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Negotiating a strategic performance in the biopsychosocial interface

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He saw a soft, suffering expression which was intelligent and touching: she seemed to him altogether graceful... and simple; and he longed to soothe her, not with drugs, not with advice, but with simple, kindly words.

Anton Chekhov, The Doctor

Introduction

When I learned that Aris brought Jane to the hospital after an attempted abortion, my personal struggles became clear to me. As an older cousin of Aris, how would I approach him? Would I be empathetic with him as he goes through this emotionally-laden experience in his relationship with his girlfriend? Would I reprimand him for his actions? Would I inform his parents? As a doctor and employee in the hospital they went to, would I facilitate Jane's admission and therapy? Would I blame them for resorting to an unhealthy abortion technique? Was it time to be an advocate for women's rights or should I intervene for an unborn niece or nephew? As a consultant to Mitch, Jane's receiving doctor, should I suggest any management approach or not? Would I be compassionate or stern, helpful or sarcastic, participative, tolerant or distant? Is it purely Aris and Jane's concern or is it my own, too?

It is not difficult to imagine that when a doctor meets a client, the tableau is more than medical in nature. The interface is "an interpersonal activity in the pursuit of rational healing" (Puustinen, Leiman and Viljanen 2003). It is, in fact, a biopsychosocial interface (Engel 1997). Through this paper, I intend to examine how doctors execute an interface

with clients in a setting that highlights constructed communication structures, power, experiences, and sense of right and wrong. When the client is an acquaintance and is not really the patient, when the doctor is accountable to the client's older cousin who is also a doctor, when the setting calls for personal values and significant emotions to come into play, how do the actors cook up a scene?

I will explore the characteristics of the biopsychosocial interface and argue, towards the end of this paper, that a process of negotiation is the appropriate model for such an interface. In the course of my exploration, I will be informed by Mikhail Bakhtin's theory of language (1986), Pierre Bourdieu's (1991) and Michel Foucault's concepts of power, and views on the doctor-patient relationship as elucidated by Barry Bub (2004), Iona Heath (2001), Richard Evans (2003) and Raimo Puustinen (2000). The discussion will be limited in the sense that I only have secondary sources of Bakhtin's theoretical stretch. Nevertheless, I find Bakhtin's concepts of "dialogue," the "monologic," and "heteroglossia" very appropriate in providing a theoretical base for some portions of this paper.

My discussions will spring from the narratives of Aris and Mitch (not their real names). Aris is my cousin, a 22-year old college student. Mitch, in her early thirties, is a resident-in-training in the same clinical department in the hospital where I work as a consultant. Both of them consented that I write about their experiences. I interviewed Aris and Mitch separately, although each of them knew that the other's account would eventually be considered in constructing this paper. Aris's girlfriend, Jane (not her real name, too), would have been an equally important person who could shed light upon this paper, but I deeply regret not to have interviewed her because of her unavailability. She broke up with Aris before I interviewed him and has been very difficult to contact since then. Her experience is, therefore, mentioned here only briefly from the accounts of Aris and Mitch.

I planned for this paper to be a phenomenology of the biopsychosocial experience. I tried to execute this inquiry as closely as possible to the principles of phenomenological inquiry and writing as described by van Manen (2002). In writing the narratives, I took the liberty of rearranging pieces of each of the accounts in order to string through two meaningful versions of a single encounter.

It will be clear later that I was actually a virtual participant in this encounter, so while I inch through this phenomenological inquiry, I will

insert my own lived experiences and feelings, as I deem it appropriate. At any rate, I will not deny that my act of (re-)writing the narratives of Aris and Mitch already smears the narratives with my own interpretations of their lived experiences and feelings and my own construal of their attendant meanings. I am a married male and a family physician by profession. I am aware that my sex and my medical training could well influence the ideas that I articulate through this paper. And then again, influencing the meaning of the text is really what phenomenological writing is all about (van Manen 2002).

The full-length narratives of Aris and Mitch are at the end of this paper. I will constantly quote from the narratives as I write this paper, but in a manner whereby the chronology of the events will probably not be given much attention. And so for purposes of leveling-off, here is the synopsis of the case.

Synopsis

Aris brought Jane, his girlfriend, to the hospital because of an excruciating abdominal pain. By the usual history-taking skills of Mitch, the admitting doctor, she found out that Aris talked Jane into taking an abortifacient pill after they learned that she was pregnant. I was informed by Mitch of the incident through text messages. Aris talked of dissatisfaction with the way they were received by hospital personnel and about feelings of not being treated well during the course of the consult. He also discussed about how he regarded his values, especially around the time that he was contemplating an abortion for their baby. Mitch talked of how personal upbringing, previous training and conditions in the workplace shape the dispositions of doctors and eventually determine the behavior of doctors in their interface with clients. She also related how she preached to Aris about what he has done.

Shifting locations of the strategic platform

By the time I knew from Mitch through a text message that Jane was in the emergency room with Aris, they had already dealt with each other lengthily as doctors and clients are wont to do. As Aris remembers it,

> When we arrived at the hospital, Jane was not given something for the abdominal pain right away. There were lots of questions during

> the initial interview. I knew Mitch, the doctor who interviewed me first. You introduced her to me before. But she did not recognize me that time. She asked a lot of questions.

The person's situatedness in a physical space imposes a role that is to be performed. The moment Aris entered the hospital with Jane, he was forced to temporarily set aside his acquaintanceship with Mitch, because now, he is a hospital client bringing an ailing patient, and Mitch is his doctor. Upon the commencement of an interface, actors situate themselves in a strategic platform where they can engage in a conversation appropriate to the roles that they play. This is equivalent to Bakhtin's concept of a "dialogue" (Klages 2001). It is characterized by a "language use from a point of view, in a context, to an audience" (Lye 1998). Given a certain human interaction, "everything anybody ever says always exists in response to things that have been said before and in anticipation of things that will be said in response. We never, in other words, speak in a vacuum. As a result, all language (and the ideas which language contains and communicates) is dynamic, relational and engaged in a process of endless redescriptions of the world" ("Dialogic" 2005). The succeeding scenes were carried out in a medicalized fashion, and the sole concern of the agents is the relief of Jane's abdominal pain. According to Mitch,

> he asked me first where to bring patients with abdominal pain. When I learned that the patient was, in fact, not him but his girlfriend who was with him, I immediately investigated to establish pregnancy. When I have made a probable diagnosis of pregnancy, I told Aris that I was the triage doctor, not the admitting physician for Obstetrics, and that they may go to another doctor in the emergency room for his patient's condition.

The strategic platform is somehow elusive at times. Mitch was running through the "medical education" part of the interview and Aris perceived the conversation to be off-tangent, as can be gleaned from his expression of confusion:

> They kept on telling me that Jane could die because of what I gave her. Why would hospital people say that? I brought Jane to the hospital precisely because I wanted her to be relieved of her complaints.

The strategic platform is also characteristically restless, although there is an element of personal choice that informs the decision as to where the actors would situate it. Aris's "re-introduction" to Mitch was obviously his attempt to relocate the platform from the doctor-

patient viewpoint to one wherein he would be friends with Mitch. It is "strategic" in the sense that it aims for the best location whereby personal ends can be met. According to Aris,

> I didn't have enough money at that time, so when I had to spend for some tests to be run, I re-introduced myself as your cousin to Mitch... [M]y introduction worked. Jane was referred to an obstetrician right away, and was given intravenous fluids in no time. But still, she was not given any pain reliever. We had to wait for a long time to be admitted to a temporary room at the emergency department.

Mitch remembers this part of the encounter in this way:

> The moment I recognized him, I immediately called his girlfriend who was outside the emergency room at that time... I made it a point... to endorse to the Obstetrics resident that the patient is the girlfriend of the cousin of my consultant. Such endorsements would really facilitate things.

When the interface started, Mitch was a doctor to Aris. When Aris "re-introduced" himself to Mitch, they became friends (once more). During the later part of Mitch's narrative, it was apparent that she proposed yet another role shift, as she later explained,

> In fact, I was not really counseling or advising him. It was really more like scolding and reprimanding him. I treated him like my own brother. After all, I already knew him before through you. The way I saw it, Aris was not ready to face that problem at that time.

With relentless feeds from the dynamic environment, from the changing perceptions of actors, from the varying topics of conversation or even from the manner of execution of the concomitant interlocution, the strategic platform shifts to appropriate positions. It is apparent that the interface is a not a single straight course of interaction, but a montage of scenes played by the same actors in a restless platform. Such is what Bakhtin calls "heteroglossia," which is "the idea of a multiplicity of languages all in operation in a culture" (Klages 2001). The language in heteroglossia does not only refer to national languages, but also to

> ... the ideologies inherent in the various languages to which we all lay claim as social beings and by which we are constituted as individuals: the language and the inherent ideologies of our profession, the language and inherent ideologies of our age group, of the decade, of our social class, geographical region, family, circle of friends, etc. (Park-Fuller 1986).

In a single setting, the doctor and the client may, in fact, employ various "socio-ideological languages," as deemed appropriate. The many positions that the actors shift to and from in the course of the doctor-client

encounter (Puustinen 2000) makes for this multiplicity of languages, as well as worldviews (Zappen 2000). This is, indeed, reminiscent of Engel's biopsychosocial model of the medical consultation (Engel 1997).

There is always an initial tendency for doctors to downgrade the medical interaction into a simple biomedical affair (Puustinen 2000). Bakhtin labels the resulting conversation as using "monologic" language – "language that seems to come from a single unified source" (Klages 2001). In the encounter with Jane, Mitch seemed to have succumbed to this tendency:

> I made a chart for her and proceeded to take her blood pressure. When I found out that she was hypotensive, I was alarmed. The condition was probably more than a simple pregnancy. I immediately started intravenous fluids before I referred her to Obstetrics. While I was inserting the intravenous line, I was keen on establishing a diagnosis so I asked further questions on what they did prior to the onset of abdominal pain. It didn't take me a lot of effort to extract the information from Aris that he talked his girlfriend into taking an abortifacient pill.

Within that monologic framework, mainstream Western (hegemonic) medicine regards health as solely – or almost always – physical. Those who have ill-health have either malfunctioning organs or deranged bodily biochemical processes. Even mental illnesses that often manifest as pathologic thought processes, affect, and behavior, are mainly managed with drugs that are supposed to normalize the release of neurotransmitters. For medicine, there is only one truth out there, and its existence can be proven by hard evidence (Hodgkin 1996). Effects are predictable, given a set of causes; personal choices and motives are not factored in because they hardly matter (Alderson 1998). Psychosocial concerns must be distanced from biologic conditions, in order for the latter to be controllable.

Whatever it is that does not fit in the equation is not a concern of medicine. In the eyes of hegemonic medicine, therefore, only the conditions that are manifest in the physical body can be approached with preventive, diagnostic, curative, or rehabilitative measures. Only the physical conditions can be planned for and evaluated.

Yet there is also that constant and irresistible nag of clients, situations, and personal values at doctors to take an approach that is more than biomedical. The biopsychosocial approach to medicine is an attempt "to know the other in order to respond as oneself, to gain as full an encounter between whole persons as one can" (Evans 2003). Attendant to one's wholeness is the strategic context one is in. This

heteroglossic encounter, therefore, presents as a phenomenon whereby actors constantly invite each other to engage in a dialogue; this is what Bakhtin calls a dialogized heteroglossia (Zappen 2000).

"As each one of us appropriates words for our own purposes, we add our own particular shade of meaning" (Heath 2001). The situatedness of the biopsychosocial interface in a shifting platform locates the meaning of the language that it engenders not in the actors themselves but somewhere in between the speakers and the listeners (Zappen 2000). The meaning is itself strategic, and only actors who are deeply engaged in the encounter can rightfully work out a meaning from the ensuing dialogue.

Power

As with any other form of communication, the linguistic exchange in the biopsychosocial interface can express relations of power (Thompson 1991). It is loaded with opportunities for emotional catharsis, lament and freedom, as well as manipulation, modification and constraint (Bub 2004; Heath 2001). In Aris and Mitch's case, Aris was obviously at the receiving end of the "domination" that ensued. He says,

> I could see that some other doctors who were with Mitch were talking about me, and they were laughing. Some of them approached me, made fun of me, and accused me of poisoning Jane. It was a very awkward experience. I felt very much embarrassed and guilty.

And according to Mitch:

> I believe that, to some extent, the doctor should impose some values on the patient, especially if such values would affect the patient's health.... All the while that Aris was in my desk, I was constantly reminding him of the possible consequences of his actions.... In fact, I was not really counseling or advising him. It was really more like scolding and reprimanding him.

As Thompson (1991) puts it, "individuals speak with differing degrees of authority... words are loaded with unequal weights, depending on who utters them and how they are said."

It should also be noted that, while I was not physically present during the encounter between Aris and Mitch, I was, to all intents and purposes, influential in the unfolding drama. Mitch sent me a text message to inform me about what happened to Jane and Aris, but even prior to the text message, there was already a good amount of personal and "dialogic" deliberations among them that refers to me. Aris told me that,

> I hesitated to go to the hospital at first. I was afraid that you would find out and get mad at me. On the other hand, I also contemplated asking for your help, when things would really call for it.

Later Mitch was to explained to me that

> ...before I texted you, I asked permission from Aris. He refused at first. He didn't want you to know what happened. I tried to explain to him what the course of his girlfriend's condition would probably require... I told him I could help him, but it would be best to inform you, as well. He eventually consented that I would inform you. But he specifically requested me to tell you not to inform his mother... So, I started texting you. He was in front of me all the while that I was texting you. And everything you said in your messages, I read to him.

I was, in fact, enraged upon receiving the news. My immediate response was to instruct Mitch to scold Aris. I was going to regret that reaction later. But Mitch gave Aris a lengthy preaching anyway, enough to make him feel guilty about what he did. Aris was going to tell me much later too, that the scolding did not really do much good to him. If anything, it made him very dissatisfied of the hospital services and caused him to stereotype doctors as individuals who are very insensitive to people's emotions.

While I recall those events, it became clear to me that my virtual presence counted as a determinant of the course of events. It shows a character of the power that actors acknowledge in a strategic performance. That power need not be an overt physical force; nor does it have to be as immediately apparent as the power gradient in the doctor-client relationship of Mitch and Aris. Bourdieu (1991) refers to it as "symbolic power" – "that invisible power which can be exercised only with the complicity of those who do not want to know that they are subject to it or even that they themselves exercise it." It is the power that makes one achieve, through utterances – or, in this case, through text messages – or mere presence the equivalent of what is achieved through force. The fact that Mitch is older than Aris and that she underwent more years of education situates her in a position of "symbolic domination" over him. That I am Mitch's consultant and I am older gives me that similar privilege over Mitch and Aris. The fact that Aris is a relative of Mitch's consultant also bestows upon him that "symbolic power" over Mitch. And let us not forget that, in a patriarchal society like ours, men – as Aris and I – speak from positions of dominance (Flood 1995) while

women – as Mitch – carries with them a whole history of subjugation (Peczon-Fernandez 1996; Sobritchea 1996).

The subtlety of the exercise of power in the biopsychosocial interface may also be understood from Foucault's (1990) theory of power.

> Perhaps the equivocal nature of the term *conduct* is one of the best aids for coming to terms with the specificity of power relations. For to "conduct" is at the same time to "lead" others (according to mechanisms of coercion which are, to varying degrees, strict) and a way of behaving within a more or less open field of possibilities. The exercise of power consists in guiding the possibility of conduct and putting in order the possible outcome.

Foucault also stresses that the exercise of power is determined by the one who wields it, and modifies certain actions of the one on whom power is exercised. But the manner of exercise implies that the other's actions, which are to be modified, are ongoing or, at least, have the possibility to be done.

> In itself the exercise of power is not violence; nor is it a consent which, implicitly, is renewable. It is a total structure of actions brought to bear upon possible actions; it incites, it induces, it seduces, it makes easier or more difficult; in the extreme it constrains or forbids absolutely; it is nevertheless always a way of acting upon an acting subject or acting subjects by virtue of their acting or being capable of action. A set of actions upon other actions (Foucault 1990).

Hence, if we are to locate the instances of exercise of power in what happened to Aris, Mitch and me, they are to be found everywhere. There was Aris's exercise of power over Mitch when he re-introduced himself to her, knowing that the introduction will facilitate things and work towards his end. There was also Mitch's power over Aris in her act of conducting the history taking to arrive at a diagnosis, to the extent of setting aside the emotional manifestations that Jane and Aris were experiencing at that time. And of course, the way that Mitch tailored the contents of her preaching to Aris to reflect her own personal beliefs was, in fact, her power exercised on Aris. My power over Mitch also affected the way she sent me text messages to update me of things, her act of "reprimanding" Aris on my behalf and in her act of endorsing to Obstetrics the "connection" of Aris to me, her consultant. And finally, my power over Aris was manifested in his choice of hospital and in his manner of deciding, as perceived by Mitch, on whether or not I should be informed about his hospital visit.

Power was in full operation everywhere in the performance. The whole interface was, in fact, propelled and sustained by the ramified exercises of power among the actions of actors.

I mention linguistic power here because our use of words could produce a force that is either liberating, or restrictive.

> There is a terrible certainty about much medical rhetoric and in much of what we say to patients... Through the... abuse of words, doctors may often constrain and limit their patients' stories, consigning many of them to stories of failure, and reducing their capacity to celebrate, or even recognize achievement (Heath 2001).

Because the whole montage of the biopsychosocial interface is subject to power, it becomes a discursive field. Conflicts of interests surface and there arises a tendency for each of the actors to determine the course of events or the others' behavior to conform to one's own end. The individuals' ends could, of course, be either parallel to or incongruent with those of the others.

> In the communication [between]... doctors and patients... different discourses of power are at stake... I see power in the context of the medical encounter not as a unitary entity, nor as something that is only repressive, but rather as something that is constitutive and enabling, producing subjectivity and knowledge (Hansen 1997).

The exposition of locations of power is crucial in everyday practice. When properly recognized, power can be resisted, defused, or undermined. The titration of power to produce positive ends can be a conscious effort of all the actors concerned.

Lament

The biopsychosocial interface is not actually a detachable event from the life that we live outside of the hospital or the clinic. Doctors quickly realize that "the professional self is only a specialized part of the personal self" (Salinsky and Sackin, as cited in Evans 2003) and clients present to doctors with a language that is not very different from that of the non-medical world.

What, therefore, applies to the personal selves of actors should be reflected in the biopsychosocial interface. And in turn, the biopsychosocial interface should also be performed so as to give meaning to and reinforce the actors' personal selves. It was quite unfortunate that, while Aris narrated to me a well-examined, emotionally-laden

personal struggle, such significant episode in his life did not surface in his interaction with Mitch. He says,

> In fact, I really didn't know what to do when I learned that she was pregnant. I was confused. I thought *I would go crazy. I was* always ill-tempered during those times. I was afraid of many things. I am still studying and I couldn't afford to support a family financially. I did not want my mother back home to know that I got my girlfriend pregnant. Besides, Jane's father never approved of me. Many years back, when I went with Jane to her province, her father warned me that he would get back at me if I ever hurt her.

From the accounts of Aris, it is clear that he would have really appreciated a conversation about how he is dealing with his guilt feelings. He kept on repeating that it was his fault, that he is to blame, that he has done something which would not please his parents. According to him,

> It was a very awkward experience. I felt very much embarrassed and guilty. They kept on telling me that Jane could die because of what I gave her. Why would hospital people say that? I brought Jane to the hospital precisely because I wanted her to be relieved of her complaints... We were just left in the room without knowing what was to be done to her. We felt so helpless. They never really cared about us. The people in the hospital were just too casual about our complaints... Then again, I could surmise that it was their way of making me feel guiltier about what I have done.

Even during their stay in the emergency room, Aris was into a lot of suffering that was dismissed by Mitch as something unavoidable, given the conditions in the hospital. She said,

> Aris was complaining that they were not entertained right away at the Obstetrics section of the emergency room. I explained to him that it is not always possible to attend to patients quickly during those hours in the emergency room, when there are a lot of other patients to be managed. Working conditions could really influence a doctor's approach to patients.

Most often in a biopsychosocial interface, the client's agenda assumes a discrete form, as exemplified by Aris's "complaint" to Mitch about the slow service. It is seldom articulated, even if it is something rife in the doctor-client interaction. Bub (2004) calls this agenda a "lament": "an expression of suffering... a crying out of pain – physical, emotional and spiritual – so pervasive that it may well be considered the hidden agenda in every patient until proven otherwise... " Mere acknowledgement of the lament may already be therapeutic (Bub 2004; Evans 2003). The beauty

of the biopsychosocial approach to a client lies in the doctor's discovery of the many other routes to healing other than by drugs or surgery.

The opportunity for a therapeutic presence was there in the scene, but it was missed by Mitch, as she was preoccupied with – what doctors are wont to do – "preaching". After all, she had my blessing to reprimand Aris for what he had done. She saw her actions in this way:

> I wasn't really able to keep track of the rest of the events after I referred the patient to Obstetrics. All I knew was that she would not be admitted to the ward for hospitalization. While she was with Obstetrics, Aris stayed most of the time at my desk, as I didn't have that many patients... All the while that Aris was in my desk, I was constantly reminding him of the possible consequences of his actions.

A therapeutic presence in the biopsychosocial interface requires the three key aspects of person-centered therapy as originally described, developed and practiced by Carl Rogers: congruence, empathy, and unconditional positive regard (Michael 2003). Congruence refers to the genuineness of attitude that the doctor presents during the interface (Pescitelli 1996). Empathy refers to the doctor's appreciation of the client to see the world from the client's perspective (Michael 2003). Unconditional positive regard means offering a warm, caring, and non-selective acceptance of the client as a person (Iberg n.d.). These three sum up the appropriate attitudes of a good active listener. Active listening enables the doctor to be sensitive to the client's lament, and thus, to respond therapeutically (Bub 2004).

The other, no less important, side of the story is really the often unarticulated lament of the doctor, as well. It was recognized by Aris in his narrative: "Yes, there were lots of other patients that doctors were entertaining in the room, but wasn't Jane's condition worthy of immediate attention?" and later insinuated by Mitch when she said: "It was a busy hour when I passed her on to Obstetrics... Working conditions could really influence a doctor's approach to patients." For Mitch, there was even an unspoken pressure from my virtual presence that prodded her to risk being ignored by the busy Obstetrics resident, if only to "facilitate" things: "I made it a point, however, to endorse to the Obstetrics resident that the patient is the girlfriend of the cousin of my consultant. Such endorsements would really facilitate things." The "emergency room condition" was what both Aris and Mitch were referring, but it was actually an allusion to the physically, mentally, and emotionally demanding lifestyle that resident physicians on training in

a tertiary hospital lead. "Physicians, deprived of empathy themselves, tend to lack the capacity to empathise with patients" (Bub 2004).

Lament in the biopsychosocial interface is, thus, universal and significant. It is important that actors work out a strategic position whereby they acknowledge and address each other's lament in order for the interface to be meaningful and satisfying.

Values

Another important attribute of the biopsychosocial interface is its capacity to be fashioned by the permeating personal values of the actor. "We live, breathe, and excrete values. Value orientations and value relations saturate our experiences and life practices from the smallest established microstructures of feeling, thought, and behavior to the largest established macrostructures of organizations and institutions" (Fekete 2001).

That Aris's emotional struggles were referable to his personal value system was readily apparent with the way he reasoned in his narrative:

> If only I had money, I would have brought her to a more expensive hospital. We would have received better treatment. Money could really affect how people would treat you. Then, again, I could surmise that it was their way of making me feel guiltier about what I have done. I knew I have committed something wrong towards Jane. That's what they told us in the Christian school I graduated from. That's what my parents told me, too. I have been sleepless lately because of that thought. But I did not come to the hospital to be reminded of it.

At the tail end of my interview with Mitch, it became clear that biopsychosocial interface also poses a provocative rhetorical question to the doctor's personal values. Mitch justifies her words to Aris in this way,

> I believe that, to some extent, the doctor should impose some values on the patient, especially if such values would affect the patient's health. It is, in fact, an error of omission if the doctor does not impress on the patient such things that could have influenced the patient's decisions over very morally-laden actions, such as abortion. Of course, the values that doctors instill on patients have a lot to do with how the doctors were nurtured by society, educated and trained medically.

While there was a sense of conviction in her words when she described what the doctor "should impose," she preceded it with a qualifier, "to some extent," and wrapped it up by saying: "Of course, the values that doctors instill on patients have a lot to do... " Mitch was, in fact, suggesting that

the values that doctors impose on the patient are intrinsically contentious, and contingent on the manner they are constructed. This situation even complicates further the nature of the biopsychosocial interface. In the heat of the interaction of actors, personal values could clash and the whole interface could end in failure. It is imperative that, as they begin to shape the emerging dialogue, personal values be recognized as a social construction rather than a rigid truth that must determine the directions of the doctor's or the client's actions.

Negotiation

Thus far, I have explored the nature of the biopsychosocial interface. It is a montage of performances in a constantly repositioning strategic platform. It is vulnerable to power and possesses several vague and unarticulated actors' agenda. It is also heavily charged with socially constructed personal values.

While we are awed with such a volatile, if seemingly unmanageable, nature of the biopsychosocial interface, it is important to notice that the actors can consciously discuss terms in order to a work out a mutually meaningful interface and a fulfilling end. Doctors and clients can haggle with each other for mutually comfortable positions of the strategic platform. They can also expose, titrate, and even undermine their own symbolic power in order for them to perform in an egalitarian milieu and achieve liberating and empowering outcomes. Each one's laments can be proactively recognized and dealt with through a synergistic process that aims to heal each other. And, finally, doctors and clients can agree, implicitly or explicitly, on which values (emotional, religious, moral, economic, etc.) they can evoke while they contrive a montage of scenes and strike up a meaningful dialogue within the interface.

In this light, I thus argue that the prevailing process of interaction between or among actors in a biopsychosocial interface should be one of negotiation. In practical life, our behaviors could really be seen as products of our continuous negotiation, reflection, and then renegotiation with the people with whom we interact. Through negotiation, the socially constructed elements that characterize the biopsychosocial profile can be reconstructed towards egalitarian ends. In negotiating for a strategic performance that is cognizant of the shifting nature of the interactive platform and the lament, power and values that saturate the scenario,

doctors and clients need to be open for collaboration, transparency and sincerity about their feelings and reasons within the interface. They should also be willing to incorporate, borrow, or derive meaning from each other's legitimate agenda and be sensitive to their own positions of privilege and the potential excesses that those privileges can engender. Doctors and clients should be committed to effectively use these privileges for emancipatory ends.

Doctors and clients should also be self-reflexive. The dialogue should take off from a humble acknowledgement of mistakes and with a commitment never to let past mistakes happen again. Alongside these should be the willingness to take criticisms from the other. Only within the practice of self-reflexivity can doctors and clients constantly keep an eye on the unfolding meaning within the dialogue and, when deemed necessary, reposition their platform as they work towards a liberating, empowering, and satisfying outcome.

The rest of the story

The interface of Aris and Mitch did not lead to their desired ends. Mitch obviously sounded frustrated that she was not able to bring home a point to Aris: "I noticed that he was just alternately moving in his seat and grinning at me while I said those things." But Aris was more explicit: "We went home without Jane receiving any pain reliever. I was never really satisfied about how they treated us in the hospital." I myself was, at that moment, wishing I was there in the hospital to personally reprimand Aris for not being responsible enough for his actions.

Aris talked to me, just the same, after the hospital incident. It wa around that time that I started to realize what an undesirable reactio I had when Mitch sent me the news. I wanted to make amends fo collaborating with Mitch to make him feel guilty, so I invited the both to a karaoke bar to unwind over beer and singing. It was my w of saying sorry – quite a vague way – but I felt less guilty afterwards a Aris wasn't exactly mad at me.

A reconstructed scene

Now, while I am developing this section of my paper, I imagi reconstructed scene. As Jane starts feeling an excruciating abdor

pain, and after careful deliberation with Aris, they both go to this hospital, precisely because it is where I work. Aris realizes that he knows Mitch and so he briefly re-introduces himself and he gives her a concise medical history. He then sends me a text message informing me of what happened. I probably call him, ask him a few questions, reassure him that Jane will be fine, and then ask for Mitch on the phone. Then I discuss with Mitch her plan of action. Mitch tells me that she will refer Jane to Obstetrics but Mitch will ask the Obstetrics resident to refer Jane back to her once the medical condition is resolved. Then Mitch plans to carry out a few counseling sessions with Aris and Jane. I approve of her plans and suggest that she talks to Aris right then and there if she has time.

Meanwhile, Mitch will bring Aris to a less busy corner in the emergency room because he looks anxious and he keeps on returning to her desk and she does not have too many patients, anyway. She then asks him how she can be of help, and he asks her to just be with him for a while. Aris talks and talks, and probably cries and lets out his feelings. Mitch actively listens, affirming the feelings of Aris. She consciously resists the temptation to preach or advice, trusting that what happened was a product of his careful deliberation with himself and with Jane. They return to the emergency room after Aris thanks Mitch for listening to him and after he tells her that he feels lighter, somehow.

Mitch and Aris find out that Jane is still in pain but has been reassured by the obstetrician that the pain will probably not worsen. Upon Jane's prodding, Aris insists upon the obstetrician for Jane to receive some pain relievers and she eventually receives some. Whether Jane will be discharged from the emergency room or admitted, Aris will call me and I will facilitate for the plans of the obstetrician to be done. Mitch calls me and reassures me that both Aris and Jane are well taken care of. Everybody is happy.

Myself while writing a phenomenology

Today, while I have been writing the narratives and outlining this paper, I am having a taste of the pain that my cousin Aris used to feel. It is not the kind of feeling I had when the whole story unfolded through the text message exchanges, or even through the "aftermath" stories of both Aris and Mitch. I wasn't really there for Aris. If anything, I even

contributed to his emotional restlessness that was more pronounced right after the hospital visit.

When I set out to write this paper, I imagined it to be a good exercise of self-reflexivity and an inviting opportunity to examine my own practice as a family physician. Now, I am experiencing the "doctor's guilt" for my active complicity in the symbolic power I wielded on Aris and on many of my clients. A very wide gap yawns between what I am now and what I want to be as a doctor. I see myself in Mitch's predicament. There are lots of things in my professional practice that need to be undone if I am to constantly build a therapeutic presence to my clients.

I have the tendency to look at this paper as an unfinished business, though. It was really my intention to be silent about abortion in this paper. I recognize the potentially intense discourse that the abortion issue can stimulate if it is properly pursued, but right now, I do not feel theoretically equipped to tackle such a complex issue. In the near future, however, I intend to pursue this method of research writing and the phenomenology of the biopsychosocial interface when the medical diagnosis is abortion. Barring complications, this will, most likely, be my master's thesis.

On the whole, putting the narratives down in words and writing this whole paper have that powerful force that stirs my seemingly composed self and that propels me to shift the locations of my emotional platform even within this electronic phenomenon that feeds on handed down information and memories. It is, in itself, an enriching phenomenon worth experiencing.

Conclusion

I have just examined how doctors and clients perform in a biopsychosocial interface. I have also described the characteristics of the interface. It is a collection of scenes in a constantly repositioning strategic platform. Power permeates its structure. It is also characterized by several vague and unarticulated actors' agenda. Finally, it operates within the confines of constructed personal values. All the elements in the biopsychosocial interface – strategic positions of performance, power, lament, and personal values – are socially constructed. They are not absolute. They are malleable, contingent upon the conscious will of actors to carry out a meaningful and satisfying interface and, hence, can be

reconstructed. And so, towards the end of this phenomenological inquiry, I have also proposed that the appropriate model for the biopsychosocial interface is a process of negotiation. It is a model that engenders liberating, empowering, and satisfying outcomes for the biopsychosocial interface.

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Appendix A

Aris's narrative

We were in my boarding house when Jane took the pill for the second time. My friend told me that the pill has to be taken during the night. After minimal bleeding, the pregnancy would be expectedly over the following morning. But it didn't happen that way.

It didn't work the first time she took the pill. That was when Jane was only a few weeks pregnant. So on the fourth month of her missed menstruation, when I felt that she was still pregnant, we decided for her to undergo another pregnancy test. I wanted it done in a diagnostic laboratory this time, as I couldn't trust a positive result obtained from an over-the-counter pregnancy test kit. She went to the laboratory alone. I had to go to class at that time. When we met later that day, she was crying, because the test still turned out positive.

In fact, I really didn't know what to do when I learned that she was pregnant. I was confused. I thought I would go crazy. I was always ill-tempered during those times. I was afraid of many things. I am still studying and I couldn't afford to support a family financially. I did not want my mother back home to know that I got my girlfriend pregnant. Besides, Jane's father never approved of me. Many years back, when I went with Jane to her province, her father warned me that he would get back at me if I ever hurt her.

The first time she knew about it, Jane wanted to keep the baby. But after we thought about our situation for a long time and considered all angles, I managed to convince her to have an abortion. We never quarreled about it. We thought it would be the best way to solve our problems. My housemate had a similar experience so I asked him how to get rid of the pregnancy. We had a choice of whether to go to an abortionist or to take the abortifacient pill. Having an abortion done by an abortionist costs a lot, so we opted for the pill. The pills were very difficult to purchase, but we managed to buy a few, somehow, from an underground distributor.

When the first attempt failed, we really would have wanted to keep the baby if not for fear that something might have happened after the first time she took the pill. We thought that, if the baby was harmed the first time she took the pill, we would have problems later on.

So a few hours after she took the pill for the second time, she began to experience a very excruciating abdominal pain. She was writhing in pain until morning, until she almost lost consciousness. I hesitated to go to the hospital at first. I was afraid that you would find out and get mad at me. On the other hand, I also contemplated asking for your help, when things would really call for it. So, when I saw that she was so pale and she could not take the pain anymore, I decided to seek medical attention anyway.

When we arrived at the hospital, Jane was not given something for the abdominal pain right away. There were lots of questions during the initial interview. I knew Mitch, the doctor who interviewed me first. You introduced her to me before. But she did not recognize me at that time. She asked a lot of questions. She even blamed me for giving poison to Jane, and asked me if I realized what I just did to my girlfriend. Did I know that I could kill Jane with the poison I gave her? Then she was telling all these things about medical consequences and Jane's chances of dying. And all the while we were talking, Jane was in a corner, alone and twisting in pain. I was so confused. Why was I hearing all those things when all I would have wanted was for Jane to be relieved of the pain?

I didn't have enough money at that time, so when I had to spend for some tests to be run, I re-introduced myself as your cousin to Mitch. After

that, I could see that some other doctors who were with Mitch were talking about me, and they were laughing. Some of them approached me, made fun of me, and accused me of poisoning Jane. It was a very awkward experience. I felt very much embarrassed and guilty. They kept on telling me that Jane could die because of what I gave her. Why would hospital people say that? I brought Jane to the hospital precisely because I wanted her to be relieved of her complaints.

But my introduction worked. Jane was referred to an obstetrician right away, and was given intravenous fluids in no time. But still, she was not given any pain reliever. We had to wait for a long time to be admitted to a temporary room at the emergency department. Yes, there were lots of other patients that doctors were entertaining in the room, but wasn't Jane's condition worthy of immediate attention?

I used to think that I would be relieved somehow of my anxieties once we would be inside the hospital. There would be doctors who would receive us without delay, decide immediately about what to do and administer the necessary medications quickly. And I expected people to be reassuring somehow that they will do everything they can to heal an ailing patient. But when we were inside the room, nobody attended to Jane for a long time, despite her complaints of severe abdominal pain. No medications were prescribed. Or, I couldn't really remember if something was prescribed or not. But we were just left in the room without knowing what was to be done to her. We felt so helpless. They never really cared about us. The people in the hospital were just too casual about our complaints.

If only I had money, I would have brought her to a more expensive hospital. We would have received a better treatment. Money could really affect how people would treat you. Then again, I could surmise that it was their way of making me feel guiltier about what I have done. I knew I have committed something wrong towards Jane. That's what they told us in the Christian school I graduated from. That's what my parents told me, too. I have been sleepless lately because of that thought. But I did not come to the hospital to be reminded of it.

After several hours, Jane was reassessed by the obstetrician and we were told that she needed to be admitted in the ward for further observation. We couldn't afford to pay for the admission. But more importantly, we did not want anybody else, especially our family, to know what happened to Jane. Our parents would surely get mad at us. The obstetrician allowed us to go home, but instructed us to come back if vaginal bleeding starts. We went home without Jane receiving any pain reliever. I was never really satisfied about how they treated us at the hospital.

We never got to go back to the hospital. Jane's father arrived from the province a few days after our hospital visit. It was also around that time that the

abortion was completed and Jane had profuse bleeding. At a certain point, her father wanted to bring her to the hospital because she became very pale and weak. But for fear that her father would know what was actually happening with her, she forced herself to get up and pretended that she could manage her condition.

Jane recuperated, at any rate, despite the lack of medical attention. But a few months after, when things were back to normal, I found out that she had been dating other boys. I couldn't take it. I was faithful to her all the years that we were together. So when I found out that she was entertaining other boys, I called it quits with her. We still see each other these days, but things have been different now.

Appendix B

Mitch's narrative

Unlike other patients or informants who would readily tell the doctor their chief complaint, Aris was a bit hesitant to tell me why he came to the hospital. He asked me first where to bring patients with abdominal pain. When I learned that the patient was, in fact, not him but his girlfriend who was with him, I immediately investigated to establish pregnancy. When I have made a probable diagnosis of pregnancy, I told Aris that I was the triage doctor, not the admitting physician for Obstetrics, and that they may go to another doctor in the emergency room for his patient's condition.

Aris probably knew me already, but I didn't recognize him the first time I saw him at the emergency room because of the shorter hair he was sporting. I thought I had seen him before, but I could not recall where. So when I directed him to the obstetrician of the day, he temporarily left my desk, only to return a few minutes after. Maybe, he really felt that his girlfriend's problem was very urgent, so he approached me again. This time, he introduced himself as your cousin, and told me that you had actually introduced us to each other before.

The moment I recognized him, I immediately called his girlfriend who was outside the emergency room at that time. When I started to take the medical history, both of them were just grinning. I asked for the date of her last menstruation and if there was new-onset bleeding after the menstruation. The good thing with Aris was that he answered all my questions honestly. The fact that we knew each other before was probably a great factor.

I made a chart for her and proceeded to take her blood pressure. When I found out that she was hypotensive, I was alarmed. The condition was probably more than a simple pregnancy. I immediately started intravenous fluids before I referred her to Obstetrics. While I was inserting the intravenous line, I was keen on establishing a diagnosis so I asked further questions on what they did prior to the onset of abdominal pain. It didn't take me a lot of effort to

extract the information from Aris that he talked his girlfriend into taking an abortifacient pill. He told me that it was his housemate who instructed him on how to carry out the abortion.

The girlfriend was silent most of the time. It was Aris who gave most of the information. I just asked her a few questions. I asked why she took the pill that Aris gave her. She just told me that it was Aris's idea. Couldn't she refuse? Why was she too submissive to her boyfriend's suggestion? She just kept on repeating that she just followed what Aris told her to do. Then she would just be grinning every time I asked her a question.

She was not really in severe pain. I could imagine that the abdominal pain was equivalent to the pain of dysmenorrhea. I was more concerned about the drop in blood pressure, so I hydrated her to stabilize her condition. I performed a pregnancy test and, when it turned out positive, I referred her to Obstetrics.

It was a busy hour when I passed her on to Obstetrics, so she had to wait for her turn to be examined. I told the Obstetrics resident to coordinate with me if curettage is to be performed. The resident told me later, however, that the diagnosis is probably threatened abortion, so they would not probably admit her for hospitalization.

Aris was complaining that they were not entertained right away at the Obstetrics section of the emergency room. I explained to him that it is not always possible to attend to patients quickly during those hours in the emergency room, when there are a lot of other patients to be managed. Working conditions could really influence a doctor's approach to patients. I made it a point, however, to endorse to the Obstetrics resident that the patient is the girlfriend of the cousin of my consultant. Such endorsements would really facilitate things. As a matter of fact, the resident was constantly apologetic to me that it took a while for the patient to be accommodated.

It was also around this time that I started sending you text messages. Before I texted you, I asked permission from Aris. He refused at first. He didn't want you to know what happened. I tried to explain to him what the course of his girlfriend's condition would probably require. I opened the possibility of curettage if the baby would be found out to be dead inside the womb. It was my way of scolding him and making him realize what he had done to his girlfriend.

I always question decisions of couples if they claim that both of them contributed to the decision to do the abortion. Why would a girl consent to have an abortion if she knows that the procedure will put her life at stake? I made Aris realize that abortion was not the solution. It might even lead to another problem, like when his girlfriend would experience vaginal bleeding that needs curettage. Where would he look for the money to pay for the procedure? I told him I could help him, but it would be best to inform you, as well. He eventually

consented that I would inform you. But he specifically requested me to tell you not to inform his mother.

So, I started texting you. He was in front of me all the while that I was texting you. And everything you said in your messages, I read to him. He was just grinning most of the time that I told him how enraged you were, so I couldn't really relay to you what his true emotions were at that time.

I wasn't really able to keep track of the rest of the events after I referred the patient to Obstetrics. All I knew was that she would not be admitted to the ward for hospitalization. While she was with Obstetrics, Aris stayed most of the time at my desk, as I didn't have that much patients. I think there was a request for an ultrasonography to determine the status of the pregnancy, and there were probably prescriptions of medications that would relax the uterus and prevent abortion. But I was not really sure. It was from you that I learned much later about the status of the pregnancy.

I believe that, to some extent, the doctor should impose some values on the patient, especially if such values would affect the patient's health. It is, in fact, an error of omission if the doctor does not impress on the patient such things that could have influenced the patient's decisions over very morally-laden actions, such as abortion. Of course, the values that doctors instill on patients have a lot to do with how the doctors were nurtured by society, educated and trained medically, as well as with the professional experiences that precede them.

All the while Aris was in my desk, I was constantly reminding him of the possible consequences of his actions. I told him that, in a way, having an abortion could only be the solution to their problem if it was successful. But, as taking abortifacient pills would have lots of adverse effects, it would often lead to more practical problems later on. Then there would really be times such as this when abortion would not ensue. Then I told him that he should have thought more responsibly even before he had premarital sex with his girlfriend. Otherwise, I said to him, if the pregnancy would be carried through term, would he be willing to have an abnormal child who suffered from the effects of the abortifacient drug? Could he personally take, all throughout his life, the consequences of his actions?

In fact, I was not really counseling or advising him. It was really more like scolding and reprimanding him. I treated him like my own brother. After all, I already knew him before through you. The way I saw it, Aris was not ready to face that problem at that time. I noticed that he was just alternately moving in his seat and grinning at me while I said those things. But he never reasoned out nor justified his actions. Neither did he blame his girlfriend for anything. And then again, his face never really showed any remorse for what he did or, at least, not that I noticed.