WHY DO WOMEN CONSENT TO SURGERY, EVEN WHEN THEY DON'T WANT TO? AN INTERACTIONIST AND BOURDIEUSIAN ANALYSIS

Mary Dixon-Woods, Simon Williams, Clare Jackson, Andrea Akkad, Sara Kenyon, Marwan Habiba

Abstract

The 'informed consent' process has been placed at the centre of bioethical and policy discourses about how the autonomy and rights of patients can best be protected. Although there has been critical analysis of how the process functions in relation to participation in research and particular ethical 'dilemmas', there has been little examination of the routine business of consenting to medical procedures. Evidence is now beginning to emerge that people may consent to surgery even when reluctant to do so. In this paper we develop an analysis informed by Bourdieusian and interactionist social theory of the accounts of 25 women who consented to surgery. Of these, nine were ambivalent or opposed to having an operation. When faced with a consent form, women's accounts suggest that they rarely do anything other than obey professionals' requests for a signature. Women's capacity to act is reduced as they become enmeshed in the hospital structure of tacit, socially-imposed rules of conduct. However, the interactionist account of power operating through the social rules of particular situated encounters, and the sanctions associated with rule-breaking, may not provide a sufficiently powerful explanation for why women submit to surgery they are opposed or ambivalent towards. Bourdieu's concepts of habitus, capital and symbolic power/violence offer a potentially more elaborated account, by showing how the practical logic that women apply in the field of surgery confers a 'sense of place' relative to professionals. Women experience deficits in capital, intensified by their physical vulnerability in critical situations, that severely constrain their ability to exercise choice. This work demonstrates the weakness of the consent process as a safeguard of autonomy. Far from reinforcing autonomy, the process may reinforce rather than disrupt passivity, but more generally our findings call into question the extent to which autonomy may be an illusory goal.

Introduction

Beginning perhaps with Fox's (1976) call for sociologists to explore medical ethics, recent years have seen the emergence of a critique of bioethics by social scientists (Frank 2000, Zussman, 1997; De Vries and Conrad, 1998; Haimes, 2002, De Vries, 2004). Hedgecoe (2004) notes that this critique involves, first, exploring how the social sciences can contribute to bioethics by providing some of the empirical and theoretical foundations that might inform ethical decision-making, but second, and crucially, the development of more fundamental sociology *of* bioethics itself. Both of these projects require a sound empirical base, and there is now talk of the "empirical turn" in bioethics (Borry, Schotsman and Dierickx, 2005). There is a growing literature on people's experiences of consenting to medical research (e.g. Corrigan, 2003; Cox, 2000), but research on routine medical care has been more neglected. Work to date has tended to focus on what happens when ethical "dilemmas" arise, in areas ranging from genetic counselling and paediatric intensive care to organ transplantation (e.g. Bosk, 1992; Anspach, 1993; Guttmann and Guttmann, 1993). Such analyses, while valuable, do run the risk of focusing on the exotic at the expense of the ordinary, and, ironically, of confining themselves to medical constructions of what makes for an ethical dilemma. In this paper, we suggest that "the ordinary" provides a rich source for social science theorising of the operation of bioethical principles in practice. We focus particularly on people's experiences of a routine and everyday practice in hospitals worldwide - consenting to surgery – through the application of interactionist and Bourdieusian social theory to the analysis of 25 accounts of consenting to emergency and non-emergency surgery.

The valorisation of consent within bioethical discourses as an ethical panacea that counteracts the danger of paternalistic and autocratic practices has been identified by Corrigan (2003). This valorisation is also evident in professional codes of practice, government policy and law, which increasingly see consent as the means by which ethical ideals of respecting individuals, their rights and autonomy can best be realised, and institutionalise the place of consent as fundamental to good practice (Department of Health, 2001; GMC, 1998) both in research and treatment. Although it is sometimes argued that different standards of consent are required for research compared with standard therapy, this is not a view universally shared (Chalmers and Lindley, 2001) not least because it could be argued that while the standard of consent is invariant

(i.e. people should understand what they are consenting to and do so voluntarily), what is required to satisfy it may be variable in different situations.

We propose that a critique of informed consent must focus on the constraints and possibilities of its realisation in praxis. Some evidence suggests that achieving the standards demanded to satisfy the requirements of informed consent may not always – perhaps not even often – be achieved in routine clinical situations. Our survey of 734 women at a large obstetrics and gynaecology department (Akkad, Jackson, Kenyon, Dixon-Woods, Taub and Habiba 2004) showed that 33% of women who consented to an elective operation, and 55% of women who consented to an emergency operation, felt frightened by signing the consent form. Of these women, 24% of elective patients and 40% of emergency patients reported that they had no choice about signing the form, and many reported that they did not read or understand the consent form, or feel they had an opportunity to ask questions. In a separate qualitative study involving interviews with 25 women who had consented to surgery (Habiba, Jackson, Akkad, Kenyon and Dixon-Woods 2004), accounts from nine of the women suggested that they were uncertain of their desire for surgery or felt that it was imposed on them, with three actively rejecting the legitimacy of the surgical procedure proposed for them. Nonetheless, all but one signed the consent form when requested to do so.

These findings raise important questions about the constraints on the realisation of the ideals of informed consent in praxis. In this paper we attempt to theorise, using contributions from both interactionist and Bourdieusian social theory, why some women sign consent forms even when they do not wish to consent to surgery or sign despite having reservations.

Interactionist theory: the rules of conduct

Broadly speaking, interactionist theory is an interpretive, voluntaristic approach focusing on self-society relations, conceived in term of social meanings, social symbols and social (inter)actions. Interested in the symbolic work of interpretation and negotiation involved in producing the patterns and regularities of social life as an interactional 'accomplishment', work within this paradigm has identified the significance of rules of conduct in producing and reproducing the orderliness of everyday life. Tacit rules of conduct simultaneously guide, regulate and constitute the structure of social interaction (Goffman,1967a; Strong, 1983; Manning, 1992). Ceremonial

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rules can be viewed as 'rules of etiquette', and function to maintain moral and social order through interaction rituals and the like, the selves lodged, proferred or presented in everyday life and routine social encounters (Goffman 1967a,b). Rules of conduct may be symmetrical and reciprocal, or asymmetrical and lacking in reciprocity, in which case they may express patterns of power distribution (Goffman, 1967a): a 'micro politics' of the social order, in effect (Ditton, 1980).

Goffman was particularly interested in the ceremonial or etiquette rules of social encounters, believing that formal and informal rules mesh together to constitute the ritual or ceremonial order of any social encounter. Strong (1979; 1988) and Strong & Davis (1977) subjected these to detailed scrutiny in an ethnographic study of doctor-patient/parent interaction, concluding that power is produced and maintained in the doctor-patient relationship through this ritualised or ceremonial order of the encounter.

Theory of practice: habitus, field, and capital

The French social theorist Bourdieu was critical of interactionist approaches for their tendency to focus only on the interpretations of individual agents and failure to provide an account of the structures within which people operate (Bourdieu, 1984). It is clear nonetheless that there are important links between Goffman's and Strong's conceptualizations of social life/the life of the clinic and Bourdieu's theorizations of social life, particularly the concern with rules, (symbolic) power and practice.

Four key concepts within Bourdieu's overall theoretical framework are particularly relevant for our purposes here: habitus, practice, capital, and field. Through the concept of *habitus*, Bourdieu attempts to explain the orderliness of social life, while also emphasizing its negotiated quality. In the proposal that participants in social life have a background understanding (in the form of dispositions and competence bestowed through the structuring effects of the habitus) of how they should behave, Bourdieu is clearly referring to an implicit understanding by social actors of, among other things, the kinds of internalized rules of conduct postulated by Goffman and Strong. Importantly, Bourdieu (1989) recognizes the constraints imposed by people's social locations, including the ways in which people become imbued with a sense of their 'place' relative to others, which may include forms of hierarchical positioning. The habitus operates in everyday settings to influence *practice* – attitudes and behaviours (Bourdieu, 1990). Habitus incorporates the reflexive

capacities of embodied agents (Crossley 2001), thereby going some way toward addressing the charge that Bourdieu's sociology is too deterministic – see also Bourdieu and Wacquant (1992).

The concept of *capital* points to the resources available to people in this negotiation of social life. Capital can take a number of forms, including economic, cultural, social, and symbolic capital (Bourdieu, 1990). Symbolic capital includes such resources as prestige, authority, and charisma, and, importantly, the legitimate ability to define situations (Hallett, 2003).

The concept of *field* (Bourdieu and Wacquant, 1992) refers to the discrete, though overlapping, social spaces into which society is differentiated. A field is a distinct social space comprising interrelated and vertically differentiated positions, and a network or configuration of relations between positions. What positions people within fields is their possession of particular forms of capital and power (Bourdieu and Wacquant 1992). Each field has its own distinct logic and norms, with varying distributions of the value of particular forms of capital, and requires people to act in strategic ways that can be likened to game-playing. People in a field must accept the '*illusio*' – the social reality of the game. They must work out the rules of the game that form the logic of practices in that field, deploy or 'invest' their capital in the game, and draw on their knowledge of their positioning within that field. The logic of practice, therefore, runs as follows: '[(habitus) (capital)] + field = practice' (Bourdieu 1984: 101).

Within a field, symbolic struggles may unfold, including struggles for the imposition of specific meanings or perspectives. Such struggles are the process by which agents or institutions— consciously or not—try to impose their vision of the world, as well as the categories they use to understand it, upon other agents. The power relations implicit in those operations are, Bourdieu proposes, generally hidden from the participants, and contribute to the social efficacy of these perspectives (Contandriopolous, 2004: 322). Bourdieu thinks of symbolic power as 'world-making power' – the power to impose the legitimate vision of the social world and its divisions (Swartz, 1997). It is in this context that related notions of 'symbolic violence' and 'misrecognition' come to the fore for Bourdieu. Symbolic violence, succinctly stated, is the 'violence which is exercised upon a social agent with his or her complicity' (Bourdieu and Wacquant 1992: 167). Misrecognition pertains to 'recognizing a violence which is wielded precisely inasmuch as one does not perceive it', given the pre-reflexive assumptions of social agents who take the world for

granted and accept it as it is (1992: 168). Of all forms of 'hidden persuasion', Bourdieu reminds us, 'the most implacable is the one exerted, quite simply, by the order of things' (1992: 168).

The benefits of marrying Bourdieuan and interactionist insights have recently been proposed. Hallet (2003), for example, draws upon Bourdieu and Goffman to good effect in an analysis of symbolic power and organizational culture. Organizational culture, for Hallet, is conceptualized as a 'negotiated order' (similar to a ceremonial order) that emerges through interaction between participants; an order which itself is interpreted by people with what Bourdieu terms 'symbolic power' – the power, that is, to define the situation. This approach, Hallet (2003: 131-36) stresses, starts from Bourdieu's theory of practice. Theories of interaction, in turn, facilitate a move from practice to the 'meso-level of organizational culture', while theories of practice provide a 'micro-macro link' that links interaction, symbolic power and the emergent organizational culture. Whilst Hallet's concerns here are not specifically health-care focused, the relevance of this proposed synthesis of Boudieuian and interactionist themes, we contend, extend precisely to such settings, including the dilemmas of consent to surgery.

Methods

The study was conducted between December 2001 and November 2002 with the approval of the Leicestershire Research Ethics Committee. It involved semi-structured interviews with women who had recently undergone surgery in obstetrics and gynaecology and signed a consent form at a large teaching hospital in the East Midlands, UK. The project team included a panel of eight lay members, who had recently undergone surgery, and who represented a mix of experiences. This panel advised on appropriateness of approach and construction of the prompt guide, and helped to ensure that the project was explicitly attentive to a patient perspective.

Participants

Semi-structured interviews were conducted with 25 women who had recently undergone surgery for obstetric or gynecological conditions at a large teaching hospital in the East Midlands, UK. Purposive sampling was used to select potential participants, with selection based on whether they had undergone emergency or planned (elective) surgery, and on demographic characteristics including age, socioeconomic background, and ethnicity.

Interviews

After obtaining consent, all participants were interviewed individually at home by CJ. An interview prompt guide based on a review of literature, discussions within the project team, and contributions from a panel of patients who had recently undergone surgery was used to guide the interviews but was used flexibly in response to the directions in which participants wanted to take the interview. The prompt guide, which covered women's experiences and views of decision-making and information, consenting, and relationships with healthcare staff, was modified (albeit only modestly) throughout the project in response to emerging themes. All participants were given the opportunity to contact an independent nurse counselling if they had concerns or were distressed following interview.

Analysis

All interviews were tape-recorded and transcribed verbatim. Data analysis was based on the constant comparative method (Glaser and Strauss, 1967). "Open" codes to describe each unit of meaning were initially generated. Through comparison across transcripts, the open codes were developed into higher order thematic categories and sub-categories to provide a framework for coding, assisted by QSR N5 software. CJ continually checked and modified the framework categories to ensure an adequate "fit" with the data and MDW independently validated the assignment of the data to the categories. An audit trail of the development of the framework and its categories was maintained in the reflexive diary.

Results

Three women who were approached refused to be interviewed. Twenty six women agreed to participate in the study, but one tape was unusable for technical reasons, leaving accounts of 25 women aged 19–70 years available for analysis. Eleven had had planned surgery and 14 had emergency operations (Table 1). Each woman had signed a consent form for surgery in the 4 weeks before the interview took place. Six patients worked at home caring for their families, 16 were employed, two were unemployed, and one was a student. Four patients were from ethnic minority groups. We do not, however, offer an analysis of class, gender, or ethnicity here, though we recognise the importance of such forms of capital.

Participants mostly offered detailed and lengthy accounts of their experiences of surgery, although a few had limited recollection. However, it is important that these accounts are not treated as allowing direct access to some "reality" of what happened; they are instead narratives that allowed women to describe their experiences from their own perspective. We have previously shown (Habiba, Jackson, Akkad, Kenyon & Dixon-Woods, 2004) that women appeared to have four distinct orientations towards surgery, and we use these to label the quotations we offer to illustrate our analysis.

i) Surgery as fulfilment of want or desire. All ten participants in this category underwent planned procedures. Here, surgery was seen as a much-wanted solution to often long-standing and distressing health problems.

ii) Surgery as rescue. For the six participants (five emergency and one planned) in this category, surgery was experienced as salvation from an acutely painful or distressing situation. These patients accepted the need for surgery.

iii) Surgery as imposed rescue. The six participants (all emergency) in this category recognised that they needed help but felt the surgical solution to their problem was imposed upon them and that they had had no say in the process.

iv) Surgery as imposition. The three participants (all emergency) in this category had not anticipated surgery, and did not recognise surgery as a necessary or legitimate intervention. They talked about consenting in terms of submitting to a decision made by doctors.

In this paper we are particularly interested in exploring why women in the "surgery as imposed rescue" and "surgery as imposition" categories signed consent forms despite their reluctance or opposition to surgery. However, the accounts of all participants are relevant to explaining the experiences and views of women who were reluctant to have surgery, and therefore all are included in the analysis.

It is clear from women's accounts that they recognised that they had entered a state of "patienthood" that involved both entitlements and obligations, and that required their participation in ritual forms. Women's accounts suggested that in response to their position as patients, individual agency evaporates: their capacity to act is reduced as they become enmeshed in the

hospital structure of tacit, socially-imposed rules of conduct. When faced with a consent form, patients' accounts suggest that they rarely do anything other than obey professionals' requests for a signature, even when they are unsure about whether they need or want the procedure, or understand what procedure they are agreeing to. A loose set of strategies allowed women to respond to the environment of the hospital, by simply "going with the flow". In interactionist terms, these accounts demonstrate that participants in social encounters internalise tacit rules of conduct which guide and regulate behaviour. Women clearly understood that they were expected to sign the consent form.

I just signed it [the consent form] as a matter of course. You know, it was a natural thing to do. (participant 9, planned, surgery as fulfilment of want or desire)

Well they're [consent forms] all standard, standard protocol, isn't it, what you have to do and I just go with the flow and sign 'em. (participant 2, planned, surgery as fulfilment of want or desire)

For women who wanted surgery, the rule that patients must respond positively to requests to sign consent forms was unproblematic. For women who did not want or were ambivalent about surgery, this rule posed significant problems. Bioethical and policy discourses around consent characterise consent as an individual's autonomous decision, based upon adequate knowledge, to undergo a medical intervention. However, as Hedgecoe (2004: 127) point outs, "applied ethics relies on the assumption that the categories in a moral problem (e.g. 'patient,' 'informed,' 'non-directive', 'decent quality of life') mirror those in the ethical theory being applied." Our analysis demonstrated the aptness of this insight; crucially, women recognized a misalignment between what happened and their supposed status as independent decision-makers, more usually adopting the role of a compliant and passive patient. A striking feature of accounts was the tendency for women who had signed the form (without wanting to) to see their behaviour as being "out of character".

I'm just questioning you know, "God I just signed this form", why (laughs) you know yeah, it's weird. [...] No, no, I wasn't saying yes I wanna go for a caesarean, I was just told to sign this form and so I signed this form (participant 23, emergency, surgery as imposition)

Yeah, they just told me to "put an X in there", if I couldn't focus. Didn't see any of the writing, I did afterwards, I did afterwards because they accidentally left my folder in the same room as me, so I had a look through it and I saw the squiggle and that made me cry as well because I thought you know, this is why it was so important that I spoke to you [researcher] because, I didn't agree to it. I never, even signing the paper- it's like being drunk, it's like being a drunk und und saying yes to a man und you know having sex with man and afterwards you think, "I didn't want that" because I wasn't in the right frame of mind, I didn't know what I was doing (participant 17, emergency, surgery as imposition)

In these accounts women appear to be describing their submission to more powerful agents. Strong (1979) suggested that power is produced and maintained in the doctor-patient relationship through the ritualised nature or ceremonial order of the doctor-patient encounter, which may mask power differentials through the imperative to preserve an apparently harmonious encounter. Open conflict, such as refusing to sign a consent form, is then effectively suppressed, while power is covert and operates beneath a 'façade of compliance and acquiescence' (Stimson & Webb 1975; p. 58). However, challenges arise when one or other party is perceived as 'difficult' (McKeganey 1988; Strong 1980). Women's submission to the request to sign the form might be explained in part by the sanctions that accompany rule-breaking in social encounters (Stokes, Dixon-Woods, and Williams, forthcoming). Where the patient disagreed with the treatment proposed by the doctor, their accounts suggested that they found it difficult to decline surgery because this would risk losing their status as a "good patient".

[…] the last thing they need is somebody turn round and saying "I've changed my mind I don't want to have this", because it messes you know all their sort of thing up. (participant 14, planned, surgery as fulfilment of want or desire)

However, the interactionist account of power operating through the social rules of particular situated encounters, and the sanctions associated with rule-breaking, may not provide a sufficiently powerful explanation for why women submit to surgery they are opposed or ambivalent towards. Bourdieu's concepts of habitus, capital and symbolic power/violence offer a potentially more elaborated way of explaining individuals' responses to social contexts. The habitus operates to shape people's behaviours and attitudes, which are termed "practices". In

Bourdieu's (1990) terms, each party in a field has a 'feel' for the game and their practices reflect the practical logic that they apply to the game. For women in our study, this included a feel for their moral and social positioning in a publicly funded and sub-optimally resourced service (Jackson, Dixon-Woods, Hsu and Kurinczuk, 2005; Goode, Greatbatch, O'Cathain, Luff, Hanlon and Strangleman, 2004), where their responsibilities to use the care available in a public-spirited way had to be balanced with their own entitlements to resolve needs and anxieties.

You think oh you [doctor] ain't got time to listen, you know what I mean, because you have got other patients waiting outside, you gotta think of them, you know what I mean, so I'm that sort of person, so no I would have liked to have asked now but it is too late now. (participant 16, planned, surgery as fulfilment of want or desire)

Yeh, because they were there really pressurising me. It was like I was signing for a loan or something and they had got this pen and they go "right then are you ready to sign" and you just feel like they are stood there waiting for me […] they had got a load of other patients and I am thinking well you really haven't got time to, they are busy which I do appreciate that they are busy. (participant 15, emergency, surgery as imposition)

Crucially, the habitus also confers a 'sense of one's place' including a sense of place relative to others (Bourdieu, 1995). Women were acutely aware of their place relative to the professionals in the hospital. They described the identities that were granted to "professionals", often referring to an idealised public character (Strong, 1979; 1988; Strong and Davis, 1977), and the obligations imposed on patients when interacting with someone of in this social category.

Inevitably you are going to listen to the professional as with, you know, with in any sphere of work whether it be as a teacher or as a doctor or somebody who supposedly knows their stuff, then you are going to take note of what they're saying, you need, no, they're the experts if you like (participant 8, emergency, surgery as rescue)

Yeh, doing their best for every patient because that is what his job is really. So you just, I trusted all the doctors to know what they are doing. They are supposed to be qualified in that, because I suppose you have to even when you go in theatre, you are having to trust them, that they're

doing, they know what they are doing and they are doing everything right. (participant 20, emergency, surgery as imposed rescue)

The idealised public characters bestowed on professionals were founded crucially on perceptions of capital. Professionals were seen to have significant cultural capital (Bourdieu 1984; Bourdieu and Passeron 1977), including educational credentials and scientific knowledge, that gave them status and power. Again, where women accepted the legitimacy of these identities, the inequitable distribution of such forms of cultural capital was unproblematic. However, some women experienced their social positioning relative to this form of capital, and the contrast between their identity and those of professionals, as profoundly constraining.

It is important, but I don't think a lot of people haven't got a choice over it anyway, because even if people didn't want to have it done they would still sign it because they probably felt pressured into signing it. […]Because all the doctors and that are there and they know what they're talking about it and they're telling you that you have got to get the baby out and you're saying no I don't want the operation. (participant 4, emergency, surgery as imposed rescue)

Women's accounts suggested that their own capital in the field of surgery is seriously diminished by a number of features of the situation. First, and importantly, the exigencies of the medical situation, including their embodied vulnerability, meant that they felt required to submit to those with authority, credentials, and skills. This was particularly the case when their unborn baby was involved. Extreme states, including pain and the influence of drugs, further reduced their capital.

I didn't have a choice, I had to go along with […] whatever they were saying so, which the first time round I wasn't in control of anything. It was just you know like rush in rush out, which err I think in that respect as well that daunted me as well me cause I, I wa..I didn't make the choice to havin' a caesarean. (participant 14, referring to previous surgery as imposition)

I think the pain was taking over, I don't think I was completely in, and I was on morphine anyway, I was having gas and air so I don't think I was completely compos mentis as such (participant 26, emergency, surgery as imposed rescue)

The ways in which routines in the hospital were orchestrated, including the sometimes short time allowed for patients to sign consent forms, even where there appeared to be no medical need to proceed quickly, contributed further to the erosion of patients' capital.

Maybe if they had come back after, you know, given me time to think about what they had said, because you have to, I have to take it in and then I start thinking of questions after but I hadn't got anyone to ask at that time. […] There were just two ladies sitting there and they gave me a pen and asked me to sign the consent form, so I felt a bit pressured, a bit rushed to read it and then they said basically it was just what, what the information they had just given me is what that basically covers. […] Really, because like I say, there was no rush really for me to sign straight away because I didn't have the operation until later that night (participant 20, emergency as imposed rescue)

Emergency patients were particularly likely to experience their lack of medical knowledge and information about the procedure, and their lack of fluency in medical language, as deficits in capital that meant they were more likely to give consent to surgery even when they were unsure about whether they wanted an operation. As participant 15's account showed, attempts to exercise any form of power in this situation were crucially linked to her recognition of these deficits as well as to the possible sanctions associated with attempts at challenge.

Even in that situation I think I probably could of said no but I didn't have nothing to justify why I was saying no […]. I didn't have anything to come back with to support my decision with why I was saying no and I felt by saying, if I would have said no, then they would have frowned on me and said how can you make that decision and I hadn't got any information at all to support if my decision would have been no (participant 15, emergency, surgery as imposition)

Social capital, which refers to those characteristics of social relationships that act as resources for individuals, might have functioned to restore or bolster patients' capital, but women's accounts showed that they were often not even aware of who was around them.

I don't know. I couldn't even tell you the names of the doctors I seen, I seen that many. Just a doctor came in and said we are going to take you down for surgery. We won't leave you no longer (participant 11, emergency, surgery as rescue)

Patients in hospital were removed from most of their usual social relationships and had access only to people who accompanied them. Women's accounts suggested that in emergency situations they usually turn to their partner or mother, if present, for support. However, current procedures for consent, and English law, limit the extent to which patients may draw on such support by insisting that no-one can sign a consent form on behalf of another competent adult. Some patients were surprised and troubled to find that, where they felt incapable of making a decision about surgery due to extreme states such as pain or drugs, they were still obliged to sign a consent form rather than delegating this responsibility to a trusted advocate.

I said "I want me mum to sign it cause I don't know really what I'm signing to be honest" and I sez "I want me mum to sign it" and they sez "you can't" then me mum came over 'cos they were with me all through the labour and that and err she come over and she sez you've got to sign it darling, you know you've got to go for surgery and and soon as mum said that she held me hand and I don't know what what the signature looked like it must 'ave been scribble or something (laughs) so….that's it (participant 10, emergency, surgery as imposed rescue)

I didn't, I couldn't see, I couldn't see it, my mum held the pen to the paper where the box was and I just squiggled. [I] Was scared, I cried, as soon as I did it. I cried cause I wasn't sure what I'd let myself in for (participant 17, emergency, surgery as imposition)

Whilst Bourdieu's analysis of the efficacy of symbolic power/violence rests, in large part, on the process of misrecognition, our analysis suggests that far from "misrecognising" their position, women who did not want to have surgery were acutely aware of the flows of capital that, while reducing their power, simultaneously bolstered that of professionals. This would appear to be confirmed by the single negative case (Lincoln and Guba, 1985) we identified. In this case, the request for the patient to sign the consent form was initially declined, thereby allowing us to evaluate our emergent theoretical model.

The surgeon came back, they tried to consent me before he came back and I wouldn't sign a consent form, I was still being stubborn at this point (participant 26, emergency, surgery as imposed rescue)

This patient's position within the field of hospital medicine was different from that of the other women who participated in the research. As a healthcare professional, she was familiar with the hospital environment, routines and medical terminology. She also had a shared language in common with the doctors treating her and had some scientific knowledge.

She started going into what I was having done and we'd misinterpreted as well what the consultant actually said he was having done because he actually muttered about a laparoscopy which obviously is not as big as a laparotomy and then she puts the consent form in front of me and it's got laparotomy. I went, "Whoa, I'm not having that, that's major surgery." Yeah I was consenting to a laparotomy plus or minus the salpingoophorectomy and the removal of an ovarian cyst.

In refusing to sign the consent form, her needs for further information and reassurance were met, and she crucially draws on the notion of "rights" as a source of capital.

The doctors, the consultant was fine, when he came back he was probably the one that set my mind at ease more than anybody else. His sidekick was lovely afterwards but she weren't very nice before. No, no I wasn't complying and therefore, you know, she didn't want to know basically, I wasn't making things very easy for them. But I think I was within my rights to question what they were doing and to voice my opinions, saying, "No I'm not having it done.".

This patient had resources of her own which decreased the capital gap between herself and particularly the junior doctor who first requested a signature on the consent form. In this case the symbolic power of the doctor was diminished, allowing the patient to assert herself.

I found it quite easy to say no to the doctors because I've worked with doctors therefore I felt a different relationship with them, but I should imagine it could be quite frightening. But I wasn't, I didn't feel intimidated at all by them. (laughs) Not one little bit.

DISCUSSION

Bioethics, as Fox (2002: 249) astutely notes, is not just bioethics. It pertains to more than just medicine and ethics. It also serves both as metaphor and symbolic medium through which the social uncertainties and anxieties of life and living in the western world today are reflected and

refracted, and thus necessitates the entry of sociology into its debates. Our analysis of women's consent to surgery clearly shows that the ideal of informed consent as the outcome of rational choices exercised by autonomous agents was far from being achieved, particularly in emergency situations; women signed consent forms even when reluctant or opposed to surgery. Far from consent being the outcome of informed decision-making process, and far from protecting and reinforcing women's autonomy, we suggest an analysis informed by interactionist and Bourdieusian approaches allows us to recognise that these women's 'choices' were, in large part, circumscribed if not pre-determined by the rules of the game in this particular field and the power relations contained therein.

In these circumstances, ethical aspirations of 'autonomy', 'informed' and 'consent' may be suppressed, illustrating the relevance of Denzin's distinction between substantive and ceremonial rules (Denzin, 1970). Ceremonial rules, crucially, create rituals in which women's participation is required, including the ritual of consenting. Such rules operate and are communicated through the organization of the hospital and the practical tasks and talk of health professionals, who are thus endowed with symbolic power. Bourdieu thinks of symbolic power as 'world-making power' – the power to impose the legitimate vision of the social world and its divisions (Swartz, 1997). Within a field, symbolic struggles may unfold, including struggles for the imposition of specific meanings or perspectives. Such struggles are the process by which agents or institutions— consciously or not—try to impose their vision of the world, as well as the categories they use to understand it, upon other agents. As our data show, not all women accepted the legitimacy of the vision of surgery proposed for them, but the consent process does not offer a safeguard against the functioning of power within a relationship (Habiba, 2000); it simply becomes incorporated within that relationship and is part of the game within which the relationship is located.

Our findings reinforce work in medical sociology over a number of decades showing how patients appear passive and deferential inside the consultation, even while active and critical outside it (Stimson and Webb, 1975). Our work suggests that women who are candidates for surgery find themselves interacting with powerful agents in the form of health professionals, to whom much of the capital in the field accrues, and find it difficult to resist expectations that they will comply with requests or instructions from professionals. Capital derives not only from specialist technical knowledge and skill, but also from the routines and tacit rules of the hospital and encounters

between 'lay people' and 'professionals'. The embodied contingencies, predicaments and vulnerabilities associated with women's consent to surgery (which may be intensified when an unborn baby is involved) add a further crucial dimension. Women appeared to place, or felt required to place, considerable trust and faith in the competence and credibility of professionals who were socially and practically positioned as 'knowing what they are doing'. Viewed in this light Parsons' (1951) seemingly moribund analysis of the doctor-patient relationship, and the asymmetrical power balance contained therein, may not be quite so moribund after all (see Williams 2005): the habitus of both doctor and patient continues to display or incorporate many traditionally characteristic features, not least that 'doctor knows best'.

It has been argued that the power relations implicit in such situations are generally hidden from the participants, and contribute to the social efficacy of these perspectives (Contandriopolous, 2004: 322). Bourdieu and Wacquant (1992) describe "misrecognition" as the complicity of individuals in hierarchical positions that derives from their beliefs that that is simply the way things are. Our analysis suggests, however, that some women – particularly those who were ambivalent about consenting – were highly sensitised to the distribution of power. Their apparent complicity derived not from their failure to recognise distributions of power, but from their sensitivity to the rules of the game and their deficits in capital. Asking women to sign a consent form in such circumstances in fact, we suggest, reinforces rather than disrupts their passivity. Women's accounts emphasise that it is the *procedure* of consenting that is instrumental in producing their docility, and thus subverts the original intention of the consent process in ensuring their autonomy. These findings recall Merton's (1949) classic analysis of goal displacement.

It is of course true that some of the specificities of law and hospital organisation will vary from setting to setting – for example the law on nomination of advocates is different in North America – and there can be little doubt that the legal environment acts as a powerful constraint on the possibilities of interactions between health professionals and patients (Dingwall, 1994). Nonetheless, it is important that our empirical findings and our theoretical treatment of these issues are not read simply as 'problems' in the consent process as enacted in the particular setting where the study was conducted. What our analysis shows is that it is, above all, the social accomplishment of consenting that should be the focus of interest. Such an understanding must

rest on a recognition of the differential flows of capital, symbolic power and the rules of the game, which serve to circumscribe consent to surgery.

At the same time we are mindful of the limitations of our own data. Most obviously, perhaps, we have not (because of the limitations of our data) offered an analysis here of the implications of forms of capital such as gender and social class, nor have we offered a comparative analysis. More particularly, Bourdieu himself has cautioned against a reliance on informants' accounts alone. Women in our study may simply be justifying rather than describing their behaviour in a post hoc fashion: a case of *reconstructed* logic, with all the moral baggage this entails, rather than logic in *use*.

It is nonetheless clear, following Bourdieu, that many of the practices reported in our study rest on tacit rules and forms of 'hidden persuasion' exercised, quite simply, by 'the order of things'. Aspirational models of shared decision-making and bioethical pronouncements about the importance of consent are likely to continue to founder in such circumstances. These data suggest a need to think about the *taken for granted assumptions* that guide events in hospital and how they may serve to reproduce the submissive patient. There is also a need to be sensitive to the *socially determined culture* of patienthood and the meanings patients may attribute to their experience. At the heart of all this, of course, lies the body as both the existential basis for our being in the world and the body as the site and source (cf. Shilling 2005) of power relations: a veritable 'embodied politics' as Bourdieu himself puts it (Bourdieu and Wacquant 1992: 172). From this it follows that it is not simply a case of the body as mere *generator* of ethical dilemmas, in some abstract, disembodied fashion, but an *embodied site* for their very enactment (Russell 2000). Re-thinking bioethics, including the dilemmas of informed consent and the limits of autonomy, must of necessity involve a call to re-embody it.

CONCLUSIONS

As Kleinman (1999:70) notes, "bioethics is confronted with an extraordinarily difficult quandary: how to reconcile the clearly immense differences in the social and personal realities of moral life with the need to apply a universal standard to those fragments of experience that can foster not only comparison and evaluation but also action." Although bioethics has succeeded in placing "consent" at the centre of relationships between doctors and patients (Lopez, 2004), our study of

women's experiences of consenting to surgery suggests that the consent process not only fails to operationalise bioethical ideals such as respect for autonomy and a challenge to paternalism, but through its enactment may actively contribute to the disempowerment and disenfranchisement of patients. Recourse to both interactionist and Bourdieusian theory shows how the rules and identities of those participating in the field of surgery operate to ensure that patients are deprived of crucial forms of capital, to the extent that they may sign consent forms for surgery even when they do not want to.

Table 1 Surgical procedures undergone by study participants

	Number of participants
Planned procedures:	
Abdominal hysterectomy (removal of the uterus through an abdominal incision)	2
Vaginal hysterectomy (removal of the uterus through the vagina)	1
Tubal reconstruction (repair of damaged fallopian tubes)	1
Sacrocolpopexy for prolapse (abdominal suspension of a prolapse)	1
Endometrial balloon ablation (removing the uterine lining using a thermal balloon)	1
Hysteroscopy and endometrial biopsy (telescopic examination of the uterus)	1
Dilatation and curettage (scraping of the uterine lining)	1
Caesarean section	3
Emergency procedures:	
Salpingectomy and/or oophorectomy (removal of fallopian tube)	4
Abdominal hysterectomy (removal of the uterus through an abdominal incision)	1
Caesarean section	6
Caesarean section, hysterectomy and repair of bladder injury	1
Manual removal of placenta	2

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