Pastoral Power and the Confessing Subject in Patient-Centred Communication

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Abstract

This paper examines the power relations in "patient-centred communication". Drawing on the work of Michel Foucault I argue that while patient-centred communication frees the patient from particular aspects of medical power, it also introduces the patient to new power relations. The paper uses a Foucauldian analysis of power to argue that patient-centred communication introduces a new dynamic of power relations to the medical encounter, entangling and producing the patient to participate in the medical encounter in a particular manner.

Keywords: Pastoral power, Patient-centred, Confession, Michel Foucault

From the middle of the twentieth century the relationship between the patient and physician has increasingly occupied the attention of sociologists, psychologists and social theorists. Through work of figures such as Talcott Parsons and Michael Balint, the encounter between the patient and the physician came to be questioned and critically examined. A concern that occupied initial studies of the medical encounter and continues to feature heavily in contemporary examinations is medical power, particularly when expressed through forms of paternalism. The concern with paternalism is that the patient's autonomy, liberty and personhood are diminished, resulting in ethical, legal and medical dilemmas. The primary response to the problem has been to establish laws and ethical principles to protect the patient and help guide the conduct of the physician; however, a current approach is "patient-centred" care. The patient-centred approach seeks to remodel the medical encounter to avoid the dangers of paternalism and other practices that negatively impact on the relationship between the patient and physician. Further, the patient-centred approach is not considered to be merely a precautionary but a positive way to guarantee the patient's autonomy, liberty and personhood. As will be demonstrated through a survey of the patient-centred literature, a key component of the patient-centred approach is communication. This literature suggests that through patient-centred communication the potential paternalism of the physician is diminished and the empowerment of the patient is possible.

In this paper, I will argue that while the patient-centred approach may successfully untangle the medical encounter from paternalism and create a more ethical encounter, it does so only to entangle the patient and physician in new and different forms of power relations. Drawing on the work of Michel Foucault I will argue that the patient-centred approach does not adequately address the subtle and productive way that power operates. Power in the context of the medical encounter is viewed as a possession—something that the physician holds and that the patient lacks. However, for Foucault, power is not something that an individual or group possesses and uses as a repressive force. Rather power is a relational and productive force that constructs each actor to act, think and expect certain responses from themselves and others. Using this approach, we can see that while the patient-centred approach may free the medical encounter from a paternalistic power that constructs the physician as expert and the patient as docile, in doing so it introduces the patient and physician into a new complex of power relations. This paper seeks to explore the new power relations that the patient-centred approach introduces.

Despite the widespread acceptance of the patient-centred approach, "patient-centredness" is a slippery concept that resists a distinct definition. Jozien Bensing suggests that patient-centred medicine is, "a global concept, that everybody will recognise in its overall meaning, but yet can have a quite different connotation for different people when going into more detail"(Bensing 2000, 21). Further, Julian Hughes et al. survey the literature on client-, family-, patient-, person-, and relationship-centred care noting, "any single paper relating to a type of centredness is unlikely to encompass all of these themes"(Hughes et al. 2008, 460). Nicola Mead and Peter Bower suggest a more pragmatic approach to the definitional ambiguity arguing, "the concept of 'patient-centredness' is increasingly regarded as a proxy for high-quality interpersonal care"(Mead and Bower 2000a, 71). From these sources it is evident that there is a degree of theoretical haziness surrounding the concept of patient-centredness and ambiguity over the patient-centred approach to medical practice.

Although the concept of patient-centred care has emerged relatively recently commentators suggest that it is not strictly a new approach but the retrieval of a buried thread that travels through medical practice back to the Hippocratic physician. Medical historian Roy Porter describes the Hippocratic doctor as presenting themselves as "faithful friends to the sick" (Porter 2003, 30). The historic ideal of the Hippocratic "faithful friend" is an element of medical practice that the patient-centred approach seeks to restore. Moira Stewart et al. draw on this historical thread, suggesting that "the principles of patient-centred medicine date back to the ancient Greek school of Cos, which was interested in the particulars of each patient" (Stewart et al. 2000, 796). The attraction of the Hippocratic tradition for patient-centred care can be seen in the way that it provides historical legitimacy and an authoritative avenue through which the biotechnological approach can be supplemented with medical humanism. The veracity of this account aside, the Hippocratic tradition places the patient-centred approach at the birth of Western medicine, suggesting that prior to the overcrowding of the medical encounter with medical technology, the biomedical model, and laboratory tests there was meeting between the patient and the physician.

Further to the restoration of the physician as the Hippocratic faithful friend to the sick, the patient-centred approach seeks to reinstate the patient as a person at the centre of medical care, not as mere organism that has succumbed to a particular pathology. Debra Roter suggests that through the dominance of the biomedical model of medicine and medical technologies there has been a "loss of

focus on the patient as person" (Roter 2000, 5). The biomedical model places strong emphasis on the pathology and physiology of the patient, which implicitly excludes the patient from the encounter due to the highly specialised and technical knowledge required. Given the combination of a paternalistic attitude to the medical encounter and an overemphasis on the biomedical approach, critics suggest that the patient has not only lost their autonomy, but they are not respected as persons.

Mary Beach et al. argue that paternalism results in "the systematic devaluing of patients" (Beach et al. 2005, 337). Further, Beach et al. suggest that it is not enough to treat the patient as autonomous; rather, the physician needs to regard, "the patient as having inherent value ... treating each patient with respect and dignity" (Beach et al. 2005, 337). The concern that the patient-centred approach has with the paternalistic medical encounter is that by marginalising the patient's autonomy and liberty the patient is not awarded the respect and dignity deserving of a person. It is suggested that a central reason the patient has been marginalised is that as a result of the emphasis on pathology and physiology in the biomedical model the patient is no longer required to speak in the medical encounter. Instead their biology—tissue, blood, urine—speaks for them, reducing the patient to a silent and passive organism to be investigated.

The literature on the patient-centred approach seeks to counter this by emphasising the importance of patient-centred communication. The emphasis on communication can be seen in the title of an editorial for a special edition of the journal *Patient Education and Counselling* on communication in health care: "Communication: The royal pathway to patient-centred medicine" (Bensing et al. 2000). The editors argue that this title crystallises the message of the entire special issue on communication. Christina Gillis expands on the importance of communication arguing that the physician needs "to listen to the patient, not as a bundle of symptoms but as a whole person" (Gillis 2008, 7). The implication is that through patient-centred communication the devaluing effects of the paternalistic medical encounter, such as disrespect and marginalisation of the patient, can be avoided. Further, it is argued that not only is listening to the patient the best approach to the medical encounter ethically, but patient-centred communication assists in the physicians moving from the biomedical model to the "biopsychosocial" model, which several commentators suggest is best practice medically. Thus patient-centred communication is central to the promotion of both the best ethical and medical practice. However, in addition to promoting ethical and medical benefits for the patient and physician relationship, I will show that patient-centred communication introduces the patient and the physician into new webs of power relations that incite each agent to act and think in particular ways. Before this argument can be made, however, a closer analysis of literature on patient-centre communication is required, particularly the complex interaction of the goals of patient-centred communication as an ethical end and a medical means to diagnosis.

The entanglement of the ethical and medical objectives of patient-centred communication can be seen in Mead and Bower's suggestion that "in order to understand illness and alleviate suffering, medicine must first understand the personal meaning of illness for the patient" (Mead and Bower 2000b, 1088). This emphasises the need for patient-centred communication in the ethical objective of respecting the patient's personhood and individuality, as well as the vital importance patient-centred communication has for the medical objective of diagnosing and alleviating illness. The above-mentioned editorial also demonstrates the convergence of the ethical and medical objectives of patient-centred communication in suggesting that "Physicians can only learn about possible

diseases and their impact on the patient by listening to the patient's story. That gives power to the patient" (Bensing et al. 2000, 2). This highlights a disavowal of the biomedical model in diagnosis, suggesting that the physician is at the mercy of the patient's story to be able to produce a correct diagnosis. Further, it is held that in the telling of their story the patient is empowered and achieves recognition as a person. Both of these examples serve to highlight the convergence of the objectives of patient-centred communication.

The biomedical approach to communication is regarded as being physician—or disease-centred, marginalising the lived experience of the patient. Roter describes the biomedical approach suggesting that "the practice of interviewing patients [derived] from a written outline designed around a series of yes–no hypothesis testing questions" (Roter 2000, 6). The point here is that this approach to communication, sometimes called doctor-centred but better described as pathology-centred, aims at determining the pathological condition of the patient, and thus only seeks to engage with the patient on topics that serve that end. In Roter's description there is a strong intimation that this approach to communication follows the scientific method and is only interested in facts. Anthony Stevenson goes further than Roter in arguing that "the goal of the doctor-centred consultation is to make an 'objective' diagnosis—an approach characterised by the interruption of the patient's story and closed biomedical questioning" (Stevenson 2002, 1104). Roter and Stevenson highlight the problems with the biomedical or doctor-centred approach to communication as being overly scientific and as reducing the patient to a silent biological mass. Whereas the medical and ethical objectives of the patient-centred approach converge, Roter and Stevenson suggest that there is necessary divergence between the medical practice and ethical care in the biomedical model. They argue that in adopting a scientific approach to the medical encounter the patient is necessarily marginalised.

As mentioned, the remedy for this situation, according to the literature, is patient-centred communication. Paul Kinnersley et al. argue against the biomedical approach in emphasising the importance of communication for diagnosis, suggesting, "the patient is more valuable for achieving an accurate diagnosis than either the physical examination or subsequent investigations" (Kinnersley et al. 1999, 711). Stevenson suggests that in the encounter between the patient and the physician, "the fundamental requirement of this relationship is communication: a patient's story and a physician's response" (Stevenson 2002, 1103). In both examples, communication is the key to best medical practice and necessary for the recognition of the patient as a person. It is suggested that through a shift in the mode of communication—from doctor- to patient-centred—it is expected that the patient will be respected as an autonomous person capable of sharing responsibility and power in the medical relationship. In addition, patient-centred communication addresses the social and psychological elements that contribute to the patient's wellbeing, an understanding of which assists the patient and physician in diagnosis and treatment.

Patient-centred communication has the goal of liberating the patient from the domination and control of the paternalistic doctor and authoritative medical practice. Importantly, the communicative act is also viewed as being an ethical good in itself. The literature suggests that patient-centred communication enables the patient's best interests, both medically and ethically, to be served within the medical encounter. However, while patient-centred communication serves the interests of the patient, it does not remove or buffer the medical encounter from power relations that can impact on the autonomy, liberty and personhood for the patient. Rather, patient-centred

communication is the very avenue through which the patient is exposed to new forms of power relations. The patient-centred medical encounter is itself part of medical power and not outside of it. By emphasising the importance of communication, a patient-centred approach commits the patient and physician relationship to a further complicated and enmeshed power relationship that operates in an increasingly subtle manner. By examining the patient-centred relationship through Foucault's work on pastoral power the complexity of the patient-centred relationship will be made more evident. The next part of the paper provides an outline of what Foucault means by power, with particular emphasis on pastoral power. I will argue that while patient-centred communication may empower the patient and assist the physician in diagnosis, rather than liberating the patient from the threat of medical power, patient-centred communication multiplies the avenues and capillaries through which power can affect the patient.

Power is commonly understood as something that a particular agent does or does not possess. This conception is reflected in our everyday language when we say that someone "has the power to ..." or that they "lack the power". Power is seen as something quantifiable and something that can be held. As noted earlier, the underlying ethical concern of the patient-centred approach is medical power, especially in so far as it is expressed in the form of paternalism. It has been demonstrated that patient-centred communication is a central component in achieving the ethical objectives of the patient-centred approach. However, because the patient-centred approach understands medical power as an entity to be possessed rather than as a relation, it is blind to the new forms of power relations that the medical encounter is exposed to through patient-centred communication. In what follows, I will demonstrate the way that the patient-centred approach views power, then discuss Foucault's conception of pastoral power, and finally I will argue that patient-centred communication introduces the patient and physician into a pastoral relationship in which power subtly induces the patient to think and act toward their self in a particular way.

The literature on the patient-centred approach generally conceives of power in the common way, as a possession and a repressive force. In discussing the decision-making process in the patient-centred approach Stevenson says, "egalitarianism should not mean total abdication of power" (Stevenson 2002, 1105). Likewise Roter argues that the greatest benefit for patient is, "neither physician dominance or total abdication of power" (Roter 2000, 13). Apart from the rub between physician authority and patient autonomy, the interesting point in both these statements is the use of "abdication". Suggesting that the physician could abdicate their power implies that power is something that the physician possesses. Further, the power of the physician is considered to be repressive—it can dominate the patient. The choice of "abdication"—with its monarchical connotation—is fitting, as Foucault describes this view as the "sovereign" model of power. Foucault says, "when one speaks of power, people immediately think of a political structure, a government, a dominant social class, the master and the slave, and so on" (Foucault 2000, 291). Further, Foucault argues that this model, "presupposes the individual as a subject of natural rights or original powers" (Foucault 2000, 59), and if these rights and powers are impinged upon, dominated or controlled by an external source such as the State or another individual, then the State or individual is exercising its power illegitimately. In the general context of the medical encounter, the main approach to protecting the patient from the threat of medical power has been through the patient rights movement. By securing the moral, if not legal, rights of the individual—such as autonomy—it is argued that if a power impinges on those rights then the power is operating in an illegitimate or illegal way depending on the context. While the patient rights movement has been beneficial in

protecting and restoring the rights of the patient, it is bound to a particular understanding of the way that power operates and, as such, has limited application in scenarios where power operates in a different way. Thus, the patient-centred approach, which operates under a sovereign conception of power, is unable to see or address the relational operation of power through patient-centred communication.

In *Discipline and Punish* and *The Will to Knowledge*, Foucault outlines the shift from sovereign power to pastoral power—a power that he argues is productive and relational rather than repressive. While sovereign power is possessed by an individual and operates in a clear and visible manner, pastoral power produces the individual and operates in a subtle manner so that it is not necessarily known how, when or by whom power is exercised. Foucault argues that power "comes from everywhere ... [it] is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society" (Foucault 1998, 93). Foucault uses several different names for this productive form of power: disciplinary power, biopower, governmentality and pastoral power. These terms are not synonymous, but nor are they entirely distinct. This paper will focus on pastoral power in examining the operation of power in patient-centred communication.

Foucault develops the concept of pastoral power by drawing on the Judeo-Christian tradition of the shepherd caring for the flock. The pastor, unlike a prophet, fortune-teller or shaman, "designates a very special form of power" (Foucault 1983, 214). Foucault notes four unique characteristics of pastoral power: it seeks to deliver the individual to salvation; it is prepared to sacrifice itself for the life of the flock; it is equally concerned for the one as for the many, the part and the whole; it requires knowledge of the conscience, the inside of people's minds (Foucault 1983, 214).

Foucault notes that as the context changes in which pastoral power operates the four characteristics take on different meaning. This is most clearly evidenced in the first characteristic, salvation. In the original context of the shepherd tending the flock, salvation could be taken for safe and abundant pastures; in the Hebrew context it refers to salvation from Egyptian slavery and deliverance to the promised land; in the Christian context salvation is found through Jesus Christ and deliverance to the hereafter. However, Foucault notes that in the eighteenth century pastoral power was combined with the political practice of governing people and the objective of salvation transformed to "health, wellbeing ... security, [and] protection against accidents" (Foucault 1983, 215). At this point, the life of the subject and the population is grasped by pastoral power and directed toward particular ends. As the health and wellbeing of the population becomes the target and objective of Western politics, the individual subject is increasingly caught up in various power relations directing them to such ends.

The sacrificial characteristic of pastoral power differentiates pastoral power from sovereign power. As outlined in the St Peter's First Epistle, the shepherds of God's flock are to be "eager to serve; not lording it over" those entrusted to their care (1 Peter 5:3, New International Version). The pastor is to be an example that the individual can follow. While sovereign power "demands a sacrifice from its subject to save the throne", the pastor must be prepared to sacrifice "for the life and salvation of the flock" (Foucault 1983, 214). Thus, the relationship between the pastor and the individual has an intimacy that is foreign to the relationship between the sovereign and the subject. Through this intimate relationship the pastor is able to direct the individual more delicately, but also with greater

control. A further characteristic of the pastor is the concern for the one and the many, the individual sheep and the flock as a whole. Extending beyond the Christian context, Foucault argues that this practice developed into the governance of population, resulting in a need for the State to gain knowledge about the individual and his desires, thoughts and activities. Through pastoral power, the State became a "modern matrix of individualisation" (Foucault 1983, 215). The process of individualisation is the way that pastoral power produces the individual to think and act in a particular way. As pastoral power multiples and disperses throughout society the individual is surrounded by power relations resulting in the production of the individual. However, the production of the individual is not to be thought of as akin to the production of identical objects through a particular mould. Rather, the individual is wholly permeated by power through a variety of different relationships that produce the individual as the flow of the river produces conglomerate rocks.

The final characteristic of pastoral power is the most significant aspect for this paper. This is the need to know the secrets hidden within the individual, secrets that are hidden from both the pastor and the individual. They are hidden from the pastor because the individual has yet to utter them, and hidden from the individual as the pastor has yet to interpret their meaning and reveal their truth. Foucault argues that the technique of the confession is central to the exercise of pastoral power. Implicit in the technique of confession is the belief that truth hides and is secret in nature, yet it desires to reveal itself, but only by being discovered and coaxed out of its secrecy. Foucault argues, "it seems to us that truth, lodged in our most secret nature, 'demands' only to surface; that if it fails to do so, this is because a constraint holds it in place" (Foucault 1998, 60). It is the role of the pastor to remove the constraint and liberate truth. A further important reason why the pastor figure needs to hear the confession is that the individual is unable to understand or interpret the significance of its meaning. Through the process of having the individual transform their hidden thoughts and desires into discourse, the pastor is able to reveal the truth that up until that time remained hidden within and from the individual. The importance of confessing to the pastor is that they alone can reveal the truth about the individual. Foucault argues that the pastor figure "was not simply the forgiving master, the judge who condemned or acquitted, he was the master of truth" (Foucault 1998, 67). Thus the pastor, according to Foucault, has a hermeneutical role of hearing and interpreting the confession such that they can guide the individual toward self-understanding.

Foucault argues that during the eighteenth century the value of the confession as a technique for producing truth led to its expansion and use in areas such as, "justice, medicine, education, family relationships, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites" (Foucault 1998, 59). The expansion of the confession as a technique for producing the truth can be seen in the earnest and serious disciplines of law and psychoanalysis, but also in the popular media with programs oriented around either celebrity or "reality" personalities confessing their inner secrets and thus revealing their true self. Western society has "established the confession as one of the main rituals we rely on for the production of truth" (Foucault 1998, 58) and, as such, certain institutions and relationships have employed the technique of the confession to elicit truth, or desired information.

Medicine—through psychiatry and psychoanalysis in particular, but the profession in general—has operated with rituals of confidentiality and secrecy surrounding the consultation. Through the shift from the pastoral confession to a general confession, the need for expert interpretation became

pressing. Whether in the relationships between teacher and student, physician and patient, or lawyer and criminal there is a process of confession and an expectation that the "expert" will interpret the significance and the meaning of the confession. Dreyfus and Rabinow argue that through the creation and establishment of various "experts" the individual is led to believe that "one can, with the help of experts, tell the truth about oneself" (Dreyfus and Rabinow 1983, 175). Thus, in the pastoral power relation the individual is manufactured to believe that to know the truth about oneself requires them to subject oneself to examination and expert elicitation and interpretation.

I will argue that the confession is used in patient-centred communication as a means for the physician to know the patient and for the patient to know their self. The technique of confession is used in patient-centred communication as a means to achieve the ethical and medical objectives of the patient-centred approach. Like the confession that takes place between the priest and the penitent or the psychoanalyst and the patient, the process of the patient speaking in patient-centred approach is viewed as good in itself, as the process of speaking in the medical encounter affirms the patient's personhood. Further, with the shift from the biomedical model to the biopsychosocial model the confession not only becomes ethically good for the patient but medically necessary for the physician to diagnose and determine the possible occurrence of disease. In this way, patient-centred communication echoes the pastoral power technique of confession and, as such, the patient is exposed to new forms of power relations that cannot be circumvented through an emphasis on rights.

It may be argued that the extension of Foucault's analysis of pastoral power from the context of the psychiatrist to the medical physician is forced. The practice of confession seems quite obvious in psychiatric practice but less so in the medical encounter. This objection may hold true for the biomedical model or doctor-centred approach, which is primarily interested in the biological organism and its own testimony about itself through various tests. However, the patient-centred approach requires the patient to speak as an expression of their personhood, and needs the patient to speak in order to access the psychological and the social elements of the biopsychosocial model. It is also worth noting that much of the early literature on the patient–physician encounter that sought to provide new models of relating was written by physicians with backgrounds in psychology. However, while the extension from psychiatrist to physician may be feasible it still needs to be argued that patient-centred communication operates in a similar manner to the technique of the confession in pastoral power. For the confession, as Foucault understands it, to be something more than a general discourse it needs to be made in the presence of a pastor figure. That is, it is not so much the content of the confession but the way in which the dialogue proceeds. Highlighting certain shared characteristics will demonstrate the way that pastoral power and the technique of the confession operate in patient-centred communication.

In *The Will to Knowledge* Foucault argues that an essential aspect of the confession is that it takes place before an authoritative presence. He says:

> One does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile. (Foucault 1998, 61)

There is a tension in the literature on the patient-centred approach between a desire to recognise the patient's knowledge and the fact that the physician holds particular knowledge establishing them as an authority. Mead and Bower argue that in contrast to the history of patient marginalisation, "patient-centred medicine promotes the ideal of an egalitarian doctor–patient relationship, differing fundamentally from the conventional 'paternalistic relationship'" (Mead and Bower 2000b, 1089). According to Stevenson, an egalitarian relationship operates such that the "doctor and the patient are equal knowers, who by communicating together create shared expertise" (Stevenson 2002, 1104). Despite the desire for the patient-centred relationship to be an egalitarian meeting of shared expertise, there is a strong tension between the physician's authoritative knowledge and the patient's experiential knowledge. As the patient approaches the physician, the physician will always be an authority and hold greater expertise in medical matters. This is not to deny the patient's role, but the relationship is always in favour towards the physician's authority and expertise as the patient implicitly recognises the physician as an authority and expert by making an appointment to meet with them. Thus, in the patient-centred approach it can be seen that the physician is an authority, albeit an uncomfortable one, that (to return to Foucault) "requires the confession, prescribes and appreciates it". The confession is required for the physician to share in the patient's expertise, it is prescribed for the physician to able to reach an accurate diagnosis, and finally it is appreciated as an expression of the patient's personhood and autonomy.

Patient-centred communication, like the confession, is required by the physician to diagnose illness and intervene in the patient's life. With the shift from the biomedical to the biopsychosocial model the cause and locus of illness is held to be anywhere in the patient's life, from the trivial to the significant. Like the early Christian pastor who was concerned with the ubiquitous influences of the flesh and the devil, the physician needs to hear the details of the individual's life so as "to give counsel and render a diagnosis" (Foucault 2000, 84). Through patient-centred communication, in which the patient is encouraged to tell their story, the physician is able to isolate particular behaviours of the patient that could result in disease or illness. What may seem mundane, irrelevant or harmless to the patient may hold deep significance for the physician. Kurtz et al. emphasise the imperative for the physician to carefully listen to the "story" of the patient, otherwise the physician "might well miss clues that could be important in helping the patient with their problem" (Kurtz et al. 2005, 53).

In *The Will to Knowledge*, Foucault traces the history of the problem of sex and the way that sexuality came to be considered as a ubiquitous yet hidden force that determined the nature of the individual and had an effect on the population. Sexuality thus became an object of concern for the State, police and medical practice, particularly psychiatry. Dreyfus and Rabinow describe that "for the psychiatrist, sexuality penetrated every aspect of the pervert's life; hence every aspect of his life must be known" (Dreyfus and Rabinow 1983, 173). In our present society the determining factors of health are, like sexuality in the nineteenth century, everywhere yet hidden. While the veracity of reports about caffeine curing Alzheimer's (Devlin 2009), excessive mobile phone use causing brain tumours (Wallop 2007), or broccoli preventing cancer (AAP 2008) can be questioned, it is undeniable that health has penetrated everyday life in ways unthought of in previous generations. From ergonomic office furniture to the entry of omega-3 and antioxidants into marketing discourse, health has penetrated every aspect of the patient's life, hence every aspect of the patient's life must be known in order to secure the end of health. Further, as the truth of the patient's health resides in

their private and social life—their bio-psycho-social existence—the physician must enquire of the patient and encourage them to reveal their practices, habits and behaviours.

Through patient-centred communication the patient is produced to expect to speak and be heard. The patient approaches the medical encounters expecting and desiring to confess. Through seeing others confess, and being told of the need and benefits of confession, we, as a society, have become accustom to the ritual—so much so that a certain pleasure is to be had in analysis; a narcissistic delight in hearing our words interpreted. Foucault evocatively describes the pleasurable aspect of confession and the delight of having one's words interpreted in saying:

> All the stories told to oneself and to others, so much curiosity, so many confidences offered in the face of scandal, sustained—but not without trembling a little—by the obligation of truth; the profusion of secret fantasies and the dearly paid right to whisper them to whoever is able to hear them. (Foucault 1998, 71)

Holmes and O'Byrne, in their research on the confession in the context of sexual health interviews, note that the patient desires to confess, as they believe that the content of their confession "may help resolve threatening long-term disorders" (Holmes and O'Byrne 2006, 434). They continue in saying that "the speaker wishes to divulge and will seek out a listener in an attempt to calm anxiety and learn/validate their own sexual veracity" (Holmes and O'Byrne 2006, 434). In the situation described by Holmes and O'Byrne the patient is caught in a bind between wishing to divulge and withholding the confession due to fear or embarrassment. However, the desire to know the truth about their self, what Foucault calls the "obligation of truth" wins out and leads the patient to confess. Confirming this, Stevenson notes that patients draw satisfaction from having their confessions heard, noting: "Satisfaction was significantly higher for interactions involving attention to psychosocial health than for other consultations" (Stevenson 2002, 1105). The patient expects the physician "to resolve their concerns, reduce anxiety about possible diagnoses and outline management, if any is needed" (Royal Australian College of General Practitioners 2006, 31). Through patient-centred communication, the patient is thus constructed to confession; there is an expectation to speak and belief that in speaking, anxiety will be relieved. No longer does medical power silence the patient; it now creates them to speak. The argument being made here is not that patient-centred communication is just as bad or domineering as previous forms of the medical encounter. Rather, patient-centred communication opens the patient up to new power relations. Patient-centred communication extends medical power from the clinic and the biological body to the home, the bedroom, the kitchen and the bathroom, to the everyday life of the patient.

As discussed, patient-centred communication encourages the patient to speak; a silent and passive patient is the patient of the old biomedical model. In the patient-centred approach, the patient needs to be vocal; in speaking, the patient expresses power and in listening, the physician acknowledges that the patient is valued and has unique knowledge. However, in analysing patient-centred communication through pastoral power it is clear that the patient is not free from medical power but that the patient has entered into a new set of power relations. As Foucault argues, "liberation paves the way for new power relationships" (Foucault 2000, 284). While patient-centred communication may have liberated the patient from one form of power relations, namely the paternalism of the doctor-centred approach, it opens them up to new forms. To keep silent in the

patient-centred encounter is perhaps as difficult as it was to speak in the doctor-centred encounter. For as Stevenson stresses, the silent patient stands in opposition to the patient-centred approach:

> The essence of the patient-centred method is to try to enter the patient's world and see the illness through their eyes. The patient must reveal their experiences, feelings, fears and expectations ... The key skills are to listen and facilitate 'story telling'. (Stevenson 2002, 1104) (my italics)

Thus there is an imperative for the patient to speak, to reveal their innermost feelings. Comparing the above quote to Foucault's description of the role of the confession in pastoral power is striking. Foucault writes, "this form of power cannot be exercised without knowing the inside of people's minds, without exploring their soul, without making them reveal their innermost secrets" (Foucault 1983, 214). "This form of power" could easily be replaced with "the patient-centred method" making Foucault's description of pastoral power read almost identically to Stevenson's description of the patient-centred method. Thus, like the role of the confession in pastoral power as a technique to engineer the individual as a confessing subject, it can be seen that patient-centred communication operates in a very similar way in the patient-centred approach to produce a subject that desires, or recognises as necessary, the process of revealing their innermost feelings and experiences, both as an expression of their personhood, but also for diagnostic purposes.

Mead and Bower support Stevenson's emphasis on the necessity of the patient's story when they argue that "in order to understand illness and alleviate suffering, medicine must first understand the personal meaning of illness for the patient" (Mead and Bower 2000b, 1089). In order for the physician to obtain the "vital" information about the patient's life the patient needs to be allowed, encouraged and asked to speak. The patient-centred literature seeks to include the patient's social and psychological life into the medical relationship as a way of improving diagnosis and treatment, but also as an acknowledgment that the patient is more than a biological entity. Thus it is implied that by adopting the biopsychosocial model the patient's humanity will be restored. However, this also provides an avenue into the patient's life away from the medical interview. A strong theme runs through the literature on the patient-centred approach that regards the patient's confession of intimate details as a positive step forward for diagnosis and patient power. Due to the marginalisation of the patient's voice in the past, the encouragement for the patient to speak and the importance placed on their words in the patient-centred approach is viewed as a positive development of the patient's role in the patient and physician relationship. Roter emphasises this in saying:

> The patient's ability to tell the story of his/her illness holds the key to the establishment and integration of the patient's perspective in all subsequent care. Telling of the story is the method by which the meaning of the illness and the meaning of the disease are integrated and interpreted by both the doctor and patient. (Roter 2000, 8)

The act of the patient telling their story—confessing—has come to be viewed as a good in itself: it recognises the patient as a human, not a diseased entity, and it integrates the patient's meaning of the illness into the approach to care. In the context of the patient-centred approach, communication is considered to be the key for the patient to express their autonomy, their power and to reclaim their humanness in medical practice. However, it has been argued that this key to patient autonomy and personhood also opens the door to a new web of power relations that produce the patient to

become a confessing subject. Jeffrey Bishop argues that the patient's story "becomes a tool that gains the trust of a patient, a more subtle tool because it masquerades as authentic relationship" (Bishop 2008, 19). Bishop suggests that the relationship between the physician and patient is less about empowering the patient and more about control and mastery over them. This is a rather cynical reading of patient-centred communication. However, Bishop is quick to acknowledge that a trustworthy physician would not intend to manipulate the patient, but because both patient and physician are caught in the confession game of pastoral power both are blind to the productive force involved. While this paper has focused on the production of the patient, there is another story to be told of the way that the physician is also produced through a web of power relations. The patient desires to confess because they have been produced to do so and the physician believes that it is necessary for patient empowerment and diagnosis and so encourages the patient to confess.

The goal of patient centred communication is to redress the medical domination that has silenced the patient in the past and reduced them to their biology. It has been shown that through an emphasis on communication the patient-centred approach introduces the patient to new power relations that bare resemblance to the technique of the confession in Foucault's analysis of pastoral power. Bishop argues that such an approach to the medical encounter "promises intimacy, but is really about control" (Bishop 2008, 21). However, the argument of this paper is not that the patient-centred approach is "just as" controlling, dominating or oppressive as the previous paternalistic encounter; nor is it that the patient-centred approach is control masquerading as intimacy. Rather the argument is that even if the patient-centred approach does empower the patient through communication, the patient is still held in a matrix of power relations that form and mould the patient to think and act toward their self in a particular way. Through encouraging the patient to confess, the physician is not openly manipulating the patient; rather, there is an implicit organisation and production of the patient to participate in the medical encounter in a particular manner. This is not to suggest that the patient-centred approach is sinister or misleading; the patient-centred approach, with the emphasis on communication, is a new but different set of relations and strategies that surround the medical encounter. Thus through the very liberation from one form of power the patient is exposed to new forms of power relations.

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