a chance to participate. For example, in case of the patient with a tumor (case 306), the physician tried to ask about her symptoms with 4 questions as…..

Physician : *How are you?*

Patient : *"-------"*

Physician : *Do you have the tumor?*

Patient : *"-------"*

Physician : *Where is it?, Does it hurt you?*

Patient : *"-------"*

Physician : *Oh…., Go to the specialist.*

This patient did not response any of these questions. The physician then ended the consultation by arranging her to the surgeon. The natural hermit exercised their power by the silent expression like the unexchange physicians but their power had less potential than the physicians since they could not control the direction of the consultation like in cases of the unexchange physicians. For the responder, most of them did not try to exercise their power. They complied to the physician's order without any question. The responder seemed to have less power than the natural hermit since they were more under the control of physicians than the natural hermit.

When analyzing the interaction between the exchange physicians and the unexchange patients, it was found that the exchange physicians tried to exchange their explanatory model by presenting themselves as the authorized interviewer (77 relations), the reinterviewer (64 relations) and the expert (30 relations). The results revealed that the stage of consultation and the stage of patient's illness were the crucial factors that impacted the expression of physicians like in cases of the patients. It was found that almost all of the authorized interviewers were treating patients starting their first visit for acute symptom, such as, cough and cold, headache, dog bite, while most of the reinterviewers provided the consultation to chronic patients, such as diabetes, high blood pressure.

The sources of power that the authorized interviewer and reinterviewer physicians used to exercise their power in the consultation were the explanatory model along with the biomedical model. They often asked questions in the series of pathological episodes happening with the patients. The recognition of symptom was the explanatory model that physicians used to exercising their power. Despite physicians used the explanatory model as the crucial source of power and tried to exchange their explanatory model to their patients, the exchange of the explanatory model with their patients was not ineffective. Patients did not exchange their explanatory model with

their physicians. They just answered only the physicians' questions. In addition, during the exchange of explanatory model, the physicians selectively listened only to the pathological information that was their frame of reference. Other information that did not fit into the biomedical framework was neglected and considered irrelevant. It was found that the significant explanatory model that the physicians often abandoned was the indigenous symptom such as *"Hai Jai Bau Im"* (the short of breath), *"Mot Luuk Ak Seb"* (the low abdominal pain), *"Puad Lunk"* (low back pain) or *"Roke Tai".* For example, in case of the patient who had the indigenous symptom *"Hai Jai Bau Im"* (the short of breath) (case 242), the physician did not try to exchange the explanatory model on this point, he skipped to the prescription. Or in case of the patient who had *"Puad Lunk"* (low back pain) symptom (case 244), the physician paid on attention to the patient's questions on the causation of this symptom that the patient was afraid of *"Roke Tai".* The physician passed over this explanatory model to the prescription. The physician only said: *"You don't have the gall stone. Don't have "Roke Tai".* Some of these indigenous symptoms, by using the same term, meant differently from what had been defined by the biomedical knowledge.

As the observations presented, even the exchange physicians were willing to exchange, the exchange information would come from their background only. These explanatory models still were in the frame of biomedical knowledge. The patients' explanatory model was still ignored in these relations. All of physicians did not try to understand the patient's explanatory model. They valued the patient's explanatory as the erroneous knowledge. The exchangeable explanatory model was therefore a superficial exchange. Both physicians and patients did not profoundly understanding each other knowledge.

However, there was one physician that had his own explanatory model a little differently from the general biomedical knowledge especially on the value of health and medicine. This physician believed that good health did not come from the medicine, it came the practice of controlling on food and proper exercise. He then constructed his

new explanatory model different from the other physicians. He was the only one physician that tried to correct the prescription regimen patients received. Upon his explanatory model, he tried to prescribe the least number of prescriptions. He often said: *"You take too many medicines. It is not necessary then I will change your regimen. Take the least medicine is good for you."* In addition, he usually said: *"Take too many medicines, you will have the failure kidney, or Take too many medicines, your bone will be perforated, or you will have bone decay ".* According to his different explanatory model, this physician often cut short the consultation when the patients requested on the "compatible" medicine. He was the only physician that usually supported and encouraged the food control and the proper exercise. His favorite dialogue was: *"Don't take sweet, oily, and salty food".* This example was the obvious case of the physician who strongly supported the significance of the explanatory model, since it was the very potential source of power that dominated the expression of physician. In fact, this instance reflected that although the physician had the proper explanatory model, his service could be a long way from the quality of care, since the exchange of the explanatory model was not succeeded. The different explanatory model of physicians presented different knowledge based used in exchanging but did not imply the better or more effective exchange would occur. This physician did not try to understand the patients' explanatory model as other physicians. He exercised his power by selectively listened to the information that fit into his explanatory model and the patients' explanatory model was still neglected and considered irrelevant as in other cases.

Choices of therapy that physicians used in exercising their power were very much alike other relations. Most of them were the prescriptions, next was the further investigation or referring to specialists. This study found that different therapeutic choices were ordered for the same symptom especially on the short of breath symptom. One got the prescribing medicines (case 172), and others were sent for more investigation using the EKG examination (case 322,359), and having blood sugar examination (case 250). These differences were the result of the dissimilar physician's

explanatory model. If the physician perceived this symptom was the psychosomatic symptom he prescribed the medicines without the patient's examination. On the contrary, if the physician perceived this symptom was the abnormal sign from the other disease, such as heart-failure, diabetes, they would arranged patients to have more investigation depended on the prognosis. This practice confirmed that the physicians used the main concept of biomedical knowledge. Without really understanding patients' illness or patient-centered approach or taking patients as their therapeutic alliances, no matter how much exchange physicians had tried these cases were still presented as questionable quality of care.

Furthermore, the relation of the exchangeable physicians and the responder pointed out the picture on the sharing power and responsibility in the treatment. All of patients in this relation delegated their authority in managing their illness to the physicians. They were willing to put the responsibility on their health as well as their power onto the physicians. Then there were no the power sharing in these relations with the willingness of the patients. The physicians had complete power on all of the aspect of the treatment, for example, they were the persons who chose the method of treatment, the regimens and other decisions. The patients often said: *"I don't know, it depends on the physician, or "It depends on you, patient doesn't know that".* Another instance, in case of the hypertension patient (case 11), the physician asked the patient about his opinion on the new regimen, the patient replied: *"I have no idea, I don't know, it depends on you my physician".* Along with this power, it was found that most of physicians commanded the patients to do or not do something for him, even though these practice had direct advantages for the patients. The example was that a physician asked the patient to lose their weight and examine the urination and the kidney for him, as in case of the diabetic patient (case 50), before the patient left the consultation room, the physician said: *"Please lose your weight for me, and for the next time, please examine your urine and kidney for me too".* This evidence implied that there was no sharing of power and responsibility in the treatment. All of power and responsibility was in the physicians' hand. The patients did not have the duty to

manage their treatment. In addition, it pointed out that the physicians' power came from the willingness of the patients. This picture was certainly conflicting with the dimension of the quality of care which promoted the sharing of power and responsibility between physicians and patients. To succeed the power sharing in the consultation not only the role of the physician in the consultation but the patient's needed to be redefined.

F. Exchange Physicians VS Exchange Patients

It was found that most of the physicians' power relations (46.42%) were the relations of the exchange physicians and the exchange patients. Most of these relations (144 relations from 175 relations) were the relations of the exchange physicians and the participator, while the rest of these relations (31 relations from 175 relations) were the relations of the exchange physicians and the super star. The participator and super star were the exchange patients that volunteered more details on the exchange explanatory model. For instance, in case of the chronic low back pain patient (case 372), this patient had low back pain for long time; he perceived that he had something wrong with his kidney. This idea was supported by his irregular urination. He perceived that he urinated more often than the normal guy. Both of physician and patient in this case tried to exchange their explanatory model to each other as……

Patient : *I had frequently urinated, 7-8 times/day.*
Physician : *Do you have low back pain?*
Patient : *Yes, when I urinated, I am very tired.*
Physician : *How long did you have it?*
Patient : *Long time ago, I am very tired. There is something wrong with my kidney. I want to x-ray the kidney.*
Physician : *I had urinated more often than you did, for me, it is fifteen times/day. Your kidney is OK.*
Patient : *I want to x-ray the kidney.*
Physician : *I'll prescribe the medicines for you.*

Patient : *I took a lot of medicines, but my symptom was not relieved. I want to x-ray the kidney. If my kidney is normal, my symptom should be disappeared.*

Physician : *You just had the muscle pain, it is not related to the kidney. I'll prescribe the medicines for you".*

This picture presented that the explanatory model particularly on the recognition of symptom and the evaluation of therapy were the important source of power that the patient used in exercising their power although these sources of power were more often than not ignored sources of power. Under the physicians' control, the patient did not get the x-ray that he wanted; the physician did not try to understand the patient's explanatory model. The patient did not meet his expectation on the x-ray, he went back home with his concern about the abnormality kidney and feeling that his illness had not been treated. Although, both of physician and patient tried to exchange their explanatory model to each other, the consultation ended with the unexchanged explanatory model. The explanatory model of both counterparts was not changed. It was the ineffective consultation. Even this patient and physician had more conversation in this relation it did not mean that they understand each other.

The study found that the significant explanatory models which patients often used in exchanging were the evaluation of therapies, the perception of medicines, and the therapeutic choices including both touring and noncompliance. These explanatory models were constructed as a set of the idea that they used to explain their illness and their seeking behavior. Then the touring or noncompliance behaviors were the consequence of a set of idea on their illness. Patients used the perception of medicines or *"incompatible"* with medicines as the criteria to seek the new health service. In their perspective, *"incompatible"* medicine was the ineffective medicine and could not relieve their symptoms. The unrecovery of illness was linked with the concept of *"incompatible"* with medicine and was used as the main rationale for the behaviors like noncompliance and touring. For instance, in case of the patient who had cough (case 249), she got the

prescription that was the *"incompatible"* medicines from health center, so her symptom was not relieved, she still had more cough. She decided to visit a physician at this hospital. In this case, she evaluated the therapy from the health center by the effectiveness of prescription with a set of idea that linked the recognition of symptom with the perception of medicine. This linkage was the significant rationale that she used to exercise her power by noncompliance or touring, then explanatory model was the crucial source of power that patient mostly used. Her visit this time was the result of the power exercising however during this consultation with the physician she did not exercise her power.

These explanatory models were also the crucial source that influenced the expression of the participator. From these set of ideas, the participator created the expectation on the treatment, then, they tried to meet their expectation by exercising their power as proposing or asking something they wanted when they had consultations. There were two kinds of the power exercising by the participator as the advisee and the requester.

Since the performance of the participator was clearly trying to exercise power during the consultation by exchanging or asking, this behavior to some extent induced as well as influenced the behavior of physicians. As a result, almost all of the consultations of the participator were the consultation with the exchange relationship between two counterparts. The significant explanatory model that participator used to exchange depended on the stage of illness. In chronic patients, like diabetic patients, high blood pressure patients, they usually exchanged the explanatory model on their proper behavior mostly on the food control. In addition, they regularly exchanged the explanatory model on the perception of medicines especially on the physical characteristics of medicines such as color, shape. Some of them bring the previous medicines to this visit. If it was perceived as *"compatible"* with them, they would ask the physician to prescribe these medicines again. If they perceived it was *"incompatible"* with them, they would request other prescriptions.

Besides, most of them often requested physicians for the certain amount of medicines they would want. For instance, they would ask for the 2 or 3 month supply of prescriptions instead of the general one month supply for chronic medication prescriptions. The main reason for this request was concerned with the time of traveling and the time waiting for the services. For example, in case of the chronic patients who stayed in the municipality, they spent at least 3 or 4 hours for each visit. Most of time that wasted was the step of waiting for physicians. In general they waited at least 1 hour before they could see physician for 2-3 minutes of consultation. Most of them did not want to visit the hospital very often so they tried to exercise their power on this matter. Furthermore, some of the participator exercised their power by requesting for the medicines that were not related to their illness or symptoms. These requests usually were household or over-the-counter medications such as antacid, paracetamol. For example, in case of the diabetic patient (case 350), she asked for the antacid, while in the case 478, also the diabetic patient but requested the pain killer and antacid. Some of physicians called these medicines as *"The premium drug"*. Physicians generally did not appreciate this request. There was a surprising situation about this issue as the head of the medicine department could not tolerate the request for the premium drug. After his patient asked for *"The premium drug"*, he went out the consulting room and announced to all patients waiting in front of the consulting room via microphone, he said: *"Do not ask for "The premium drug". This is the hospital, not a drugstore. Please understand..... You do not go to the market to buy some fish or vegetable, so do not ask for extra amount."*

This situation implied many concerns on this point particularly on the attitude of physicians and the physician's power. This situation depicted the negative attitude of physicians on this behavior so they refused to prescribe all of the requests. They stigmatized *"The premium drug"* as the non sense behavior, so they put the blame on the requester as the situation as mentioned. The physician did not really exchange or explain to make patients understand the reason why he did not want patients to request the premium drug.

In the blindness stage, all patients tried to exercise their power by proposing or asking for the medical technology such as the x-ray, the ultrasound. Moreover, there were a number of patients who had blindness stage that had been touring for health services particularly the private clinic (cases 276,436,438). For instance, in case of the abdominal pain patient (case 436), she had abdominal pain for 7 years ago, she made the round from private clinics, hospitals everywhere both within and outside the district. She had plentiful of X-ray and ultrasound till she cannot count on these numbers.

There was another expression of the participator, some of them tried to negotiate with the physician. There were several steps of the negotiation, first the participator proposed their expectation like the X-ray or the ultrasound. If it was not successful, then they tried to negotiate for the second choice as the prescriptions. For instance, in case of the patient with low back pain (case 452), at first she asked for the ultrasound, after the physician refused this request, she then insisted her request again. When the physician strongly refused, she proposed the second choice as: *"Do you have the pain killer, please prescribe it to me?"*

Comparing the power exercising among the group of the participator, the hermit, the responder, and the super star, the participator was the only group of patients trying to exercise their power, while the others did not exercising their. The stage of illness was the significant factor that influenced these behaviors. In the group of the participator, most of them were in the blindness stage. Almost all of them did not know and wanted to know which abnormal organ that caused their symptoms and illness. They then exercised power in any way they could mostly by proposing or requesting for what they expected to be the effective mean according to their explanatory model. While most of the hermits, the responders, and the super stars had only acute symptoms and the treatment was not as complicated, they did not try to exercise their power since their expectation would be minimal compared to participators. However, some hermits, responders and super stars could be the participator on the next consultation if their symptoms were not relieved.

The response of exchange physicians to the patient's explanatory model were two folds. First was the attempt to correct the patient's explanatory model. Most of physicians tried to use their explanatory model to correct the patient's explanatory model. For example, in cases of patients who perceived that the large hospital provided better quality of care than the small hospital (cases 182,210,211), the physicians tried to correct the patient's explanatory models by the explanation as: *"The other hospitals can treat like this hospital. They used the same medicines. Do not try to tour hospitals."* Or in case of the patient whose concern was on his urine (case 372), the physician corrected the patient's explanatory model by comparing patients' symptom with his own. The physician said: *"You urinated only 7-8 times. It was less than I do, for me 15 times. You do not have any symptom."*

The other kind of physicians' response to patients' explanatory was neglecting the patient's explanatory model. Some physicians omitted these explanatory models by not responding or asking patients about them. They did not try to exchange their explanatory model. Some of them cut short the consultations by writing prescriptions. For instance, in case of the patient who perceived she had cough from the bonefish (case 204), the physician did not ask the patient about it, he just asked only: *"Does the bone come off?"* Then he prescribed medicines to the patient.

As for patients' response, when physicians tried to correct their explanatory model, most of them did not argue. They quieted or laughed at the physician's explanation. They did not try to exchange their explanatory model. Instead, most of the exchange patients presented their recognition on physician's power by telling the physicians that they complied all of the physician's order especially on the prescriptions. For example, in case of the diabetic patient (case 49), she quickly replied when the physician asked about the prescriptions: *"No, I did not take other medicines if you did not order. If you did not order, I dare take them."* Or in case of the tuberculosis patient (case 394) who stopped taking medicine before she finished the treatment course. She tried to tell the physician that she did not stop taking the medicines by herself but it was

suggested by the previous physician. The concession on physician's power illustrated the social value on the status of physicians. Physicians had a status as the saver on patient's life. Their status was higher than their patients.

From the recognition of the physicians' power, most of the relation between physicians and patients were the smooth relations. There was no disagreement, since these patients acknowledge the physician's power and their role. Most patients usually said: *"It depends on the physician. I will comply with the physician's order."* However, there were some small conflicts particularly in the relation of the participator. These conflicts were appeared in a various styles. The significant style was the insistent style, most of the participators insisted on their symptoms though the physicians tried to correct their explanatory models. For example, in case of the patient who perceived he might have the problem on his kidney (case 441). He wanted to have urine examination. After the physician exchange the explanatory model on the causes and symptoms of the kidney problem and concluded that he did not have any sign of the kidney problem. However, the patient insisted on his symptom no matter how the physician would explain. The consultation ended by the physician guaranteed: *"You do not have the kidney problem. I am guaranty."* The other example was in case of the patient with low back pain (case 353). After the physician considered the x-ray and the urine examination, he said *"You should be glad. You did not have any disease."* The patient had immediately replied: *"I have pain, I have pain like there is an abscess. I am not glad. I still have pain when I go back home. I cannot eat."*

This picture presented the power exercising between patients and physicians. Both parties used their explanatory model as the significant source of power. The consultation ended with the unexchanged explanatory model. The explanatory model of both counterparts was not changed. The physician ended the consultation by using his power through the legal and social authority or material source as the prescriptions. In this case the physician still had more power than the patient. This situation often found in the case of chronic low back pain and chronic abdominal pain. Both of the patients

and physicians insisted on their explanatory model, the patients tried to insist on their symptoms, while the physicians persisted on the result of the examination. As well as the relation of the insistent responder, these practices were the consequence of the main concept of biomedical knowledge as physicians "treat on disease, not treat on illness". The physicians usually focused only on the investigation of the abnormal organ. When they did not find the abnormality, they finished their work even though the patient still had the illness. Although in these relations, the physicians had more power than their patients, these relations did not smooth as the relations of the unexchange patients such as the hermit, the responder. Some participators had a small conflict but they tried to keep in their mind. They said after finished the consultation: *"The physician did not do as I request, then I must go to the other place that do as I request."* The crucial reason that influenced patient's touring was the ineffective consultation. Even the patients and physicians had more conversation in these relation it did not mean that they understand each other. Each one just had a chance to say what they wanted but no one listened therefore they hardly comprehended the other's explanatory model. That was why the exchange was inadequate.

3.2.2.2.4 Gray Relation

Gray relation was the relation that could not indicate the person who had control of power in medical consultation, since both physicians and patients were in control of the direction of the consultation. Physicians used both their explanatory models and patients' explanatory model in deciding treatment alternatives for patients' illness as in case of mutual relation, but did not combine or exchange their explanatory model with their patients. There was no exchange of the explanatory model in the consultation, although the consultation was controlled by both physicians and patients as the conversation between physician and patient in case 101. The stomachache was the chief symptom that caused the patient visited the physician. After the physician finished his treatment on the stomachache, the patient requested *"Ya Kin Kao Sab" (the medicine for loss of appetite) as the following conversation:*

Physician	:	*How are you?*
Patient	:	*I had a pain on my stomach, it hurt me so much.*
Physician	:	(the physician investigate patient's stomach) *What kind of the pain that you had? Is it a burning pain or griping pain?*
Patient	:	*It was a burning pain; it hurt me when I ate some food.*
Physician	:	*Do you take food at regular time? Have you ever had the peptic ulcer?"*
Patient	:	*Yes, two years ago I had peptic ulcer.*
Physician	:	*I will prescribe the medicines for you.*
Patient	:	*I want "Ya Kin Kao Sab" too. I want "Ya Kin Kao Sab" for 1month.*
Physician	:	*Ok, I'll prescribe.*

Concerning on the power exercising of both patients and physicians, it was found that all of patients (46 cases) were the exchange patients, they exercised their power as the requester, while all physicians except one were the exchange physicians, they exercised power in various styles as the reinterviewer (33 cases), the authorized interviewer (9 cases), and the expert (3 cases). One physician that was the unexchange physician expressed as the medical reviewer.

All patients were the requester and were the successful requester since they got what they asked for. The results revealed that there were 3 items that the requester used in exercising power in the consultation. First was the request for the specific medicines (32 cases), the second item was the request for the method of treatment especially the medical technology (11 cases), and the last item was the request for the specific health service (3 cases). There was a very interesting point on the patients' request for the specific medicine. Most of the requesters (18 cases from 32 cases) asked for *"the Premium Drug"* like vitamin, pain killer, or antacid. In general, the requester usually asked the premium drug when the physician nearly finished the

consultation during writing prescriptions. From the observations, most of physicians prescribed the premium drug without any investigation or interrogation. Most of the physicians prescribed the premium drug by reviewing the previous patient medical record. From this aspect, the premium drug was the medicine that the requester took regularly. The physicians prescribed the premium drug without the exchange of explanatory model. In these cases the physicians did not take into account of the patient's explanatory model, they act as the patient's secretary.

Besides, some requesters (5 cases from 32 cases) asked for the specific drug that contained specific physical characteristics of medicine such as color, shape. The significant explanatory model that was used in these cases was the perception of medicines particularly the *"compatible"* medicine. The requester tried to exercise their power for the specific medicines perceived to be *"compatible"* with them. For instance, in case of the patient who refused to get the eye-drop with the red cover (case 230), she said: *"I don't want the eye drop with the red cover. I don't know its name. I am not compatible with this drug. It could not relieve my symptom. My symptom worsens from using this drug."* In this case the physician prescribed this medicine following the request of patient. However, there were a few physician tried to correct the patients' explanatory model, they usually said *"That is the same medicine. Do not hold on color or shape of medicines."* While in case of the premium drug, they did not exchange their explanatory models to their patients, they prescribed the medicines which the patient asked for.

In addition, there was only one case that the physician complied with the patient's request though the physician perceived that the patient did not need the service because no symptom was detected. It was the referral case (case 219) which was the patient who had low back pain. This patient perceived that this symptom was caused by the kidney's disease, so he wanted to have the x-ray. The patient was referred from the district hospital. The physician said: *"I cannot refuse this case. It is the referral case. Send him to X-ray is better for me, it saves me. His symptom was*

not the kidney's disease. He has this symptom just only for 4 days. I wonder why the district hospital sends him to me." The patient's power in this case came from the legal and social authority source: the patient's right. It might be the misuse of power, since his symptom might not necessarily need the X-ray. This case was the obvious picture illustrating the misuse of power by both parties. Although the patient received their expectation, they might not find the quality of care or the best treatment to relieve the illness. It was the consequence of unexchange of explanatory model. Each of them held on their explanatory models. They did not try to create the effective exchange during their medical consultation session. As expected, the patient's explanatory model was not the effective source of power for the physicians and it certainly was not the crucial factor influencing the physician's behavior though it was the significant factor determining the patient's request.

For the physicians, the patient's power came from their legal and social authority especially on the patient's right. While almost all of patients did not concern on their right, there was only one patient (case 356) from the total patients (455 cases) that talked about the patient's right. This patient had the chronic cough and received the care from the Tuberculosis Center. He had the x-ray at the TB center. The physician at this center suggested him to go to this hospital for confirming his symptom. At the Tuberculosis Center, the physician did not inform him about his illness and did not prescribe the medicines that he asked. He got angry with the physician at the Tuberculosis Center because he perceived that that physician did not do anything for him. The physician wasted his time. He said: *"I wonder what happens at the Tuberculosis Center. I have the right to have the prescriptions. I will tell this story to the journalist. I want to ask "Sudarat"(the Ministry of Health why I could not have the treatment at the Tuberculosis Center."*

Patients who paid the health expense out of their pocket (cases 45,340,411) were all very concerned on their service cost. It was the significant issue that these patients exchanged with the physicians instead of the explanatory model. In these

cases, the health expense was the potential source of power which limited their accessibility to care. For example, in case of the patient who had allergy (case 45), she asked the physician to prescribe the oral medicines with the budget limit of 200 hundred bath although she wanted to have injection. This case presented that the patient utilized two significant sources of power, the explanatory model source and the material (money) source. Even though her explanatory model led her to believe that the injection was better for her illness than the oral medicine, she did not ask for the better medicine since she could not afford the injection. The money was thus more significant source of power for this patient. In general, the money was the significant source of power that strengthened patient's power. Most of patients had more power than the physicians especially the private physician in case that the patients had enough money to afford their health expense.

On the contrary, this source appeared to be the ineffective source of power that limited the power of those who could not afford for their care. Comparing between the patients who had and who did not have the health benefit scheme, the patients who had the health benefit scheme did not have any concern on the health expense, they usually asked for the specific medicines or the special medical technology without worrying about the expense. Then, health benefit scheme was considered as the significant source of patients' power and could be classified as the material wealth each patient had. It was found that the health benefit scheme seemed to support the patient's explanatory model, since the patient who had health benefit scheme could exercised their power thru their explanatory model without the worry about their health expense. The study found that there was only one case (case 194), that could not afford the copayment (30 baht) though she had the health benefit scheme, so she did not take the prescription for 5 months.

3.2.2.2.5 Mutual Relation

Mutual relation was the relation that physicians combined both their explanatory models and patients' explanatory model in deciding treatment alternatives for patients' illness, both physicians and patients were in control of the direction of the consultation, the power would belong to both parties, patients and physicians, and it was considered as the mutual relation. It was found that only 4% of the physician-patient relations were the relation of mutual relation.

In this relation, patients had an opportunity to participate in the consultation. This opportunity was given by the physicians. They gave the patient a chance to choose the method of treatment, the prescriptions both of the type of medicines and the quantity and the health services that patients wanted. Then, the mutual relation was the relation of power sharing. This study found that both of patients and physicians had a variety of power exercising like other relations. For the patients, most of them (12 cases) were the participator, they expressed their power exercise as the advisee (9 cases), and the requester (3 cases). Very surprisingly, the results showed that there were the other patient's expressions that usually found in the relation of physician's power as the responder (5 cases) and the super star (2 cases). The mutual relation or the power sharing could occur with the unexchange patients who just cooperated to the physician's order. The results indicated that the direction of the relation between physicians and patients relied on the physicians, since the physicians had the authority to manage the consultation. This authority came from the legal and social authority source which provided by the social system. If the physicians gave patients a chance to participate in the treatment, then the relation of power sharing was aroused though the patients were the responder or the super star. This result suggested that the physician was the important person for promoting the patient-centered care.

For the physicians, even they exercised their power through a variety of power expression all of them were the exchange physicians. They tried to exchange their

explanatory model to their patients. All of them had the conversation with their patients. It was found that most of them (12 cases) expressed as the reinterviewer, while the rest acted as the expert (4 cases) and the authorized interviewer (3 cases). Trying to exchange the explanatory model could be the significant characteristic of physicians required in the mutual relation.

The physician was the important person that led patients to participate during the consultation sessions. For example, in case of the thyroid patient (case 257), the physician tried to exchange her explanatory model on the variety of treatment methods with the patient. Both of them exchanged their explanatory models with each other. The patient asked more questions on the advantage and side-effect of each method while the physician tried to explain them using patient's word and vocabularies. Finally, the physician asked the patient to make decision on the treatment method. Their conversation was……

Physician : *How long did you have it?*

Patient : *Two years. I had this symptom three years ago, after I took the medicines for a while, this symptom was disappeared. Then, the physician did not prescribe the medicines for me."*

Physician : *Would you like to swallow some mineral? If you take the medicines, you must take it for long times. Swallowing mineral is better than take the medicines, since it will relieve your symptom after a while."*

Patient : *Is it saved for me?*

Physician : *It may have some side effects such as if you swallow more mineral, it may stimulate your thyroid gland or if the mineral that you swallow is too little, you may have to swallow it more than 1 time."*

Patient : *What are other side effects?*

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Physician : *It may reduce your white blood cell, but it is very rare. Please choose your treatment and let me know during next visit.*

Patient : *I will consider it again, but I think take the medicines may be more appropriate for me.*

Or in cases of chronic abdominal pain (case 262,400), the physician requested the patient to selection between having more investigation and continuing on their prescriptions. Besides, the physicians in this relation usually asked for the patient's agreement on the prescriptions and the place that patient wanted to visit. The physicians did not make decision by themselves, but gave the patient a chance to step in the decision process. In addition, the physicians while were in this relation seemed to understand the concept of the *"compatible"* with medicine of the patients. They usually asked the patients about the physical characteristic of medicines particularly on the dosage form or the quantity of medicines. These pictures pointed out that both of them had exchanged their explanatory model to each other, and then physicians combined both their explanatory models and patients' explanatory model in deciding treatment alternatives for patients' illness. However, this study found that physician was the important person initiating this relation. Since the context of medical consultation allowed the physician to play the leadership role, they could give an opportunity to their patients in making decision on their treatment. This relationship was relevant to a patient-centered approach.

However, in some observations, physicians tried to correct the patient's explanatory model such as the perception on the medicines. It was found that in these relations physicians did not blame the patient's explanatory model but tried to correct these explanatory models in a friendly style. For example, in case of the patient who was concerned about the physical characteristic of medicines, the physician tried to reduce the patient's worry on this matter by saying: "*the medicine may have different color or shape. Don't worry about that. It is the same medicine. Don't worry."*

3.2.2.2.6 Patient's Power Relation

The patient's power relation was the relation that physicians based their treatment decision only on patients' explanatory model. It was observed the patients were more in control of the power relation since the consultation and decision would be centralized around their explanatory model. In this relation, physicians acted as the secretary of the patients, since they followed the patients' order. They were the authorized secretary which had power from the legal and social authority and material source. There were only 13 consultations that could be classified as the relation of patient's power relation.

In this relation, all of patients exercised their power as the successful participator since the consultation was directed by them. All patients in these relations, except one who was the advisee, expressed their power as the requester (12 cases). It was found that 4 requester requested for the medical technology method, and most requester (9 cases) asked for the old prescriptions. For instance, the chronic asthma patient (case 387) went into the consulting room for the second time asking for the medicines he wanted by saying:

Patient : *I want to change the medicines. There are many kinds of medicines. I could not take it. It was not "compatible" with me. I want only this medicine and I want four boxes.*

Physician : *…four boxes…Ok.*

The observations showed that both patients and physicians did not exchange their explanatory model. Physicians in these observations quietly acted as the authorized secretary and complied with the patient's order. There was the obvious example on the case of the chronic abdominal pain patient (case 448). The patient tried to exercise her power by going into the consulting room while the physician was

investigating the other patient. After she handed the medical record to the physician, she lied down on the bed. When the physician finished the consultation with the other patient being there before, the physician approached the bed with the patient medical record. The patient exercised her power by grasping the physician's hand and placing on the tummy where she needed examination. The patient said: *"I want the old prescriptions for 2 months and I want both the cough remedy and the antacid. I do not want the medicine in white capsule, I want the yellow capsule."* In this case the physician did not exchange her explanatory model to the patient, she did not pay attention to the patient's explanatory model, but she prescribed the medicines that the patient ordered. In fact, the physician perceived that this patient had mental illness. The physician said: *"That is the real case of psychological problem. She should go to the psychologically hospital".* In this case, though the patient had control over the encounter and she got everything that she wanted the good quality of care was not certainly included when considered from the biomedical perspective.

The study found that the physicians in these relations expressed their power as the reinterviewer (8 cases) and the authorized interviewer (5 cases). The physicians tried to exchange their explanatory model with their patients, but their exchanged followed the biomedical model and did not take into account the patient's explanatory model. They followed the patient's request without the attempt to understand the patient's explanatory model as in case of the patient who had cough symptom (case 419). This patient went into the consultation for the second time to request for the medicines. During the first consultation session, the physician ordered for here more investigation on the x-ray, and the sputum examination. After 40 minutes, she came back into the consulting room and asked the physician to prescribe the cough remedy and antidepressant for her. The significant explanatory model that influenced her request was the evaluation on symptom. The patient perceived that she did not have the serious illness therefore it was not necessary to have more investigation as the physician's order. In addition, she had misunderstood the step of care. She thought that she would not get her prescriptions until next week when she finished all of the

investigations. She then refused to have more investigation. She wanted the prescriptions on that day. During she was having the second consultation session, the physician talked to her just only: *"If you do not do, you would not know about your symptom."* She insisted on her decision and then the physician prescribed the medicines as her order. After she went out the consulting room the physician said: *"I did it because I do not want to have the conflict with the patient. Today the physician must be afraid of the patient. Today patients are not afraid of physicians as they were in the past. There are a lot of patients that request for things they wanted.*

This case illustrated that both the patient and the physician held on to their explanatory model without exchanging their knowledge to each other. If they had the effective consultation as trying to understand each other, the patient could get the better quality of care. And if the physician thoroughly explained the step of care that the patient would get the prescriptions although the investigation was not finished the consequence could be the other way around. Concerning on the source of power, though the patient used the explanatory model as the crucial source of power for making decision in her treatment and physicians had followed, it was not considered an effective source of power from the physician's perspective. The physician followed the patient's order because of the patient's right. This case was consistent with the previous analysis illustrating the legal and social authority source particularly on the patient's right as the effective source of patient power that could influence physician's behavior. It was not the patient's explanatory model that physicians acknowledged and conceded even it seemed to be the explanatory model on the prescription. However, in this case, the other source of power as the social status had played a part. The patient was the pension government civil servant and was the relative of a physician in this hospital. She said: *"I dare to visit the physician for the second time because I used to be the government officer and my sister was the physician, she treated patients in the next consulting room. I am not afraid of the physician. In general most of patients did not dare to ask the physician, they are shy. I know it does not matter."*

3.2.2.3 Service after Medical Consultation

After patients finished the medical consultation, the next service was the pharmacy department to fill their prescriptions. At the pharmacy department, the hospital's rule and procedures were still applied, patients and pharmacists thus exercised their power through the legal & social authority source very much like the stage before medical consultation. Their practices reflected the hospital's service system. Pharmacists had control of the power over patients. Even the context of services within the hospital was ended when patients received their prescriptions, the context of patients' illness had not finished but continued outside the hospital setting, where patients were surrounded by everyday environment and did not have to confront and/or interact with health personnel or their physicians.

3.2.3 The Consequences of Care

The consequences of what the process of care provided was followed and continued until the illness episode subsided. Otherwise the circle of care provision started the new round. It was therefore important to trace how the outcome of care was and how patients behaved outside the hospital system.

Although during medical consultation, the study revealed that physicians had more power than their patients. In everyday life, after patients finished the medical consultation, they lived outside the hospital context, had not confronted with the hospital's rule, health personnel and their physicians. The in-depth interview was conducted to follow some patients and at the same time study how patients exercised their power outside the hospital system. The important matter brought back from the hospital with patients was the physicians' order such as the prescriptions, physician's suggestion. By the same token of power definition used during medical consultation stage, the capability to make choices on treatment was still the criteria of the power possessor. If patients complied with their physicians' order, power of physicians was

still in effect outside the hospital system. If patients chose not to adhere with their physicians' order, patients refused to hand the power to physicians instead they decided to listen to their explanatory model.

Along with this happening, patients might have other therapeutic choices, for example shopping around or touring for other treatment alternatives, or non-compliance. These other therapeutic choices were considered the pattern of the power exercise by patients. The major sources of power outside hospital environment were connected with patients' explanatory model and their material source of power, in specific, the purchasing power or the ability to pay for the additional expenses.

The 18 patients who had been observed during the medical consultation and already finished their medical consultation were in-depth interviewed. Among them, 5 patients had the two consecutive continued consultations. The study found that during the first consultation, all of the patients were in the relation of physician's power. However for the second consultation, there were 2 relations of patient's power, 1 relation of mutuality, and the rest were still the relation of physician's power. There were 3 patients who had different power exercising between the first and second medical consultation. It was found that the perception of medicine was the crucial factor that influenced this different power exercising of the patients. The concept of *"compatible with medicine" (Tuuk Kub Ya)* was used in exercising power as in case of the patient who had asthma and peptic ulcer (case 206), and in case of the asthma patient (case 387). As for the first consultation, these 2 patients (case 206, 387) were in the relation of physician' power, after they got the prescriptions from the pharmacy department, they mentioned that these prescriptions were not the medicines that they wanted. They were not "compatible" with theses medicines. They decided to have the second consultation so that they could change their prescriptions. However, in the case of the patient who had asthma and peptic ulcer (case 206), she took more than half an hour in deciding to ask for revisiting the physician. Additionally, through this period, she was crying, since she was very considerate on the physician's feeling. She was afraid that the physician

might blame her. She said: *"I was afraid that the physician might scold me, the physician might think I am smarter than him, since I did not accept his prescription. I have been thinking for a long time whether to change or not to change. The physician prescribed only one kind of medicine, he did not give the blue one "Ya Ka-Yai" (the vasodilator) to me. Normally, I take 2 kinds of medicines for the asthma, "Ya Ruk Sa" (the treatment medicine) and the blue one, it is the "Ya Ka-Yai"(the vasodilator)."*

This picture pointed out this patient had high respect on the physician's power; she used more than 30 minutes to make her decision to go for the second consultation. However, the *"comptible with medicine" (Tuuk Kub Ya)* concept was the potential source of power that pressured her to ask for the "compatible" medicine instead of accepting the ones not wanted. There was the other reason that forced her, the financial resource. The patient did not have more money to hire the pickup if she had the severe symptom in the middle of the night. This point was the consequence of the "incompatible" medicine that she got from the first consultation. She said: *"If I take this prescription back home, the "incompatible" medicine may affect my symptom. If I have more severe symptom, I will die since I don't have money to hire the pickup to the hospital. It costs more than 500 baht and I don't have the money."* In this case, the significant sources of power that influenced the power exercising were the explanatory model: the concept of *"compatible with medicine" (Tuuk Kub Ya)* and the material source of power, in specific, the ability to pay for the additional expenses.

According to the second consultation, this case was the mutual relation. The physician gave a chance of power exercising to the patient. There was a very interesting point on the patient's power exercising, it clearly presented that the significant factor that influenced the exchange of explanatory model particular on the patient's side was the power relation between the physicians and patients. Before having the second consultation, this patient planned to ask only for the medicines needed for peptic ulcer, she was afraid that the physician might be angry with her. While having the consultation, she changed her mind and asked for more medicines for

asthma, because the physician gave her a chance to do that. In this relation, the physician let her shared the explanatory model especially on the perception of medicines, the physician did not blame or stigmatized her explanatory model, even though her explanatory model was different from the biomedical point of view. She was "incompatible" with the *Magesto*®, she perceived that *Magesto*® was the cause of her fast heart beat. Although this conversation was not completely exchanged or effective the physician treated her as the person and allowed her to share the explanatory model.

For those observations of second consultation, it was found that 2 consultations were the relation of patient's power. In these cases (case 387,419), the patients exercised their power without the concern on the physicians, both of them used the explanatory model relating with the medicines in exercising their power. As in the case 387, the concept of *"compatible with medicine" (Tuuk Kub Ya)* was used in exercising his power, while in case of 419, the patient exercised her power by asking for the prescription instead of the x-ray and sputum examination. This patient used her explanatory model particularly on the evaluation of the method of treatment to exercise her power. In addition, she used the other source of power, the social status, to support her power too. She was the pension government officer and was a relative of a physician in this hospital. Therefore she did not hesitate to exercise her power. From the data obtained, it was found that both physicians and patients in these patient's power relations had an ineffective exchange of the explanatory model similar to the cases of the physician's power relation. Both parties still had their own explanatory model. In addition, there were some conflicts in the case 419; the physician did not appreciate how the patient exercised the power.

Furthermore, the study revealed a very interesting issue on the exchange of the explanatory model. Some consultations were absolutely ineffective exchange of the explanatory model, because the physician could not recognize the patient's expectation on this treatment. They could not find what lied behind the patient's mind. In addition, there were differences between what was observed from the exchange of the

explanatory model during medical consultation and what the patient's explanatory model actually was and had never been exchanged with the physicians. An obvious example illustrating this point was the case of the patient who had severe pain from his bottom onto the whole leg (case 22). This patient came from the other province which was the main issue that the physician exchanged during the consultation. The physician tried to correct the patient's explanatory model on the perception of health service, he said: *"The treatment at your province was the same pattern like this hospital. It was the same prescription. Visiting here, it just wasted your time and money".* Both of them had a little exchange on the symptom before they finished the consultation with the prescription. Actually, this patient had the expectation on the x-ray, he wanted to examine his leg. The significant explanatory model that forced the patient to visit this hospital was the set of idea between the idea of causation and the recognition of symptom. This patient had 2 considerable ideas of causation, the first one was the pressed nerve from bone, and the second was the bone cancer. He was very concerned if he had the bone cancer. He was afraid that his symptom was caused by the bone cancer. In addition, this patient had the criteria for classifying his symptom from the muscle pain. He thought that his symptom was not the muscle pain, since he did not carry or lift heavy things. This significant explanatory model was not exchanged with the physician. The exchanged explanatory model in the medical consultation was very superficial. It was an ineffective exchange, both physicians and patients did not exchange on the significant explanatory model influencing the patient to visit this hospital. The exchanged explanatory model that the physician used in making treatment decision treatment was definitely dissimilar from the patient's explanatory model which resulted in different therapeutic choices. The physician decided to give him prescriptions while the expected therapeutic choice of the patient was the examination using the x-ray. From the ineffective exchange of the explanatory model, this patient did not get the therapeutic choice that he wanted. The study found that this patient tried to meet his expectation during the next consultation. He had already planned to visit the physician at the other hospital, if the prescription that he got was not effective. Touring behavior was the way that the patients used to meet their expectation.

It was the mean that the patients exercised their power. This result soundly verified that the explanatory model was the noteworthy source of power that pressured the patients' power exercising. Patients' belief was not to a certain extent responded then they would find a way to achieve their expectation.

The other example illustrating the differences between the explanatory model exchanged during the medical consultation and the real explanatory model of patients. It was in case of the patient who was in a daze (case 190), he had a groggy and numb symptom on the head. The physician from the private clinic told him that this symptom was the result of the trace of tapeworm in his brain and it would not disappear completely as a result the symptom could be permanent. This patient wanted to double check the explanation of the private physician; he wanted the second opinion. That was the significant reason that brought him this hospital. In addition, the other reason of this visit was he wanted this symptom to be completely cured. The first reason implied the patient's trust on the private physician. He did not wholly believe the exchanged explanatory model given by the private physician. He was afraid that the private physician might deceive him. From his explanatory model that he had exchanged with the private physician, he said: *"I described him about my understanding on the symptom, I am not sure he used my understanding to explain me back. In fact, my symptom might not be related with the story that I told him. I want to check him".* Regarding on the explanatory model of the private physician that exchanged with the patient, it resembled the patient's explanatory model. The physician explained that this symptom was caused by the parasite. The similarity explanation on the cause of symptom made the patient hesitated to believe the private physician, because this patient perceived that the private physician had the monetary interest. Their concern was more on their incomes than the patients.

The explanatory model that the patient exchanged with the private physician was the set of idea of the causes and the recognition of symptom. This patient related the present symptom with the previous symptom, since he had a similarly symptom 20

years ago. It was an itching-swell rash on his foot (case 190) and the physician told he had the intestinal worm, *"Trichina" ("Pa-Yad Tua Jeed")*. After the physician prescribed the medicine to him, his symptom disappeared for a long time. After 10 years, he had the same symptom again but different area, on his waist. The physician said he had the same intestinal worm, *"Trichina" ("Pa-Yad Tua Jeed")*, and after he took the prescription again, his symptom was vanished. At the present, it was 10 years later and he had the same itching swell rash symptom but now on the back part of the skull. He believed that this present symptom was caused by the same parasite which meant that this parasite did not die but stayed with him over the past 20 years. It crawled from his foot to his waist and now to his skull. He was afraid that this worm might go backwards. From this past experience, the patient was not sure that the parasite was completely dead, although they finished the prescription both the injection and the oral dosage form. To make sure on the death of the parasite, the patient wanted to repeat the x-ray.

The result indicated that the exchanged explanatory model in the medical consultation could not response the patient's expectation. It was the superficial exchange like in the other case. The physician did not try to exchange his explanatory model, he just asked about the symptom in the series of biomedical knowledge. In addition, he stigmatized on the patients' request which was related to the x-ray using his tone of voice and wording. For example, when the patient asked about the validity of the x-ray, the physician just replied only: *"If it has, I could see".* Or when the patient asked about the repeated x-ray, the physician said: *"The x-ray did not treat your symptom. Don't go to repeat the x-ray".* The patient failed to reach his expectation particularly on the repeated x-ray. He then planned to visit the other hospital. He said: *"I want to repeat the x-ray; I want to know whether it was really dead."* This picture confirmed that touring behavior was influenced by the patient's explanatory model. It was the way a patient used to compensate the loss of power from the previous consultation.

Actually, there was another ineffective exchange of the explanatory model at the first consultation 4 months ago. At his first visit, the physician told him his symptom was caused by the less blood flow on his brain and prescribed the medicines for him. After he trialed on that prescription, he was not "compatible" with those medicines. He then came back for the second visit. He tried to ask for the x-ray which he did not get and the physician prescribed him the new prescription. After he had trialed these new prescriptions, it was not effective since his symptom was not relieved. For the patient, he was not "compatible" with these new medicines. For the third time, he came back to this hospital and tried to ask for the x-ray again. His request was strongly rejected just like the second consultation. The patient told the researcher that the physician said: *"You just had a little symptom. Don't need the x-ray".* It was the breaking point for the touring behavior to this hospital. After that the patient went back home and went to the private clinic at his district he resided. Some conflicts were occurred during the third consultation. He perceived that the physician did not want to treat him then he should find the other place to treat his symptom. This result pointed out that those 3 consultations were the relation of physician's power, since the patient could not be in command of the consultation, the patient did not meet his expectation on the x-ray. His explanatory model was an ineffective source of power. However, this patient tried to exercise his loss power by having the other consultation that supported his power. He went to have the consultation at the private clinic. There, his request for the x-ray was responded which meant his power was recognized by the private physician. He was more in control of his wish than the previous consultation. In this case, the important source of power that supported the potential of the explanatory model was the material source of power specifically on the ability to pay for the x-ray expenses. The patient paid 4 thousands baht in exercising his power.

The study found that the ability to pay for the health expenses particular on the private health service was the important material source of power that influenced the exercising power of the patient. This source was significant not less than the explanatory model source. Most of patients who had touring behavior to the private

health service strongly concerned on this source, since the expenses at the private health service was high comparing with the expenses at the public health service. Most patients who had touring behavior usually discussed this issue. For example in case of the patient who had chronic abdominal pain (case 434), she could not count the number of physician visits. She stated that the expenditure at the private clinic was very high. She paid at least 300 baht to 1,000 baht for each visit. For each visit, the physician prescribed the medicines for one or two weeks, that meant she paid at least 600 baht per month. This expense did not include the transportation expense. In fact almost all of patients who had the touring behavior often hired the pickup to travel to the health service setting. For example, to visit this hospital at this time, this patient paid 1,500 baht for the pickup and traveling expenses. This patient told the researcher that she used to pay approximately 40 thousands baht treating at the private clinic for 11 months. After that she decided to stop the treatment at private clinics, because she did not have the money to hire a pickup. She used a lot of money with her touring behavior. Her husband said: *"I will sell the cow to treat you, In fact, selling the cow to feed the physician and the owner of the car."*

There was the other example that show the significant of the money as the source of power that the patient used in exercising the power. In case of the patient who had a chronic stomachache (case 422), she had touring behavior although she had the universal coverage scheme. Her touring behavior depended on the amount of money that she got. When she did not have the money, she visited the hospital under the universal coverage scheme. She used the prescription from this hospital to alleviate her illness. When she had more money, she stopped this prescription and had the new consultation at the private clinic that she perceived the physician could prescribe her the "compatible" medicines. She said: *"The medicines at the private clinic are better medicines than those from the public hospital. When I have money, I go to the expensive place (private clinic), when I do not have money, I go to the low cost place (the public hospital)."*

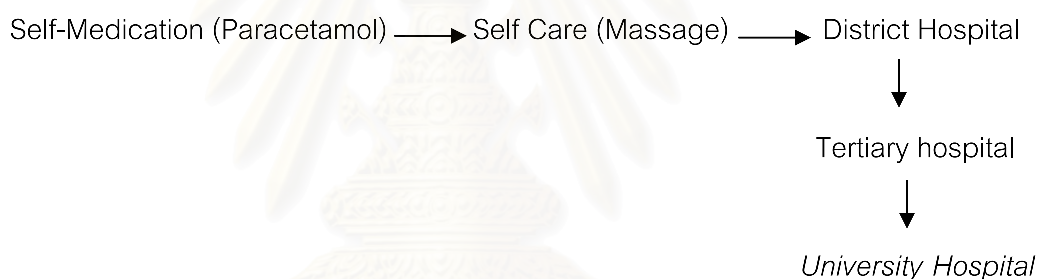
In this case, the significant sources of power that this patient used in exercising her power were the explanatory model and money. This case pointed out that in the context which the patient did not have the right on health benefit scheme, or in case of the patient who used the private health service, money might be the very important source of power that the patient used in exercising their power. If the patient had more money, this money strengthened their explanatory model. They were the powerful persons in charge of their expectation and at the same time in command of consultation. This situation usually occurred in the private health service. On the contrary, when the patient did not have any money, this source of power had negative effect on the explanatory model source. It limited the power exercising of the patient. The case 422 as mentioned was an obvious example that the touring behavior depended on the material source of power or the money. The study found that in the context of the patient who had the right on the health benefit scheme, all of them did not concern on the expenses of health service, then they have a chance to exercise their power without the limitation on the expenses. On the other hand, their explanatory model could be an ineffective source of power, since it was not strengthened by the money.

3.2.3.1 Non-Adherence and Touring Behavior: The Common Pattern of Patients' Power Exercising

Regarding on the touring behavior, it was found that almost all of patients (13 from 18 cases) who were in-depth interviewed had shopped around or engaged in touring behaviors before they visited this hospital. Most of them visited several types of health services such as drug store, private clinic, district and/or private hospitals more than 3-5 times before they visited this hospital. Some of them could not count the numbers of these visiting, for instance, in case of the chronic abdominal pain patient (case 436). She could not count the number of physician visits prior to this time since she had gone through a plenty of consultations for the past 7 years. However, in case of the patient who had a symptom for a while, they could detail their touring behavior as the road map of their treatment.

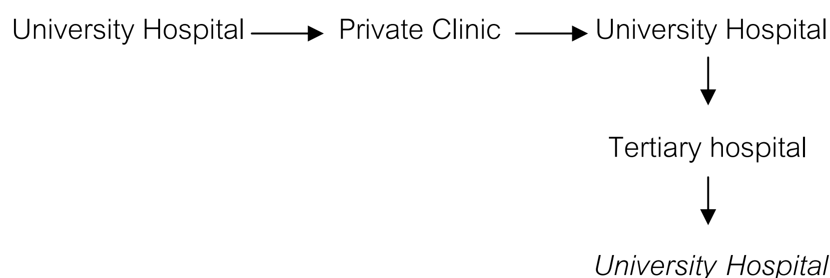
There were the examples of the route of treatment in cases of the chronic low back pain patient (case 22,244). These patients had this symptom for 2 weeks, the first case (case22) started his treatment from the self-medication he took some paracetamols for a day. When this symptom was not relieved he asked his wife to massage for him and then went to the district hospital to have injection. His symptom still appeared; he decided to have the consultation at this hospital (The Tertiary hospital). Here his expectation on the x-ray was not honored then he planned to visit the physician at the university hospital although he had not completely finished the steps of care at this hospital. The route of touring treatment of this case was mapped as following:

Figure 4.1 The Route of Touring Treatment of Case 22



For the case 244, the patient had the same symptom as in case of 22, but had the different route of touring treatment. However, both patients in cases 22 and 244 had the same plan to visit a physician at the university hospital even they he had not completely finished the steps of care at this hospital.

Figure 4.2 The Route of Touring Treatment of Case 244



The study found 2 significant reasons influencing the patients' touring behavior. The first was the attempt to meet their expectation. Most patients had the expectation on their treatment particularly on the medical equipment such as the request on the X-ray or the blood examination. These expectations were the result of the desire to know causes of their symptoms. As in case of the chronic abdominal pain patient (case 436), she had touring behavior around private clinic, private hospital, and public hospital in and around the province she resided no matter it was close by or far away, since she wanted to know causes of her symptom. She said: "*I know that my symptom could not be recovered because it has hurt me for a long time, I just only want to know what the cause is. If I know the exact cause, I will set my mind to accept my condition".*

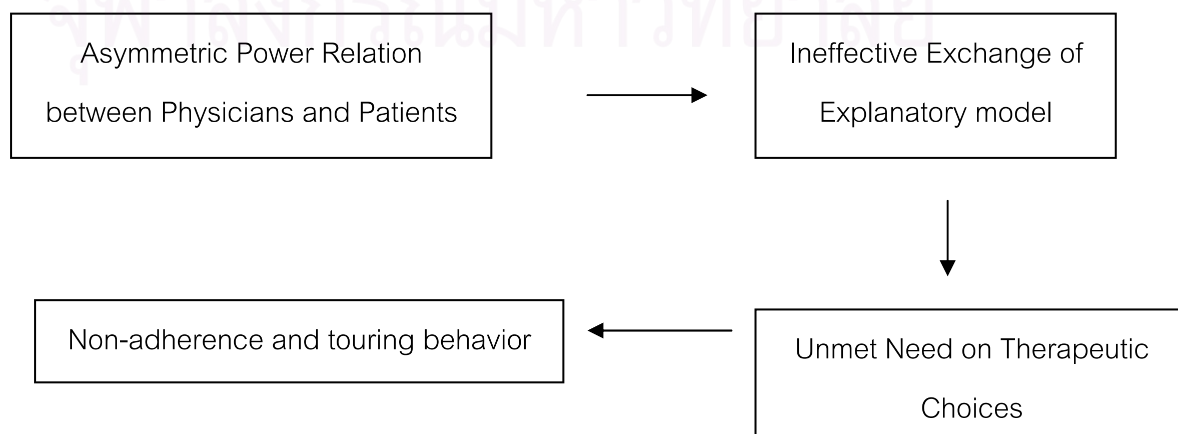
The other reason was the need to get well and/or the desire to know what went on within them since some of them did not know exactly what caused their symptoms. For example, in case of the low back pain patient (case 244), he planned to visit the new health service although he had not completely finished the steps of care in this hospital. In this case, the patient requested the X-ray to investigate his symptom, since he thought that the X-ray could detect the exact cause then the physician could prescribe the suitable prescription for him. When the physician did not respond to his need, he said: "*The physician did not do as I requesedt, then I must go to the other place that will give me my request. Only the investigation by asking questions on the symptom is not enough."*

The study found that most of physicians did not appreciate the touring behavior as in case of the patient who had a chronic stomachache (case 422). After she told the physician about her touring, the physician said: "*Visiting here you did not have to pay the money, your symptom will not be relieved. If you pay 1,000 baht as you did to the private clinic, you will get well."* This conflict affected on the patient's emotion and made her cry when she went out the consulting room, she said: "*I am very sorry with the physician's wording. I just want to explain more on my suffering from the illness".* In

this case, the physician did not concern on the patient's illness but the touring behavior. During the consultation, he blamed this patient.

Concerning on the quality of care particularly on the patient-centered approach, the results illustrated that the consequence of care was the result of the asymmetrical power relation both of during the consultation, and after the consultation. During the consultation, almost of patients could not access the patient-centered care, since it was not the emphasis or the concern of health personnel or in another word this objective was not established in the system. The process of care provided was against all of five key dimensions of patient-centeredness. Almost all of health care personnel particular physicians did not try to understand the patient's experience of illness in their context. The ineffective exchange of the explanatory model did not impact specifically the therapeutic choices that the physicians chose for the patients during the consultation. It had further created impression on the consequence of care after the consultation. The result revealed that the non-adherence behavior, the touring behavior were the consequence of an ineffective exchange of the explanatory model during medical consultation. The patients tried to meet their explanatory model by doing these behaviors. Non-adherence and touring behavior were the way that patient used to compensate the loss of power from the previous consultation. From this result, the study explained this association of non-adherence and touring behavior, power relation and the ineffective exchange of explanatory model as the Figure 4.3.

Figure 4.3 The Reason of Non-Adherence and Touring Behavior



3.2.3.2 Patients: The Actual Powerful Persons

Concerning on power use after medical consultation, it was found that all of patients (15 cases) who were in the relation of physician's power, planned to have their treatment alternatives after a trial on the prescription and seeking for the other health service or practice the touring behavior, while the patients in the mutual power relation and in the patients' power relation planned to follow the prescription that they got. As well, most of patients (8 cases) in the physician's power relation had already planned to visit the new health service although they had not completely finished the steps of care in this hospital. This picture had clearly presented that patients were the person who was in charge of their illness and how to manage their illness. Although they seemed to be powerless party during the medical consultation in the hospital system after the consultation they took the power in their hand to manage their ill health and followed what they had believed, their explanatory models. As concerning on the trial of the prescription, this was, in theory, the treatment evaluation. All of patients who decided to do the trial planned to take the prescription only for a short period, such as 2 or 3 days or a week. If the medicine that they took was not effective for them, their symptoms were not relieved, they would stop taking the medicine and then sought for the new prescription from the old hospital or the new health service.

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CHAPTER V

DISCUSSION AND CONCLUSION

The previous chapter examined explanatory models and therapeutic choices and contextualized explanatory models and therapeutic choices under patient-provider power relationship. This chapter is predominantly concerned with discussion of issues related with the results from the previous chapter. The focus on the explanatory model, therapeutic choices, power relation between physicians and patients is extended from the previous chapter. The present chapter also includes analysis on the factors that caused these results to provide a rounded view of the medical consultation. The discussion was structured into 5 parts, firstly, the key findings were detailed, followed by the factors influencing the asymmetric power relation between physicians and patients, the magic of prescribing: the silent power of communication, non-adherence and touring behavior: the power struggle of patient, finally the proposed model: *"The Chamber of Power Sharing Model"* was explained. The chapter finally concluded the study and the limitations of the study were reported.

1. Key Findings

The study argued that the asymmetrical power relation between physicians and patients during the medical consultation was the significant cause that initiated the consequences of the medical consultation. There were three crucial consequences: the ineffective exchange explanatory model, the ineffective therapeutic choices, and the outcomes of care. These consequences affected the quality of care both during and after medical consultation. Regarding the ineffective exchange explanatory model, the first consequence, it was found that most consultations were the superficial exchange of explanatory models. Neither physicians nor patients exchanged their explanatory model with each other. Therefore they remained in their own explanatory model after the end of the consultation. The physicians could not recognize the patient's expectation on the

treatment. They were not concerned by the reason that lied beneath the patient's expression. Then most of them used only their explanatory model in making decision on therapeutic choices which was not the same choices the patients expected. For the last consequence, it was found that the consequence of care such as touring behavior and non-adherence were caused by the unmet need on therapeutic choices.

Asymmetrical power relation between physicians and patients was the important cause of these consequences. Having more power did not assure the quality of care; on the contrary, it was the crucial barrier to the quality of care. The results showed that since the care during medical consultation was not patient-centred, the patients could not achieve the quality of care. Furthermore, this service was against all of the five key dimensions of patient-centredness. Most health care personnel particularly the physicians did not try to understand the illness under the patients' context. The ineffective exchange explanatory model impacted specifically the therapeutic choices made by physicians during the medical consultation; it influenced the sequence of care patients decided after the consultation as well. The result revealed that the non-adherence behavior and the touring behavior were the consequence of the ineffective exchange explanatory model during medical consultation. The patients tried to meet their explanatory model by means of doing these behaviors. Non-adherence and touring behavior were the way that patients used to equalize the power that they lost during the consultation. Furthermore, the result suggested that patients were the actual person that has greater power in managing their illness.

2. The Factors Influencing the Asymmetrical Power Relation between Physicians and Patients

The examination of the asymmetrical power relation between physicians and patients during medical consultations could be divided into four main areas. The study has

concentrated on variables determining aspects of social context particularly norms, situation context, socio-demographic factors, attitude of physicians and patients.

2.1. The Social Context: Norms

The study found that the social context particularly norms was the crucial factor that influenced the power relation between physicians and patients. This finding was consistent with the argument of Pendleton et al.; (2003: 27) that power relation between physicians and patients were profoundly influenced by the social context in which they took place. They pointed out two significant social influences on medical consultation: the values and norms. Values were relatively abstract and shared beliefs. Norms were more a concrete way of thinking which included feeling and acting derived from values. Both values and norms were learned from, and sustained by, membership of social group. This value indicated norms of Thai medical consultation especially the expected role of both patients and physicians. In general, the physicians acted as the parent, while the patients completely cooperated with the physicians. However if the patients did not adhere to physician's order, the physicians could cast in an authoritarian role.

The study found that norms were the important factor that influenced legal & social authority source, since it assigned social authority and status of both physicians and patients. Haug and Lavin (1983: 10-12) used the authority term to define the physician power. In addition, Weber (1961 cited in Haug and Lavin, 1983: 11-12) described three types of authority: traditional, charismatic, and legal-rational. Each type was based on different of power sources. According to Thai context, the physicians enjoyed both type of traditional and legal-rational authority. In the traditional authority, the acceptance on the physicians was grounded on past history and custom. The study found that most patients agreed with the physician power. They usually said *"yes" or "it depended on you (the physician)* for all of the physicians' ordering.

Legal-rational authority was the authority of official position established by law or quasi-legal rules. Physicians enjoyed this authority by virtue of laws governing licensure that forbad the practice of medicine by the unauthorized. Having the sole legal right to practice had endowed physicians with the authority of the state. Similarly, rules about the rights of physicians in hospitals, long-term facilities, and the armed services also accorded them the authority of office. This source of power embedded in the hospital's rules which established the service system for provision of care and the role of patients and physicians. The legal-rational authority of physicians had more impact on the material source particularly on the physician's side. It determined the hospital's rules especially on the management of medical resources for example medicine, medical equipment. The physicians exercised this authority and material source as providers' power.

According to the influences of the social norms on the legal & social authority source, the study realized that the social norms on the medical service was the taproot that ruled roles and attitudes of both patients and physicians in the medical consultation. There was the very affected deeply wording from the patients when they said about the physicians *"I am very concerned about the physician's feeling. It is the characteristic of a rural patient. I am worried the hierarchy (the physician), I am afraid of the physicians, they are the superiors. I am afraid they may blame me".* These words implied the power of persons with a medical degree in the interaction with the patients. It was not much coercive as legitimated. Generally the physician power was accepted as appropriate and right under the circumstances. The results revealed that more than 80% of the consultations (377 from 455 consultations) were the relation of physician's power where physicians had more power than the patients. The patients were dependent on the physicians and the resources of the physician's office such as the prescription.

However, it was found that occasionally a subtle element of coercion could enter the relationship as well. Implied threat to deny further service, or refusal to provide a desired

prescription, might compel patients to act contrary to their own wishes. It was found that a number of patients could not bear the physician's power. Some patients particularly the participator in the physician's power relation tried to exercise their power during the consultations. Some of them struggled to exercise their power by having non-adherent behavior or having touring behavior after they finished the consultation.

In the physician-patient relationship, social system provided another facet of power to physicians, the autonomy (Haug and Lavin, 1983: 10-12). While authority concerned power over others, autonomy was the power not to be compelled by others. Physicians had enjoyed both authority and autonomy: the right to give patients *"doctor's orders"* that would be accepted, and the right not to have anyone else, whether bureaucratic boss or fellow physician, interfered with their work. In the situation of Thai medical consultation, the physicians had not been applicable in earlier historical periods. They are currently being challenged by consumer-minded publics. Some of the physicians usually said "*Today the physician must be afraid of the patient, now the patient was not afraid of the physician like in the past. There were a lot of patients asking things they wanted. Some of them sued the physicians".* This wording implied that the situation of power relation between physicians and patients might be changed. The physicians had less power than before. There was the shift of power relation between physicians and patients from the paternalistic model that proposed by Parsons (1975) to the consumerist model.

It was found that the Parsons's model did not fit with the current situation of Thai medical consultation. It could not explain some of consultation circumstances, even though these consultations were the asymmetrical power relations as in Parsons's model where the physicians played the key and powerful role within the dyad and governed the relationship with patients. The patients had to comply with the medical regimen prescription, in order to be restored to the pre-illness state. The Parsons's model provided a clear explanation on the non-exchange consultation and some of the exchange consultations which the patients

were the un-exchange patients. Since the patients in these relations did not try to exercise their power, they complied with the physicians' order. Actually, the Parsons's model could describe the physician's power only in the period of medical consultation. It could not explain the patient's non-adherence and the touring behavior. It was found that most of patients did not comply with the prescription, they stopped taking the prescription that they perceived the medicines was not compatible with them. They had non-adherent behavior despite the fact that they wanted to recover. Throughout each consultation, there were the *"competency gap"* between physicians and patients as Parsons mentioned (1975). It was found that there were the differences between patients and physicians in knowledge held in which both physicians and patients had their own explanatory model. However, some patients made an effort to reduce the *"competency gap"* by attempting to exchange their explanatory model with the physicians. Most of them did not achieve on the exchange, since the physicians did not take into account their explanatory model. Then the *"competency gap"* was therefore still unbridgeable.

The study discovered that the *"competency gap"* was the result of the differences of explanatory model between physicians and patients. The physicians' explanatory model followed the biomedical model, while the patients had their own explanatory model. The differences of explanatory model affected both parties in the medical consultation particularly on the conceptualization of the health problem. The physician saw a disease while the patient experienced an illness. Disease was an objective biological phenomenon, involving malfunction of some part of the body, and could be identified and measured by indicators or signs observed during a physical examination, and by diagnostic tools such as laboratory tests. According to this concept, not surprisingly, this study found that, physicians' attention was only drawn to the investigation of the abnormal organ. When they did not find the abnormality, their mission had completed even though patients insisted on illness existence. Their practices presented the strong support of biomedical knowledge as

"treat on disease, not treat on illness". The obvious examples were in cases of the psychosomatic patients.

Whereas the biomedical approach assumed illness to be an objective state, Waxler (1981, cited in Weiss and Lonnquist, 1996: 132) proposed the labeling theory to offer the definition of illness. Labeling theory viewed illness as a subjective matter worked out in particular cultural contexts and within particular physician-patient encounters. Every society had its own particular norms for identifying the behaviors and conditions that were defined and treated as illnesses. A person with symptoms noticing some departure from the normal might chose to ignore these signals or perhaps felt some anxiety about their possible meaning. It was found that there were some indigenous symptoms that the patients used to label their illness, for example, *"Roke Tai", "Roke Pod", "Mot Luk Ar-seb" and "Har Jai Boi Im".* These indigenous symptoms were far from the biomedical knowledge. *"Har Jai Boi Im"* symptom, for example, was not explained from the biomedical point of view.

In accordance with, the significance of cultural contexts on the differences between disease and illness, Freidson (1961, 1970, cited in Haug and Lavin, 1983: 13) argued the conflict perspective for understanding the power relation of physicians and patients. He pointed out that between the parties in any consultation there was a potential conflict based on the different cultural context. The patient's desired outcomes of the interaction did not necessarily coincide with the physician's. The argument of Freidson was a very useful notion for understanding the context of this study. The patient's indigenous symptoms such as: *"Roke Tai", "Roke Pod", "Mot Luk Ar-seb" and "Har Jai Boi Im"* were the illustrated examples that confirmed the differences on cultural grounds between physicians and patients. In addition, these indigenous symptoms were the potential factors that caused conflict between physicians and patients. For instance, some physicians cut off the consultation when they heard that the patients had *"Har Jai Boi Im".* Most of these patients

who had *"Roke Tai"* planned to visit the other health service even though they had not finished all steps of care in this hospital.

According to Wolinsky (1988, cited in Weiss and Lonnquist, 1996: 106-107), there were four primary assumptions of biomedical model that sustained the *"competency gap"*. These assumptions limited their utility for complete understanding of the patients' illness. The first assumption was that the presence of a disease, its diagnosis, and its treatment were all completely objective phenomena. Symptoms and signs provided accurate and unbiased information from which valid diagnosis could unfailingly be made. The second assumption was the capability of defining health and illness assigned only to the physicians by society. In reality, however, both patients and her or his significant others were all involved in the process. While one could not discount the power that society had granted to physicians for defining health and illness, a grate deal of diagnosing and treatment occurred outside the consultations.

The third assumption indicated that health and illness should be defined solely in terms of physiological malfunction. In fact, people were not merely biological existence. They were also psychological and social creatures. Their state of health was affected by all three aspects. Finally, the fourth assumption possessed the limitation of biomedical model on the focused attention on the malfunction part of organism but excluded the rest with positively functioning being. These assumptions verified that biomedical model was essentially disease-oriented rather than patient-oriented. The key to effective medical care was believed to be correct diagnosis of some physiological aberration followed by proper application of the curative agent. Based on biomedical model, physicians intended to learn only the symptoms of abnormalities.

Furthermore, the study revealed that several expressions of both physicians and patients possessed the power exercising for position in achieving the desired results. The

participator was the obvious example in this issue. They exercised their power for the accomplished therapeutic choices. This finding was consistent with Freidson's argument (1970) that both patients and physicians possessed some power and jockeyed for position in achieving wanted results. In addition, this finding was supported by the study of Beisecker (1990: 114), that both physicians and patients used some strategies in attempting to control the consultation. The patients with different power expression such as hermit, participator might have different strategies. In this study, it was found that the two specific strategies that the patients often used to control the consultations varied and might include pursuing specific themes such as the detail of the medical technology in answering a physician's questions, and placing a responsibility on the physician to order the x-ray, ultrasound, or the specific examination for them.

For the physicians, different power expressions might have different strategies as well. The study found that some strategies that physicians used to control the consultation was different from the proposal of Beisecker (1990: 144). Some physicians namely the cut-short or the medical reviewer controlled the consultation by silence. However, most physicians used the similar strategies suggested by Beisecker (1990: 114). For instance, the expert let the patient know their incredible intelligence by providing a lot of information which considerably fit the biomedical model, while the reinterviewer, or the medical reviewer used such strategy as questioning the patient's stability or normality when the patient wanted a treatment that differed from what proposed by the physicians.

The power relations between physicians and patients during the medical consultations were the consequences of the interaction between them. It was found that the behaviors of both physicians and patients might also influence the communication behaviors of each other. That meant the interaction between physicians and patients impacted the exchangeable of the explanatory model. For instance, in the relations of the un-exchangeable physicians and forced hermit, these patients were assigned as forced

hermits, since they did not have a chance to exchange their explanatory model. The unexchange physicians had complete power in controlling the consultation; they controlled the consultation by the silent manner. In cases of the exchange physicians namely the expert, the reinterviewer and the authorized interviewer, the study found how these physicians linguistically structured a patient's responses by selectively listening only to pathological information; other information that did not fit into the biomedical framework were neglected. Sometimes physicians asked forced-choice questions or engaged in verbal tactics which discouraged questions asked by patients. This finding was also supported by Svarstad (1974), Frankel (1984), and West (1984).

In agreement with Freidson (1961, 1970), Beisecker (1990: 108), this study found that the expressions of both physicians and patients might vary depending on the situation that both of them encounters at the time of the interaction. The effects of the situation context were described as following:

2.2. The Situation Context

In agreement with Freidson (1961, 1970), this study found that competency of each sources of power relied on *"the situation context"*: the circumstances in which care was given. The study indicated that there were the 2 important situation contexts: the medical setting and related medical forces, and the stage of illness. The medical setting and related medical forces (e.g., payment mechanism) were the significant situation contexts that influenced the competency of the sources of power. For example, in the private practice, the material source of power, in specific the purchasing power or money, was the major source of power that patients used to exercise their power, then, it was the capability source of power. In other circumstances, particular in the public service practice where the health benefit scheme provided, the purchasing power or money became less capable source of

power. It was the ineffective source of power; the patients did not use this source for discussing the expected therapeutic choices that they wanted.

In addition, some physicians were client dependent in some circumstances. For instance, in case of the solo, fee-for-service practice in the area where competition from the other sources was real, the physicians might hesitate to alienate patients by requiring a stringent regimen or denying tests and medications desired by the patients since these practices might influence the patients to seek the service elsewhere and cut the physicians' income. The results showed that both of physicians and patients had different ways of power expression. In some circumstances, the physicians might express as the cut-shot, on the contrary, these same physicians might become the expert in the other context. As well, the patients might express their power as the hermit in some circumstances and could be the participator in the other circumstances.

The second significant situation context was the stage of illness. The study found that this context strongly influenced the power exercising particularly on the patient's side. The patients who had different stage of illness had the different of power expression. For instance, the patients who were in the blindness stage usually expressed their power as the participator, while the patients who, had a common symptom namely cough and cold, often acted as the responder. In addition, the study discovered the other situational factors including length of consultation, first versus repeated visits. The study found that the commonly length of consultation was less than 2 minutes/consultation. A longer physician-patient interaction might reflect stronger rapport or it might produce stronger rapport by allowing the patients more time for exercising their power such as question asking, requesting the x-ray, and discussing about their concerns. For the first versus repeated visits, the study pointed out that some of the repeated visit such as in case of the chronic patient tended to have the shorter length of consultation, leading to less time for patient to exercise their power.

2.3. Socio-Demographic Factors

For the patients, nearly 60 percent were women, most of them (84.68%) were older than 30 years old, and a half of the patients in this study (51.28%) used Thai language during the medical consultation. The study found that patients in this study were the homogenous group, since they had similarly socio-demographic factors included income, education, and cultural background. Almost all of patients had low income, low education, the same cultural background (north-eastern culture), and had the right on the health benefit scheme. It was found that the patients' socio-demographic factors did not have strong impact in explaining power relationship between physicians and patients. However, the study stated that high-status patients (i.e., those with high income, greater education and gender and cultural congruence with their physicians) tended to exercise their power more than the low-status patients.

For the physicians, there were only 1 retried physician, four intern physicians, and three specialists. Most of physicians in this study (7 physicians) were men therefore nearly 90% of the medical consultations were treated by the male physicians. In contrary to patients, the study found that the socio-demographic factors that were effective in explaining / predicting physicians' attempts to exert power when communicating with patients were age, skill and experience, and emotional factors. The result showed that intern physicians spent more time in face-to-face contact with each patient than the retried physician and three specialists did, so patients had more time to exercise their power when they had consultation with intern physicians. It was found that almost all of the mutual relations that occurred in this study were the relations by the intern physicians.

In addition, the older physicians who had more skill and experience tended to give shorter and less answer to patients' questions, leading to the interpretation that physicians might be withholding some pathological information from the patients in order to maintain

the traditional physician-patient power relationship. This result implied that more skill and experiences of the older physicians did not come with more concern on the patients. Most of them did not let the patients participate during the consultations. On the opposite, having older age, more skill and experiences might be the significant obstacles of the physicians to understand the patients' illness and to provide the patient-centred care. For the younger physicians with less skill and experiences, they tended to exercise their power less than the older physicians. These practices seemed to be more patient-centred care, since these physicians expressed higher concern on the patients' illness. For the emotional factors, this study found that physicians were affected by the emotional factors in their work as in any other professional. The patients were often impacted by these emotional factors, their request on the compatible medicine or the x-ray were ignored or denied without any other legitimate explanation rather than no mood.

2.4. Physicians and Patient Attitudes

From the data obtained, during the consultation, the physicians expressed their attitudes more often than the patients. The physicians might feel more at ease to express their emotion than the patients. The significant attitude that the physicians often presented was the attitude on the patients' illness. Most of physicians had bad attitude on the psychosomatic patients, they stigmatized these patients. The physicians' attitude was the important factor that affected their power exercising in the consultation. The study pointed out that the physicians who had different attitude on the same symptom had the dissimilar power exercising. The psychosomatic symptom was the obvious example, the physician who perceived this symptom was the psychosomatic symptom tended to cut short the consultation by the prescription without the thorough patient examination.

On the contrary, if the physicians perceived that this symptom was the abnormal sign from the other disease such as heart-failure, diabetes, they arranged patients to have

more investigation. These practices presented that the physicians' attitude was the significant factor that guided the power exercising during the consultation. It influenced the quality of care particularly the standard of care as well; the patients with the same symptom did not receive the similar practice pattern. These practices confirmed that although the physicians had more power than the patients and the direction of consultations was in control by the physicians, the consultations did not always present the corresponded quality. They did not achieve any dimension of the patient-centred care.

The frequently attitude that the patients presented in the consultation were the positive attitude about the physicians; almost all of them accepted the role and capability of the physicians; they appreciated physicians' expert power. For the patients' attitudes regarding their rights to medical information, it was found that almost all of the patients did not concern on their rights although they were the participator. In cases of participator, after they failed to exercise their power, they agreed to the physicians' authority, since they realized that they could not have more participation in the public hospital. On the contrary, they perceived that they have more rights to participate in the consultation when they used the private health service such as private clinics or private hospitals. Some of the patients said *"If you visited the private clinic, the physician must service you"*.

The study noted that there were a little conflict between the physicians and patients, particular the participator, since each of them insisted on their explanatory model, they did not share similar expectations on the treatment. In practice, however, the study found that physicians and patients often did not share mutual role expectations; physicians often failed to recognize the expectations of their patients. Moreover, a crucial element in ensuring patient compliance with therapeutic regimens was when each party recognized the nature of expectations on their roles by another party. These practices were found in the patient-centred care, which in this study happened in the mutual relation.

3. The Magic of Prescribing: The Silent Power Communication

The prescriptions were the significant therapeutic choices that most physicians used to signal an end to the consultation sessions. It was found that 70% of the medical consultations were ended with the prescriptions. The physicians used the prescriptions as the important tools of the power exercising. The study noted that some of physicians believed that every patient needed vitamins, some kinds of pain reliever, and other household drugs such as antacid, paracetamol. It was thus seen as legitimate and possibly rational to prescribe several drugs. For the patients, the prescriptions were the significant therapeutic choices that most of them expected to get from the physician visit. The *"Premium Drug"* was a case in point. The study found that the usual picture of the prescribing was consistent with the previous study of Lisbeth Sachs (1989, cited in Whyte, Geest, and Hardon, 2002: 117-129) in that:

"the physicians, who had very little time for communication, would immediately make a prescription which was 'committed to paper without any evidence…of an examination, few spoken words and little, if any, eye or body contact'. Then the patient was called".

This evidence presented that the physicians and patients hardly communicated with one another. The physicians did not concern on the patient's illness, they did not hear the patient's compliant, while the patients did not understand the physician's diagnosis. Astonishingly, both parties felt satisfied with the consultation, which always ended in a prescription. Then, the prescriptions were the good way out of any problems that occurred during the consultations, for example they were the potential tools that most of cut-short used to end the consultations although they perceived that there was no need for the patient to take the medicines. Actually, the power of prescribing and the prescriptions were the results of the social & legal authority source and the material source of power.

To discuss power of the prescribing and the prescriptions, this study used the argument of Whyte, Geest, and Hardon (2002: 117-129) to provide a rounded view of the prescribing and the prescriptions. Whyte et al., (2002) mentioned that prescribing and the prescriptions was more than brokering the dispensing of medicines; it had a magic since it had some potential which could not be explained in the accepted terms of science, an effect which did not fit in common conventional causative thinking. Prescribing and the prescriptions did magic work on people, on their mental and emotional state, on their health, and on their position in society. The magic of prescribing was the silent communication; it spoke without words, through medicines. It was an effective style of communication, since it conveyed three significant meanings that expressed power of the physicians: establishing authority, dealing with uncertainty, and token of concern. Prescribing was a symbolic act, then, the prescription was also a symbolic. Both of prescribing and a prescription communicated these three significant meanings through their symbolic meaning.

3.1. Establishing Authority

The first meaning that prescribing and a prescription communicated to people was the authority of physicians. The physicians conveyed their authority by writing the prescriptions. The rights to prescribe gave the physicians a very specific power in the medical consultation. The prescriptions distinguished the physicians from the other heath personnel and the patients. These professional authorities distanced the physicians from both, the other health personnel and the patients. The physicians used prescribing and a prescription signaled to people who they were. The prescription was the symbolic in that it stated the unequal relationship between physicians and pharmacists; it conveyed the orders of the physician to the pharmacist. The prescription embodied the authority of physicians over pharmacists. Moreover, the prescription was used to certify the sick role since it communicated that this person needed medical treatment.

3.2. Token of Concern

The result agreed with a study of Whyte et al., (2002) in that medicines were tokens of physician's concern. It was the second meanings of prescribing and a prescription. Surprisingly, the concern filled the medicines with therapeutic power; the patient's asking for *"Premium Drug"* was a case in point. Most of patients expected to have the prescriptions when they visited the physicians. Some patient said *"Please give me the prescriptions, I rely on it. I have to take this medicine everyday, when I have not, I am unhappy. Please give me".* This statement implied that this patient had more concern on the medicines. Refusal to prescribe would present a contradiction. A non-prescribing practice might be preferable from a biomedical point of view however it would be irrational by the patients who had the different of explanatory model. From the data obtained, it was found that the physicians were encouraged to prescribe not only to overcome their uncertainty, as we had just seen, but also to please their patients and increase their reputation. The prescription seemed to be the psychological tool. It reassured that both physicians and patients had 'something' done about the disease.

In general, writing a prescription signaled to patients that the consultation was nearly completed. Whyte et al., (2002) pointed out that it was closing ritual which was intended – and often succeeded- to send the patient away with hope and positive feelings towards his medical problem, himself, and the physician. Then, the prescription was the *"terminating tool"*, normally this *"terminating tool"* conveyed the positive meaning such as the physicians' concern. However, the result showed that there was some meaning of prescribing and a prescription that differed from the mentions by Whyte et al., (2002). In some situation prescribing and a prescription did not convey the physicians' concern, on the contrary, it communicated the negative attitude of the physicians. The relation between cut-short and the participator was plainly presented this point. Some cut-short used the prescription to avoid the conflict with the patients; they got around the patients'

disagreement. In this case, the prescription was used to force the patient to leave, then this terminating tool presented the negative sense, as more of the *"ejection tool"*.

3.3. Dealing with Uncertainty

According to the nature of the medical consultations, they were highly ambiguous situations, since the subjectivity of the illness experience and the limited scope for communication often created an acute situation of uncertainty. To deal with this uncertainly situation, the prescriptions were used to overshadow the unanswered questions. In this situation, it was found that most physicians usually prescribed vitamins or anti-depressants for relieving or maintaining some uncertainty symptoms. Whyte et al., (2002) noted that the prescription became a magic tool, since it had some capacity which could not deal with directly in terms of science. The magic of prescription thus worked two ways: it restored the patient's confidence in recover, and rebuilt the physician's confidence as well. In this sense, the prescription might be the positive magic tool that the physicians used to maintain their image.

Additionally, in the Thai context that had the extremely unfavorable physician-patient ratios, most of physicians used the prescriptions as the most effective way to deal with the persistent problem of shortage of time and the 'overload' of patients. Regards, the prescription was the magic symbol that the physicians used to state their power, although it was the silent communication, it conveyed a various meaning. Normally, it was the terminating tool of the physicians. In some situation, it was the ejection tool that the physicians used to force the patients to leave. However, in many cases, the physicians often wrote prescriptions because patients requested them and, conversely, patients might be skeptical and decided to do other things with a prescription than the physician intended. The non-adherence or the trial behavior was an obvious example on this point. The study was described these behaviors as the following:

4. Non-adherence and Touring Behavior: The Power Struggled of Patients

The study argued that patients were the persons who had actual power in managing their illness, although they had less power during the medical consultation. Non-adherence and touring behavior were the result of the imbalance of power between physicians and patients; they were the way that patients used to equalize their power loss from the consultation. Non-adherence and touring behavior for other physicians or treatments were most common deviant behaviors. These arguments were consistent with the previous study (Conrad, 1987) in that non-adherence was viewed as a matter of patient self-regulation, rather than viewing non-adherence as a matter of deviance needing correction. He pointed out that non-adherence was viewed as a matter of patient tailoring their medical regimens to their lifestyles and life responsibilities, this, therefore, supported that patients were the persons who had actual power in managing their illness. In addition, non-adherence was not the deviant behaviors from the patient's point of view.

In agreement with Davis (1968) and Weiss and Lonnquist (1996: 262), this study found that non-adherence and touring behavior were the results of the inadequate or poorly communicated information from physicians to patients. In addition, the study indicated that the problem within communication was the ineffective exchange of explanatory model between the physicians and patients. This finding was supported by the study of Rost, Carter, and Inui (1989), in that, allowing a patient's perspective to be revealed in a medical interview could improved patient compliance. Additionally, this study implied that patients' compliance was depended on the patient-centred care. Furthermore, the result agreed with the argument of Weiss and Lonnquist (1996: 262), in that, health beliefs of the patients were the significant factors that influenced non-adherence behaviors. The compliance was more likely when the patients believed that medical regimen was considered to be an efficacious method of deterring or eliminating the health problem.

5. The Proposed Model: "The Chamber of Power Sharing Model"

According to the association of non-adherence and touring behavior, power relation and the ineffective exchange of explanatory model as mentioned in the figure 4.5, this study has conceptualized *"the chamber of power sharing"* model to describe the exchange of explanatory model between patients and physicians in each relation. The model pointed out that during the consultation session, a chamber of power sharing was formed. In case of the physicians' power relation, this chamber was almost filled with physician's explanatory models, since it was used as the significant source of power and prescription was written out of this explanatory model with limited input or exchange from patient's explanatory model. Patients' explanatory model was then an ineffective source of power. In the consultation most of patient's explanatory model was left outside the chamber of power sharing. It was not taken into consideration by physicians. There was no or very limited exchange of explanatory models between patients and physicians in this relation. This situation often found in the case of chronic low back pain and chronic abdominal pain. For instance, incase of patient who had low back pain (case 353), after the physician reviewed the X-Ray film and the urine examination, he said *"You should be glad. You did not have any disease"*. The patient had immediately replied *"I cannot be glad, I have pain, I have pain like there is an abscess. I am not glad since I still have pain, When I come back home. I cannot eat"*. After that the physician ended the consultation by the prescription without the effort to exchange his explanatory model to his patient. This situation pointed out the obvious picture that there was no exchange of the explanatory model in the consultation, although the consultation was controlled by the physician. Both of them still had their own explanatory model.

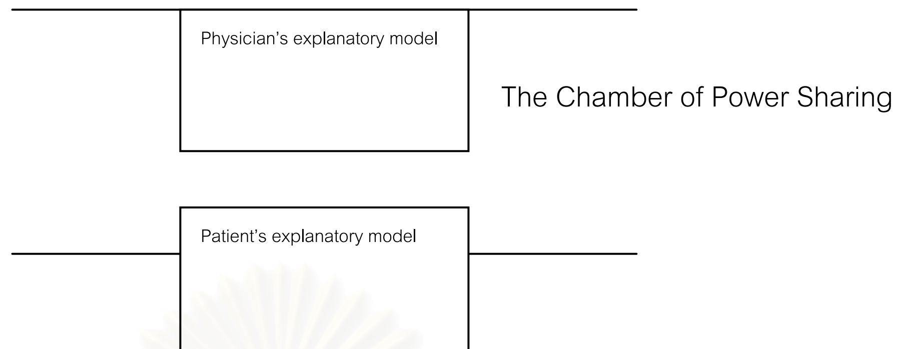

Figure 5.1 The Chamber of Power Sharing in Physicians' Power Relation

On the other hand, in the patients' power relation, patients' explanatory model seemed to be the crucial source of power, thus this power sharing chamber was completely covered with patients' explanatory model. While physicians' explanatory model was restricted in this chamber, it was turned to be an ineffective source of power. There was no or limited sharing of power or exchange of explanatory model between patients and physicians in this relation. Both physicians and patients still had their own explanatory model as in the relation of physician's power.

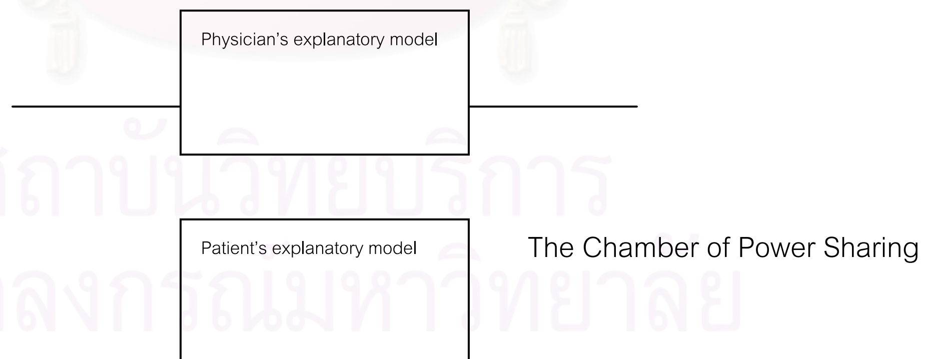

Figure 5.2 The Chamber of Power Sharing in Patients' Power Relation

These two models presented the power exercising between patients and doctors, both of them used their explanatory model as the significant source of power. The consultation ended with the unexchange explanatory model, both of them still had their own explanatory model. In case of mutual relation, both patients and physicians' explanatory models were the significant source of power, then the chamber of power sharing in this relation were enclosed with both patients' and physicians' explanatory models. There were some parts of these explanatory models that were exchanged therefore intersected within this chamber. That meant, there was an effective exchange of explanatory models between patients and physicians or power had been shared between both parties in this relation.

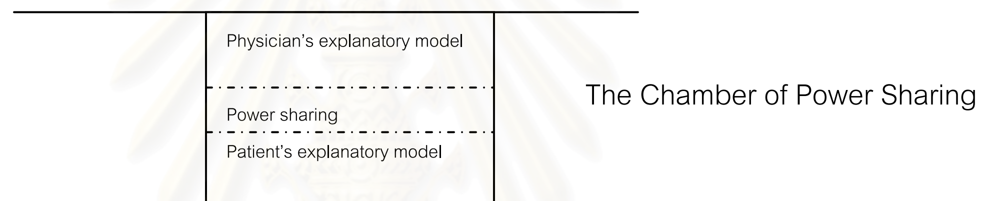

Figure 5.3 The Exchangeable Explanatory Model in Mutual Power Relation

As in the gray relation, this chamber was almost filled with both patient's and physician's explanatory models, since it was used as the significant source of power. Similar to the patients' and physicians' power relation, the prescription was written out of this explanatory model with limited input or exchange from patient's and physicians' explanatory model. There was no exchange of explanatory models between patients and physicians in this relation, power had not been shared between both parties in this relation. There were no parts of these explanatory models that were intersected within this chamber.

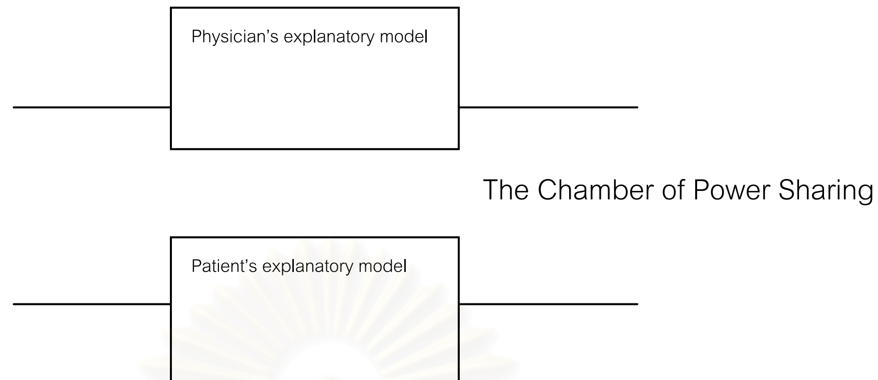

Figure 5.4 The Exchangeable Explanatory Model in Gray Relation

The study further illustrated the significant point on patients' source of power. Patients in the relation of patients' power and the gray relation used their explanatory model as the crucial source of power, since physicians complied their asking. For instance, in case of the patients who had gray relation, most of them (32 from 46 cases) usually exercised their power by asking the specific medicines, which did not relate to their current symptoms. These medicines were the common and household medicines such as antacid, paracetamol, vitamins. As shown in case of the diabetic patient (case 350), she asked for *"Ya Thart Nam Khao"* (antacid), while the diabetic patient in case of 478 requested *"Ya Kae Puad Met See Lueng"* (the pain killer in yellow tablet) and *"Ya Thart Nam Khao"* (antacid). Then there were two kinds of medicines prescribed to the patient, the first was the medicine for the problematic symptoms which the physician prescribed using their explanatory model. The second was the medicines that the patients asked; this prescription was prescribed in correspondence to the patients' explanatory model. Some physicians stigmatized these specific medicines as "*The Premium Drug"*; they did not appreciate this behavior. There was the surprising situation on this issue as the head of medicine department could not endure on the asking for premium drug, after his patient asked *"The premium drug"*, he went out the consulting room and announced to all of patients who waiting in front of the consulting room through microphone, he said *"Do not ask for "The*

premium drug". This is the hospital. It is not the drugstore. Please understand..... You do not go the market, do not buy some fish or vegetable, so do not ask for extra amount."

Although, patients used their explanatory model as the crucial source of power, their explanatory model was an ineffective source of power from the physician's perspective. In cases, that physicians agreed to prescribe what patients requested, the prescription was not written out of the understanding of patients' explanatory model. On the contrary, the requested treatment was handed over to patients because patients had their right, the legal and social authority source of power. Most physicians often said:

"At present, physicians must be afraid of patients. There are more patients' petitions particularly at the emergency service department. So not trying to have the problem with patients is the best way."

According to the chamber of power sharing in physicians' power relation, there were an asymmetric of explanatory model in the chamber. In this relation, most of the area in the chamber of power sharing was covered with the physician's explanatory model, patients then equalized the imbalanced explanatory model in the chamber of power sharing by exercising their explanatory models outside the chamber which was the decision after medical consultation on therapeutic choices by not following what physicians ordered and went to another chamber of power sharing with the next physician in the hope that this time their explanatory model would be listened or their expectation could be met. If the next visit did not end up with their expectation or in another word power was not shared, then patients would not stop touring. The chamber would thus continue with the next arrow for the next chamber.

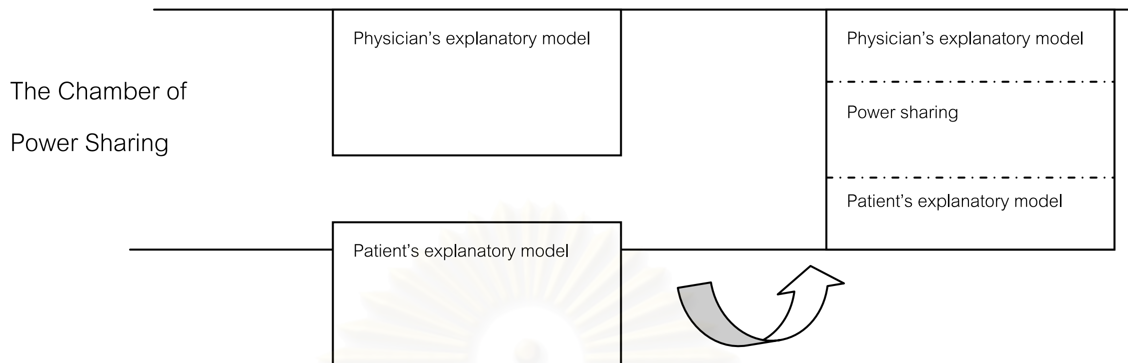

Figure 5.5 The Power Exercising of Patients' Explanatory Model in Physicians' Power Relation

Then, non-adherence and touring behavior for other physicians or treatments were most common deviant behaviors that patient used to balance the physicians' power. For example, in the case of patient who had low back pain (case 244), he wanted to have the X-Ray but the physician did not do it for him. He said *"Doctor just only prescribed the medicine, he did not do anything to me. So I must find the other place which brings me to my expectation. I want to know what is going on to me. Why could my illness not be relieved?"*.

This study revealed the very interesting point on the proper role and relation between patients and providers, the physicians' power and patients' power relation might not be the proper relation influencing the quality of care. Since the effective exchange of explanatory model between patients and physicians could not occur in both relations. As the physicians' power relation, physicians based their treatment decision on only their explanatory model, while the patients' power relation and gray relation, physicians based their treatment decision on patients' explanatory model without the exchange of the explanatory model, they acted as the authorized secretary complied by the patient's order. Patients and physicians in both relations still had their own explanatory model after they

completed the consultation session, because they did not exchange their explanatory model during the consultation. Physicians' power and patients' power relations might not be able to encourage the suitable relation between physicians and patients. As a result, this relation did not ensure the better quality of care.

6. Conclusion

This study used the concept of power and its capacity to provide more understanding about the relationship between patients and physicians. This concept was very valuable issue since it proposed the new viewpoint of explanatory model as the significant source of power that patients and physicians used to exercise their power. A key finding was that, patients were the persons who had actual power in managing their illness. They exercised their power thru their explanatory model, although their explanatory model seemed to be the silent source of power during medical consultation. The second key finding was the proposal model: *"the chamber of power sharing model"*. This model described the exchange of explanatory model between patients and physicians in each relation. Additionally, the study proposed that the effective exchange of explanatory model would occur in the symmetric power relation: the mutual relation. This finding was supported by the previous studies (Beisecker: 1990,Campbell et al.,: 2000, Mead and Bower: 2000). However, there were some different explanation among these studies, the previous studies usually described power relation between physicians and patients on the decision making model while this study pointed out on the detail of the explanatory models as the significant reason that influenced therapeutic choices behaviors both patients and physicians.

In addition, the chamber of power sharing model suggested the very useful enlightenment on the patients' non-adherence behavior. Non-adherence behavior was the consequence of the imbalanced explanatory model in the chamber of power sharing.

Patients then equalized the imbalanced explanatory model in the chamber of power sharing by exercising their explanatory models outside the chamber which was the decision after medical consultation on therapeutic choices by not following what physicians ordered and went to another chamber of power sharing with the next physician in the hope that this time their explanatory model would be listened or their expectation could be met. This finding was consistent with the previous study (Goodyear and Buetow: 2001) in that patients needed power to have their health needs met. This study stated the new view point for discussing non-adherence behavior and touring behavior. Non-adherence and touring behavior were the ways that patients used to equalize their lost power from the consultation. The results suggested that the effective exchange explanatory model under the proper role and relation between patients and providers was the solution to achieve better quality of care.

7. Limitation of the Study

Although the study provided the obvious picture of power relation between physicians and patients, there were some limitations of this research. These limitations were the result of the restricted issue of the study. Exploring the interaction between physicians and patients in clinical setting was the sensitive issue in Thai society, so it was very difficult to gather data in this setting, then, the research setting was purposively selected. The limitation of the research setting suggested a careful consideration before generalizing the results with the different type of health setting particularly on the private setting. The different type of health setting may provide the different characteristics of physicians and patients, then, power relation between the physicians and patients may dissimilarly from the results of the study.

8. Recommendations for Future Study

This study suggested that there were problems with the power sharing during the consultation which to a certain extent led to the dissatisfaction by patients as well as problems with the quality of care. To strengthen the result found by this study, further researches in this area are therefore suggested as followed:

- The similar studies can be conducted for other health personnel such as pharmacists, nurses, etc, as well as other health services setting, e.g., private clinics, community hospitals, etc.
- Different regions or groups of patients can be selected to explore the nature of their problems.
- Some action researches on the mechanisms that suggest the remedies of the problems found in this study can be introduced to find the way to increase the quality of care in the health system.

REFERENCES

Anstett,R. (1980).The difficult patient and the physician-patient relationship. Journal of Family Practice 11(2): 281-286.

Arborelius, E., and Timpka, T. (1991). Comparison of patients' and doctors' comments on video-recorded consultations. Scandinavian Journal of Primary Health Care 9(2): 71-77.

Barsky, A. J., Kazis, L. E., Freiden, R. B., Goroll, A. H., Hatem, C. J., and Lawrence, R. S. (1980). Evaluating the interview in primary care medicine. Social, Science & Medicine Part A: Medical Psychology & Medical Sociology 14A(6): 653-658.

Barrier, P. A., Li, J. T., and Jensen, N. M. (2003). Two words to improve physician-patient communication: what else? Mayo Clinic proceeding 78(2): 211-214.

Beckham, J. D. (1994). The power of primary care. Health Forum Journal 37(1): 68-74.

Beisecker, A, E. (1990). Patient power in Doctor-patient communication: what do we know?. Health Communication 2(2): 105-122.

Ben-Sira, Z. (1980). Affective and instrumental components in the physician-patient relationship: an additional dimension of interaction theory. Journal of Health and Social Behavior 21(2): 170-180.

Boesch, E. (1972). Communication between Doctors and Patients in Thailand. Part 1: Survey of the Problem and Analysis of the Consultation. University of Saar: Saarbrucken, West Germany.

Boyle, C. M. (1970). Difference between patients' and doctors' interpretation of some common medical terms. British Medical Journal 1(704): 286-289.

Campbell, S. M., Roland, M.O. and Buetow, S. A. (2000). Defining quality of care. Social, Science & Medicine 51: 1611-1625.

Cobb, A. K., and Hamera, E. (1986). Illness experience in a chronic disease-ALS. Social, Science & Medicine 23(7): 641-650.

Cohen, M. Z., Tripp-Reimer, T., Smith, C., Sorofman, B., and Lively, S. (1994). Explanatory models of diabetes: Patient practitioner variation. Social, Science & Medicine 38(1): 59-66.

Conrad, P. (1985). The meaning of medications: Another look at compliance. Social, Science & Medicine 20: 29-38.

Curry, M. D., Mathews, H. F., Daniel, I. H. J., Johnson, J. C., and Mansfield, C. J. (2002). Beliefs about and responses to childhood ear infections: a study of parents in Eastern North Carolina. Social, Science & Medicine 54(8): 1153-1165.

Davis, M. S. (1968) Variations in patients' compliance with doctors' advice: An empirical analysis of patterns of communication. American Journal of Public Heath 58: 274-288.

Emanuel, E. J., and Emanuel, L. L. (1992). Four models of the physician-patient relationship. JAMA 267(16): 2221.

Falkum, E., and Forde, R. (2001). Paternalism, patient autonomy, and moral deliberation in the physician-patient relationship: Attitudes among Norwegian physicians. Social, Science & Medicine 52(2): 239-248.

Falvo, D., Woehlke, P., and Deichmann, J. (1980). Relationship of physician behavior to patient compliance. Patient Counseling Health Education 2(4): 185-188.

Frankel, R. M. (1984). From sentence to sequence: understanding the medical encounter through microinteractional analysis. Discourse Processes 7: 135-170.

Freidson, E. (1961). Patients' views of medical practice. New York: Russell Sage Foundation.

Freidson, E. (1970). Professional dominance Chicago: Aldine.

Garrity, T. F. (1981). Medical compliance and the clinician-patient relationship: A review. Social, Science & Medicine. Part E: Medical Psychology 15(3): 215-222.

Gesler, W. M. (1999). Words in wards: language, health and place. Health & Place 5(1): 13-25.

Goodyear-Smith, F., and Buetow, S. (2001). Power issues in the doctor-patient relationship. Health Care Anal 9(4): 449-462.

Greenfield, S. F., Borkan, J., and Yodfat, Y. (1987). Health beliefs and hypertension: a case-control study in a Moroccan Jewish community in Israel. Culture, Medicine and Psychiatry 11(1): 79-95.

Gregg, J., and Curry, R. H. (1994). Explanatory models for cancer among African-American women at two Atlanta neighborhood health centers: The implications for a cancer screening program. Social, Science & Medicine 39(4): 519-526.

Hall, J. A., Roter, D. L., and Rand, C. S. (1981). Communication of affect between patient and physician. Journal of Health and Social Behavior 22(1): 18-30.

Harris, G. S., and Shearer, A. G. (2001). Beliefs that support the behavior of people with asthma: a qualitative investigation. The Journal of Asthma 38(5): 427-434.

Haug, M., and Lavin, B. (1983). Consumerism in medicine: Challenging physician authority. Beverly Hills: Sage.

Helman, C. G. (1978). 'Feed a cold, starve a fever' - folk models of infection in an English suburban community, and their relation to medical treatment. Culture, Medicine and Psychiatry 2(2): 107-137.

Helman, C. G. (1985). Communication in primary care: The role of patient and practitioner explanatory models. Social, Science & Medicine 20(9): 923-931.

Helman, C. G. (2000). Culture, health and illness: an introduction for health Professionals. 4 th ed. Great Britain: Biddles Ltd.

Heszen-Klemens, I., and Lapinska, E. (1984). Doctor-patient interaction, patients' health behavior and effects of treatment. Social, Science & Medicine 19(1): 9-18.

Hunt, L. M., Jordan, B., and Irwin, S. (1989). Views of what's wrong: Diagnosis and patients' concepts of illness. Social, Science & Medicine 28(9): 945-956.

Johansson, E. E., Hamberg, K., Lindgren, G., and Westman, G. (1996). "I've been crying my way"--qualitative analysis of a group of female patients' consultation experiences. Family Practice 13(6): 498-503.

Jones, D. R. (1979). Drugs and prescribing: what the patient thinks. Journal of the Royal College of General Practitioners 29(204): 417-419.

Kanittanan, V. (1985). Language uses in Hospital. Proceedings of the Symposium on The language uses in Biomedical Social Sciences. (78-85). Bangkok: Pisansilp Press.

Kaplan, S. H., Gandek, B., Greenfield, S., Rogers, W., and Ware, J. E. (1995). Patient and visit characteristics related to physicians' participatory decision-making style. Results from the Medical Outcomes Study. Medical Care 33(12): 1176-1187.

Kaplan, S. H., Greenfield, S., and Ware, J. E. Jr. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. Medical Care 27(3 Supplement): 110-127.

Karasz, A., and Anderson, M. (2003). The vaginitis monologues: women's experiences of vaginal complaints in a primary care setting. Social, Science & Medicine 56(5): 1013-1021.

Kavanagh, A. M., and Broom, D. H. (1997). Women's understanding of abnormal cervical smear test results: a qualitative interview study. British Medical Journal 314(7091): 1388-1391.

Kernick, D. P., Reinhold, D. M., and Mitchell, A. (1999). How should patients consult? A study of the differences in viewpoint between doctors and patients. Family Practice 16(6): 562-565.

Kleinman, A. (1980). Patients and Healers in the Context of Culture. University of California Press.

Lang, F., Floyd, M. R., and Beine, K. L. (2000). Clues to patients' explanations and concerns about their illnesses. A call for active listening. Archives of Family Medicine 9(3): 222-227.

Liamputtong Rice, P., and Ezzy, D. (1999). Qualitative research methods: A health focus. Melbourne: Oxford University Press.

Lupton, D. (1995). Perspectives on power, communication and the medical encounter: implications for nursing theory and practice. Nursing Inquiry 2(3): 157-163.

Lupton, D. (1997). Consumerism, reflexivity and the medical encounter. Social, Science & Medicine 45(3): 373-381.

Mead, N. and Bower, P. (2000). Patient-Centredness: a conceptual framework and review of the empirical literature. Social, Science & Medicine 51: 1087-1110.

Mickey C. Smith, and A. I. W. E. (1996). Social and Behavior Aspects of Pharmaceutical Care. New York : Pharmaceutical Products Press.

Nations, M. K., and Nuto, S. d. A. S. (2002). "Tooth worms", poverty tattoos and dental care conflicts in Northeast Brazil. Social, Science & Medicine 54(2): 229-244.

Nichter, M. (1980). The layperson's perception of medicine as perspective into the utilization of multiple therapy systems in the Indian context. Social, Science & Medicine. Part B: Medical Anthropology 14(4): 225-233.

Ong, L. M. L., de Haes, J. C. J. M., Hoos, A. M., and Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. Social, Science & Medicine 40(7): 903-918.

Ong, L. M., Visser, M. R., Lammes, F. B., and de Haes, J. C. (2000). Doctor-patient communication and cancer patients' quality of life and satisfaction. Patient Education and Counseling 41(2): 145-156.

Parrott, R., Burgoon, J. K., Burgoon, M., and LePoire, B. A. (1989). Privacy between physicians and patients: More than a matter of confidentiality. Social, Science & Medicine 29(12): 1381-1385.

Parsons, T. (1975). The sick role and the role of the physician reconsidered. Milbank Memorial Fund Quarterly, Health and Society 53: 257-278.

Pendleton, D., Schofield, T., Tate, P., and Havelock, P. (2003). The new consultation: Developing doctor-patient communication. New York: Oxford University Press.

Phillips, D. (1996). Medical professional dominance and client dissatisfaction: A study of doctor-patient interaction and reported dissatisfaction with medical care among female patients at four hospitals in Trinidad and Tobago. Social, Science & Medicine 42(10): 1419-1425.

Podell, R. N., and Gary, L. R. (1976). Compliance: a problem in medical management. American Family Physician. 13(4): 74-80.

Pollock, K. (2001). "I've not asked him, you see, and he's not said": Understanding lay explanatory models of illness is a prerequisite for concordant consultations. International Journal of Pharmacy Practice 9(2): 105-117.

Reeler, A. V. (1996). Money and friendship: modes of empowerment in Thai health care. Amsterdam: Het Spinhuis.

Rost, K., Carter, W., and Inui, T. (1989). Introduction of information during the initial medical visit: Consequences for patient follow-through with physician recommendations for medication. Social, Science & Medicine 28: 315-321.

Roter, D. (2000). The enduring and evolving nature of the patient-physician relationship. Patient Education and Counseling 39(1): 5-15.

Rothschild, S. K. (1998). Cross-cultural issues in primary care medicine. Disease- A-Month 44(7): 293-319.

Ruusuvuori, J. (2001). Looking means listening: coordinating displays of engagement in doctor-patient interaction. Social, Science & Medicine 52(7): 1093-1108.

Shapiro, M. C., Najman, J. M., Chang, A., Keeping, J. D., Morrison, J., and Western, J. S. (1983). Information control and the exercise of power in the obstetrical encounter. Social, Science & Medicine 17(3): 139-146.

Sirima Chiengchowvai. (2000). Pediatrist-Patient Clinical Interview. Master's Thesis. Department of Thai Language, Graduate School, Chulalongkorn University.

Sleath, B. (1996). Pharmacist-patient relationships: authoritarian, participatory, or default? Patient Education and Counseling 28(3): 253-263.

Sparr, L. F., Gordon, G. H., Hickam, D. H., and Girard, D. E. (1988). The doctor-patient relationship during medical internship: The evolution of dissatisfaction. Social, Science & Medicine 26(11): 1095-1101.

Svarstad, B. L. (1974). The doctor-patient encounter: An observational study of communication and outcome. Unpublished doctoral dissertation, University of Winconsin-Madison.

Svarstad, B. L., and Bultman, D. C.ad, B. L. (2000). The Patient: Behavioral Determinants. In Gennaro Alfonso R. (Ed.), Remington: The Science and Practice of Pharmacy, pp.1948-1956. Baltimore, Maryland: Lippincott Williams & Wilkins.

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The, A.-M., Hak, T., Koeter, G., and van der Wal, G. (2003). Radiographic images and the emergence of optimism about recovery in patients with small cell lung cancer: an ethnographic study. Lung Cancer 41(1): 113-120.

Van Dulmen, A. M. (2002). Different perspectives of doctor and patient in communication. International Congress Series 1241: 243-248.

Trostle, J. A. (1988). Medical compliance as an ideology. Social, Science & Medicine 27(12): 1299-1308.

Weiss, G. L. and Lonnquist, L. E. (1996). The sociology of health, healing, and illness. 2 nd ed. New Jersey: Prentice-Hall.

West, C. (1984). Routine complications. Bloomington: Indiana University Press.

Wright, A.L. and Morgan, W.J. (1990). On the creation of 'problem' patients. Social, Science & Medicine 30(9): 951-959.

Whyte, R. S., Van der Geest, S., and Hardon, A. (2002). Social lives of medicines. Cambridge: Cambridge University Press.

Yotin Sawangdee, Pimonporn Isarabhakdi, and Malee Sanpuwan. (2000). Problems and Suffering Experienced by Patients Obtaining Services at Health Care Facilities. Nakorn-Prapthom: Mahidol University, Social and Population Research Centre.

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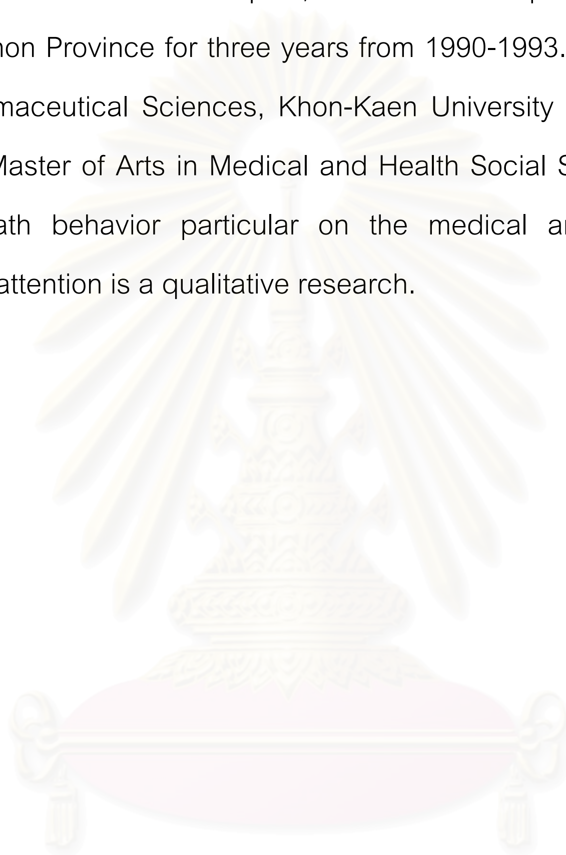

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