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“ What’ s wrong with that woman?” – Positioning Theory and Information-Seeking Behaviour

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Abstract

We offer social positioning theory (Davies and Harre 1990) as a framework for exploring the ways in which the visibility of an individual’ s health status is linked to socially constructed subjectivities that can affect the individual’ s information-seeking behaviour. Qualitative analysis of data from two doctoral studies (collected through participant observation and 40 semi-structured interviews) illustrates the utility of social positioning theory as a framework for studying two specific health contexts: systematic lupus erythematosus, and twin pregnancy. Adopting a ‘ position’ involves the use of discursive practices which define the relations between self and others. Such practices frequently draw upon common social representations of particular phenomena (Van Langehove and Harre 1994). Our findings indicate that the visibility of health status is related to subject positioning, and that positioning theory offers insight into the mutually specifying correspondence between local discursive practices and styles of information behavior. The pregnant woman’ s expanding abdomen makes her health status evident to others, often positioning her as a willing recipient of advice and information (Browner and Press 1997). Cultural assumptions associated with “ twins” can both facilitate and constrain the woman’ s information seeking (“ Better you than me.”). However, the stock of shared cultural understandings associated with lupus is comparatively sparse (Senecal 1991). Symptoms such as hair loss, skin rash, and weight gain may therefore lead to positions which are experienced by novice patients as stigmatizing (“ What’ s wrong with that woman?”). Even when evident symptoms disappear, the stigmatized position

can be maintained through secrecy (“ No one can tell I have lupus.”). In these situations, information-seeking is relegated to the confidential encounters characteristic of expert disciplinary regimes. As a heuristic tool, then, positioning theory provides an opportunity for analysis of the means by which the information-seeking subject is configured through discursive encounters.

1. Introduction

A great deal of research on health information-seeking emphasizes the communication that occurs – or fails to occur – between physicians and patients. Good and Good found in 1982 that “ information seeking is a foremost goal of patients in primary care settings” (1982, 287). However, Waitzkin found in 1985 that although the average physician-patient encounter lasted 16.5 minutes, patients spent an average of only 8 seconds asking questions of their physicians. Physicians, on the other hand, believed they spent an average of 9 minutes providing information to their patients, when they actually spend only 40 seconds on average. In a similar study, Roter and Hall reported in 1989 that “ the minority of patients are given adequate information about the drugs they take or their medical condition. What is worse, patients forget a great deal of what they are told; in fact, on average most estimates of patient recall are only about 50 per cent of the facts communicated by the physician” (Roter and Hall 1989, 167).

While patients seem to expect information from their physicians, it appears that doctors are more concerned with the notion of compliance. Trostle (1988), for example, notes that more than 4,000 articles have appeared in the medical literature on the subjects of patient non-compliance with physician directives and on the failure of many public health-promotion/information campaigns. Trostle argues that much of this literature emphasizes the medical profession’s conviction that “ the problem lies in the patient’s behavior or in the doctor/patient relationship.” In other words, the failure of a certain kind of health information to be effectively transferred to its intended population is thought to lie with the population itself.

The evident disparity between the patient's needs and the physician's professional interests coincides with much speculation about the power of the biomedical establishment, specifically its power to legitimate concepts of health and illness and to configure the patient in such a way as to regulate the patient's subjectivity. Some of this discourse sees the biomedical establishment as a documentary regime whose power rests in the texts it produces. Critical approaches to scientific and medical writing suggest that the textual practices associated with these regimes negate the local, idiosyncratic experience of a particular medical condition by configuring the condition itself as a series of hypotheses that may or may not be verified through universally applied diagnostic procedures. Such procedures remain the exclusive territory of the expert: "The inscription of the body, which medicine deciphers in its examinations, is not straightforward, it cannot be read 'correctly' by just anyone: the reader must be an expert" (Fox 1994, 29). The regulatory power of the biomedical establishment is therefore seen to rest in its ability to inscribe the patient as a generalized subject who exists mainly as a passive site for the operation of rationalist procedures.

Such themes of control and regulation are not limited to scientific documents, but also tend to occur in information resources written for by physicians for lay persons. For example, Schur (1998, 6-7) portrays patients in such a way as to legitimate the physician's control over aspects of their conduct that have little to do with physical illness. A patient may improve her or his chances of enjoying good health if she or he observes a series of rules whose purpose is to improve the physician-patient relationship, the quality of which is portrayed as being essential to somatic fitness:

Utilize time efficiently: Arrive somewhat early if forms have to be completed. If you expect to be late call the office so that another patient can be rescheduled. If you need to cancel call the office as soon as possible.

Bring concise notes that track your symptoms, bring copies of pertinent medical records, laboratory test results, and x-rays.

Bring a list of medications you are taking, their names (spelled correctly), their doses (how many mg. per pill), and the frequency with which you take them. A list of previous medications taken and whether or not they were effective, or caused side effects, is also useful. A discharge summary from any hospitalization is useful as it is designed to condense relevant material into two pages?

Bear in mind that your physician will have to spend some of the time allotted to you in scanning the material you' ve brought before a productive discussion can begin?

Remember that your physician has probably scheduled you for a certain amount of time for your visit.

Schur' s document achieves several effects: 1) It configures the patient as a bureaucratic subordinate of the physician, subject to the same constraints, schedules and frames of reference; 2) It establishes the physician' s authority to regulate aspects of the patient' s behavior that have nothing to do with organic illness as such; 3) It limits the patient' s opportunity to ask questions. Although Schur advises patients to “ be sure that before you leave all your questions are answered,” it is clear that, at least in this representation of an ideal consultation, much of the visit will be taken up with the interpretation and analysis of various records and documents (Schur is careful to note that time is limited due to organizational exigencies).

However, medical anthropologists such as Emily Martin (1994), while not discounting the power embodied in these kinds of texts, have interrogated the ways in which the power implicit in such texts migrates to truly local encounters. Martin found, for example, that lay persons react in various ways to scientific inscriptions of the human body: “ ...the scientific questions impelling the production of these images are not necessarily the questions that grip

nonscientific people as they marvel at them, reject their relevance, or integrate them creatively into ordinary life... what for one person is a dreadful prospect is, for another, a spectacle filled with awe and, for another, simply a mildly interesting byproduct of a scientific conversation that ignores what is most important: the social and economic conditions that lead to suffering and illness in a poor urban neighborhood” (Martin, 1994, p. 182). This observation, which emphasizes the variability of lay persons’ interpretations of scientific inscriptions, opens a space to investigate the problematic aspects of health information-seeking from the perspective of the patient, with particular regard to the discursive practices that constitute the patient’s engagement with the health care system. Specifically, we are concerned with finding a way to regard the power of the biomedical establishment -- and its effect on information-seeking -- not solely as function of textual practice but also as a function of local talk, the nature of which may vary depending upon the speakers and their situations. To this end, we offer positioning theory as a framework for exploring discursive encounters in the context of health information-seeking.

2. Positioning Theory

Positioning theory has been introduced by Harré and his co-authors as a metaphor to identify the ways in which speakers are situated or positioned within discursive encounters. By “ positioning,” Harré means the use of rhetorical devices “ by which oneself and other speakers are presented as standing in various kinds of relations” (van Langenhove and Harré 1995, 362). These include relations of power, knowledge, ignorance, dominance, submission and so on. The act of positioning refers to the assignment of “ parts” or “ roles” to speakers in discourse that make the person’s speech or action intelligible and relatively determinate as social acts. In a conversation between a teacher and a pupil, the right to make a certain kind of remark – a reprimand, for example – varies between the two speakers. Thus, the teacher occupies one discursive position, the student another; the social meaning of what is said depends upon the position of the speakers. Yet conversational positions may be highly motile,

shifting as the conversation proceeds or as the circumstances of the speakers change. The pupil, for example, may challenge the teacher' s authority to issue a reprimand, thereby refusing the subordinate position of " pupil" and changing the nature of the relations between the speakers. So, while positioning theory recognizes the force of discourse – that is, the way power is both manifest in and constituted by talk – it also affords speakers the opportunity to exercise a degree of choice. By refusing a position, a speaker challenges the other speaker' s moral or social authority. Since positioning theory extends itself to the " whole set of rights, duties and obligations that speakers have," (van Langenhove and Harré 1995, 362), the theory can be used to study the means by which power is localized through discourse:

Positioning theory can thus be applied to many institutionalized discursive processes, such as law, science, politics, art criticism and so on. In each case, the practices of such an institutional field can be understood in terms of the positioning activities of the participants and of how the discursive practices typical of that field generate specific redescriptions of certain aspects of the world? (van Langenhove and Harré 1995, 363).

In the following sections of this paper, we would like to explore specific types of discursive positioning, and how they may be applied to the study of information-seeking. Our examples are drawn from our respective studies of people with systemic lupus erythematosus and women pregnant with multiple fetuses.

3. Textual Practice As First Order Positioning

The inscription of the patient' s subjectivity evident in Schur' s text is characteristic of first-order positioning, a term Harré uses to refer to the means by which a speaker locates her- or himself and others within a social space or moral order: " For instance, if Jones says to Smith: ' Please iron my shirts,' then both Smith and Jones are positioned by that utterance. Jones as somebody who has the moral right (or thinks he has the moral right) to command Smith, and Smith as somebody who can be commanded by Jones" (Harré and van

Langenhove 1991, 396). Smith, of course, may contest or negotiate this role in the course of subsequent conversation. However, texts which position patients – that is, texts which assign patients a specific place in a certain moral order, with attendant privileges and constraints – afford no opportunity for the direct negotiation of first-order positions. The following examples are illustrative of the ways in which medical inscriptions assign patients – in this case, pregnant women – first order positions as information-seekers that are essentially subordinate to the imperatives of the biomedical establishment.

As Hahn found in 1987, obstetrical texts for medical practitioners represent “ the course of childbirth as inherently pathological and in need of pervasive attention and control,” and ascribe little or no agency to the pregnant or birthing woman. An obstetrical textbook used in the training of undergraduate medical students at the University of Western Ontario (DeCherney and Pernoll, eds 1994) describes the necessity for the pregnant woman actively to seek information in order to optimize her eventual birth outcome:

A high level of anxiety during pregnancy has been associated with decreased uterine activity and with longer and dysfunctional labor. Therefore, it is important for the prospective first-time mother to attend prenatal education classes to alleviate her fears, to make labor and delivery more understandable, and to learn that she will be supported psychologically as well as physically.(207)

Browner and Press (1997, 117) suggest that such representations put forward information exchange as the fundamental function of American prenatal care and highlight becoming informed as “ foremost among the responsibilities conferred by pregnancy.” Representations of information-seeking in professional pregnancy texts, however, constrain the style of information-seeking to that which facilitates the pregnant woman’ s confidence in and co-operation with her “ obstetric team.” Although popular pregnancy books are much more likely to represent the pregnant woman as an active entity, they concur with the professional literature in representing the ideal patient is an active information-

seeker, but only insofar as the information-seeking facilitates confidence in the medical care team and, through this, compliance with practitioners' directives.

You want your own focus to be on delivering your babies, and this is best accomplished by feeling confident that the medical details are being handled by experts trained to do their specialized jobs. (Agnew, Klein and Ganon 1997, 181)

Popular books for pregnant women represent the physician-patient information seeking relationship in one of three ways:

1. The physician and patient as collaborative members of an "obstetrical team":

If you have any questions that you forgot to ask at your last checkup, or that have come up on the interim, now is the perfect time to bring them up. Your successful participation in this partnership depends on your being well-informed every step of the way. We are used to hearing a twin pregnancy described as "high risk," but much of the time twin pregnancies are almost more about a high level of alertness and involvement. (Agnew, Klein and Ganon 1997, 65)

2. The physician as an expert providing guidance:

Your practitioner has most likely "been there, done that" when it comes to guiding couples through multiple pregnancies. Take advantage of all that wonderful experience.... Ask questions: communicate with your practitioner. (Agnew, Klein and Ganon 1997, 68)

3. The physician as an authority to be obeyed:

Follow the dietary rules that you and your practitioner have discussed and enjoy knowing that you are providing for your growing babies. (Agnew, Klein and Ganon 1997, 76)

Although representations of physician and patient as collaborative partners in the health care process suggest an equality of status, the physician is clearly in charge. Textual representations of the pregnant woman's duties, responsibilities and rights in relation to those of the biomedical establishment serve a performative function insofar as they assign distinct limitations to the patient's subjectivity as an information-seeker. In no case is the woman accorded authority to direct her medical team, to resist their superordinate positions, or even to act as the ultimate authority on the status of her own body. Professional and popular pregnancy texts invoke the imperative of avoiding risk to augment the authority of the physician both as an information source and as the director of the health care process. At best, the information-seeking subject is encouraged to be a passive but attentive receptacle of expert knowledge.

4. Reclaiming the Local: Negotiation and Second Order Positioning

As we have noted, we are concerned with the ways in which the power manifest in such textual representations migrates to local discursive encounters. We are also concerned with the means by which people who are seeking health information accommodate, evade, resist, or negotiate such positions through discourse. First order positions can be challenged in two ways: either within the conversation as it is taking place, which Harré calls second order positioning, or within another discussion about the first conversation, which he terms third order positioning. Accounts of first or second order positioning that arise from interview data can therefore be considered a variety of third order positioning. However, such accounts also constitute a first order positioning between the researcher and participant.

In an example of second order positioning in the context of a research interview, a woman pregnant with twins rejected the interviewer's attempt to represent her

as knowledgeable about childcare by virtue of her being an aunt to several children:

Natalia: I didn' t know anything. Yeah. My life has been childless. And carefree of those kinds of things.

Pam: I don' t know, you' ve got at least 14 nieces and nephews. [laughs] From adding up two sisters-in-law. [laughs]

Natalia: [laughs] That' s right. All sorts, and my sister, 15. Yeah, so we knew nothing before. I didn' t know anything before.

By refusing to be positioned as a childcare expert, Natalia represents herself as a novice, a representation she draws upon later in the interview when legitimizing her childcare concerns and thereby her information-seeking.

Accounts of second order positioning are also interesting because they suggest ways in which patients negotiate their places within a moral or social order prescribed by the biomedical establishment. In the following example, a lay person with lupus describes a second-order positioning during a discursive encounter with a health professional:

Lynne: At this conference in Cancun, a psychologist came and spoke with the patients, and he stood up there and denied that lupus patients suffered from cognitive dysfunction, or central nervous system involvement. Seventy patients are sitting there saying, ' But, we do.' And he said, ' It is very, very rare, and in most lupus patients that does not occur,' and we continue to tell him that it does occur. Finally, I stood up at the mike and I said, ' Read our lips. We are telling you that every lupus patient, to some degree, suffers from cognitive dysfunction or lupus fog.'

Here, Lynne resists the psychologist' s authority to position her and other lupus patients by invoking her own knowledge of the illness, which is based on her experience rather than on professional training. In so doing, she repositions herself and other people with lupus in relation to medical knowledge and

authority by treating as legitimate a form of knowledge which does not correspond to that imposed by the biomedical establishment. Such discursive practices are also performative insofar as they question or subvert the extent to which an institutional authority has the moral right to make claims about any group.

5. Positioning and Information-Seeking

When the researcher is attuned to information-seekers' accounts of first or second order positions, she or he is better able to interpret the ways in which participants see themselves in relation to various sources of information. Invariably, these positions involve relations with a moral order (the institutional aspects of social life which assign roles to people in discursive encounters – teacher/pupil, physician/patient, etc.). However, people can not only be positioned in relation to a moral order, but also according to their personal idiosyncracies (for example, “ Dr. Smith never pays attention to me when I’ m talking to him”). As Harré and van Langenhove point out, “ when people are positioned or position themselves, this will always include both a moral and a personal positioning” (1992, 398). This conflation of the moral and the personal has important implications for information studies; by specifying the relations between an individual and various exponents of knowledge, the researcher and participant do two things: 1) They uncover an opportunity to interrogate the ways in which local manifestations of power shape or constrain information-seeking; 2) They make it possible to explore ways in which individual information-seekers accommodate, evade, or resist their positions in order to get the information they need. In the following section of this paper, we would like to share three themes from our research related to positioning and health information-seeking.

“ What’ s Wrong with that Woman?” : Positioning as a Catalyst for Information-Seeking

In some cases, the visibility of health status is related to subject positioning. In particular, others' positioning of the individual as a “ pregnant woman” or “ sick person” can act as a catalyst for information-seeking. The pregnant

woman's expanding abdomen makes her health status evident to others, often inviting unwanted comments and advice. Jacquie, pregnant with twins, describes a situation in which a stranger questioned her trust in her doctor's referral for multiple ultrasound examinations.

She was just very against ultrasounds and then, I've asked a few people that I know that work in that related field. I've looked it up in my book, *What to Expect when you're expecting*. I just kind of did a little bit of research, because I just took the doctor's word that everything, you know, ultrasounds were safe. Now and, everybody that I've talked to or the research or the books that I've read, they've all said that, so it's probably just her opinion.

However, the stock of shared cultural understandings associated with lupus is comparatively sparse (Senecal 1991). Symptoms such as hair loss, skin rash, and weight gain may therefore lead to positions which are experienced by novice patients as stigmatizing. In the following passage, Christine, who had not yet been diagnosed with lupus, recounts the first time she was positioned as visibly different because of her illness:

I was standing in line at the bank one day, and I heard somebody say to me...to another person standing in line, 'What's wrong with that woman? Do you think she has leprosy?' [laughs]. And that's when it hit me, that I guess I look hideous [laughs]. And that bothered me...That started bothering me...To hear 'leprosy' like that. Okay, this is bad [laughs]. So that bothered me and it started me wondering more what was going on, because I didn't really think it was an allergy.

7. "I'm Just a Pebble in the Pond": Ambivalence and Positioning

In other situations, patients' positioning of themselves and their physicians delimits physicians' appropriateness as information sources. A patient may accept her or his subordinate role in the moral order while at the same time recognizing that such a role constrains information seeking from physicians. In

the face of such ambivalence, a patient may seek other information sources. Here, Brian describes why it is easier for him to seek information from a support group for people with lupus than to ask his doctor:

I guess... because I figure they [the other people in the support group] understand me, they know me, they know what it's like. Whereas the doctor doesn't. I'm just a little pebble in the pond, you know [laughs]. They've [the doctors] got a lot more concerns about a lot of other things. My own concerns, I don't know whether they want to know...

Similarly, Karen describes alternative means of obtaining information by turning to a nurse in her family instead of calling her doctor's office.

She has been invaluable. I mean, when something happens and sometimes you just don't think you can phone the doctor about everything, you know what I mean? I would be a pain in the neck.

Karen accepts the superordinate position of the doctor, both in terms of the authority of biomedical interpretations of her symptoms, and in her construction of the doctor's time as limited and precious. In the face of this position, Karen represents herself as a well-trained patient who avoids "bugging" her doctor by turning to another source whose moral position (nurse) validates her as a repository of authoritative knowledge, while her personal position (sympathetic family member) exempts her from the physician's bureaucratic constraints. Natalia represents her physician's behaviour as both adequate and appropriate, and thereby clearly delineates the areas she does not need to ask him about.

I was just there. He asked me probably the three most important questions that a pregnant woman needs to be asked, "Are you bleeding? Are you cramping? Are you Niagara Falls?" Right? [laughs] Then he says, "Lie down." He feels my tummy, tells me my uterus is okay. And I leave. I don't think I need to ask him

anything else. I don't need to whine, I don't need to ask him questions that that book upstairs answers for me.

By positioning her doctor as acting appropriately within the moral order of their encounter, Natalia takes on the position of the “good patient” to delineate a boundary between appropriate and inappropriate information-seeking. In this way, she is able to place limits on her obligations as an active information-seeker. She frames asking her doctor additional questions not as a demonstration of her competence as a pregnant woman, but instead as evidence that she is a whiner.

8. “I'm the Best Teacher About My Body” : Positioning and Reciprocal Communication

Finally, patients can reject representations of themselves as compliant and subordinate in relation to health care providers, thereby reconfiguring the physician-patient relationship in an attempt to facilitate truly reciprocal communication. Lynne, a person with lupus, described her relationship with her doctor:

Yes, you're knowledgeable and you've got that education behind you, but...we're still both human beings...I am best teacher about my health. Even though you're educated doesn't mean you're educated about my body and my health and how I'm feeling. So I am teaching you me, and be prepared to listen to me, just as I'm prepared to listen to you.

A pregnant woman (Lynn) positioned medical professionals as aloof and difficult to communicate with. This created a discursive space in which she could justify her positioning of herself as an active information seeker.

I like to go into any meeting with a few questions. Specially medical people, I find that you can go in, and you can get a whole bunch of information, [laughs] and then you come out and you have all these questions. And then you realize: You know, my questions weren't addressed. They just told me all these things, and now I'm sitting

here and I'm wondering what to do. Or, you know, I'm wondering about this. And so I've often felt like, with medical people, too, that there's always more. You can always find out more, And, you know if you don't ask it you're not going to [whispers] get an answer. [laughs]

Although Lynn's description challenges a particular representation of the physician-patient relationship, her whispering recognizes that her version is not the standard interpretation.

9. Conclusion

Adopting a "position" involves the use of discursive practices which define the relations between self and others. Such practices frequently draw upon common social representations of particular phenomena (Van Langehove and Harré 1994). Our findings indicate that positioning theory offers insight into the mutually specifying correspondence between local discursive practices and styles of information behavior. Our studies have involved two disparate populations of health information-seekers. While cultural assumptions associated with "twins" can both facilitate and constrain the pregnant woman's information seeking, symptoms of lupus such as hair loss, skin rash, and weight gain may lead to positions which are experienced by novice patients as stigmatizing.

Nevertheless, participants from both studies exhibit similar strategies when negotiating, accommodating, or resisting the positions imposed by the moral order that is characteristic of the health care system. As a heuristic tool, then, positioning theory provides a framework for analyzing the ways that talk -- which is structured by both a moral order and by the personal characteristics of the actors -- shapes the individual's experience of the information-seeking episode.

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