EXAMINING THE DOCTOR-PATIENT RELATIONSHIP

KNOWLEDGE, VULNERABILITY, AND POWER IN WOMEN'S HEALTH CARE NARRATIVES

AGNIESZKA ARLETTE KOSNY

0-612-42404-9

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By

Agnieszka Arlette Kosny

A thesis submitted to the

School of Graduate Studies

in partial fulfilment of the requirements

for the degree of

Master of Women's Studies

Women's Studies Programme / Faculty of Arts
Memorial University of Newfoundland

May 1999

St. John's Newfoundland

Abstract

This study examined women's perceptions of their interactions with doctors. I interviewed twenty women with different levels of formal education. One group had no more than a high school diploma and another group had completed at least four years of university.

In my research, I used in-depth, semi-structured interviews to collect data. I asked women about their health and about the specific aspects of the doctor-patient interaction they found positive and negative. I involved women in an exploration of their own experiences by asking them to theorize about why they were treated in certain ways by doctors and the health care system. The interviews were analyzed using meaning condensation and theme analysis.

Most of the women I spoke with saw their health and health care in a holistic manner. Their narratives encompassed three different levels of experience; the relational, the personal, and the social. Women wanted doctors to recognize that a variety of economic, social, and societal factors influence their well-being. The themes of communication, information, power, quality and quantity of time spent, value given to the patient, and the doctor's personal manner had the greatest influence on the quality of the doctor-patient relationship. Many women told me about experiences connected to gynecological and reproductive health. These experiences (both good and bad) seemed to have a profound impact on patients.

There were several differences between the two groups of women I interviewed. High school educated women were more often concerned that a doctor was not being

honest with them and they seemed to be less confident about asking questions and demanding information when they were having a negative interaction with a doctor. Women in the university educated group were more likely to expect that a doctor personalize a treatment or service to fit their individual needs. University educated women also wanted physicians to trust their judgement, while high school educated women did not tell me about similar expectations.

Several of the participants in my study told me about incidences of sexual misconduct by their doctor. It is noteworthy that there was a general lack of awareness about the procedures of reporting a doctor's inappropriate behaviour and most participants were reluctant about filing official complaints about improper behaviour (both sexual and non-sexual). Although many women reported incidences with doctors that were negative, most women did not simply accept negative treatment. There was ample evidence of resistance and subversion in my study.

I hope that my study gives voice to women's experiences and theories about their interactions with doctors and about the health care system. The information gathered in my study can be used as a resource for medical schools, health care providers, policy makers, and other researchers. A diversity of women's input is essential if medical education and health care policies can reflect a variety of women's experiences and needs.

Acknowledgments

First, I would like to thank the women who participated in these interviews. Thank you for your valuable time and for sharing your words and experiences with me.

Thank you to all the community groups who welcomed me and this project into their centres.

Thanks goes to Joan Scott for helping me sort out my thinking at the conception of this project and to the many professors doing feminist research at MUN who shared their insight and experience with me. I would like to give special thanks to Elizabeth Church whose guidance, intelligence, and dedication helped me become a better researcher. Our discussions and her contributions were inspirational and immensely valuable.

I would like to thank the School of Graduate Studies and the Maritime Centre for Excellence in Women's Health for their generous funding.

Thank you my dear friends Nancy Peckford and Katharine King who commiserated, discussed, and supported me throughout. Enormous gratitude to my partner and companion Peter Skanes for his much needed diversions, patience, and love.

Finally, I would like to thank my mom (Barbara), dad (Aleksander), and grandmother (Babcia Stasia) for their support, interest, and motivation.

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Chapter One

Introduction

Many physical, social, and economic realities affect women's health. Some of these are broader societal issues that influence women's everyday experiences. Others occur during the face-to-face interactions women have with health care providers. Women's experiences with doctors can affect their attitudes toward health, and their health outcomes. In my research I have adopted the definition of health constructed by the Women's Health Office at McMaster University in Hamilton, Ontario:

> Women's health involves women's emotional, social, cultural and economic context of women's lives, as well as by biology. In defining women's health we recognize the validity of women's life experiences, and women's own beliefs about, and experiences of, health. We believe that a woman should be provided with the opportunity to achieve, sustain and maintain health, as defined by the woman herself, to her full potential. (Cited in Gibson, 1996, p.1)

This definition of health is useful because it indicates that health is not merely the absence of disease. Health entails physical, mental, and emotional well-being and resources. Paula Nicolson and Jane Ussher (1992) state, "Inadequate or inappropriate provision of health care and lack of recognition of what constitutes a specific individuals or group of individuals' well-being contributes to social oppression."(p.1)

My research examines women's perceptions of the doctor-patient interaction. Women's experiences with doctors are often negative and these experiences may vary according to a woman's educational level and income. By interviewing women I explored the positive and negative aspects of the doctor-patient interaction and delved into women's understanding of why they are treated in certain ways by their physicians. I hope this will help elucidate whether women feel that their doctors have an accurate and just perception of their needs, concerns, and illnesses. It is crucial that women have input in their own treatment, the identification of problem areas, and the implementation of positive changes within the health care system that serves them. As a feminist researcher, I endorse research that will lead to the just, respectful, and equal treatment of women in all facets of our lives.

In this chapter I explain why this research is important and how it will benefit women's health care. I situate myself in this research and explain, much like I did to many participants, my interest in this project and in women's health. My literature review includes a discussion of broader societal issues that affect how women are treated by doctors, and more specifically, an examination of the actual interactions between doctors and patients. I attempt to illustrate how these interact to affect women's experiences with doctors and their health in general. This provides the background from which my work emerges. Finally, I point to gaps in the current research that address women's experiences with doctors.

Why study the doctor-patient relationship?

Out of all the factors that affect our health, visits to the doctor may seem like the least significant. Up until a few years ago I did not give my interactions with doctors much consideration. I thought that going to the doctor was a necessary, mildly unpleasant experience that I had to endure a several times a year. I had a sort of awakening when my "discovery" of feminist theory coincided with a particularly negative interaction with a doctor during which I was talked down to, disrespected, dismissed, inconvenienced, and where I was not presented with options I knew existed. I do not know why I had never critically examined my experiences in the health care system in the same way that I examined other women's issues such as violence against women or men's and women's earning discrepancies. Perhaps as a psychology major trained in only the quantitative tradition, I thought of science and medicine as objective and unbiased. After doing some reading and talking to many women about their experiences with doctors and the health care system in general, I realized that many women have had experiences that have been far more negative than my own. I suspect that sometimes I was treated *better* by doctors than some other women because I am white and educated.

My feelings toward the significance of the doctor-patient relationship to a person's well-being have changed. Doctors' opinions and views, like those of other people, are influenced by the sexism, racism, heterosexism, and classism of our society. Even with the best intentions, doctors' recommendations may be based on knowledge that is flawed as a result of gender and race bias in clinical studies and medical education. With the emergence of conflicting information about the safety of birth control pills, hormone replacement therapy, breast implants, and breast cancer therapies, a doctor's advice and expertise can influence women's life-altering decisions. Finally, doctor-patient interactions can play a role in subverting or reinforcing women's views toward their bodies, their health, and even their position in society.

My experiences, and those of the women I have talked to, have been far from ideal. I feel that an ideal doctor-patient relationship would be one where a physician would be respectful of his or her patients regardless of their social-economic position, race, sexual orientation, gender, or age. He or she would try to explain why certain treatments and procedures were prescribed and try to use the least invasive treatments whenever possible. The physician would realize his or her position of power and the vulnerability of the patient. He or she would always consider the context of a patient's life and how a given treatment, procedure, or medication would affect it. The physician and patient would become partners in health care, both working together toward the health and the empowerment of the patient. This is my ideal and I recognize that different women may have different expectations of their interactions with doctors.

I do not want to seem completely negative or imply that all doctors are "bad" and all patients are their victims. Doctors are human, and it is impossible to expect a person to be perfect. Like other people, doctors will experience bad moods, family problems, and poor health. Doctors are sometimes put in high stress environments (i.e., emergency rooms) and patients may not always recognize the consequences of such working conditions. Patients also come with biases and they can have expectations that they do not always make clear to doctors. Even if a doctor tries to create a safe and comfortable atmosphere, some patients will not feel comfortable discussing certain issues or problems. Difficulties with communication often result from a variety of factors and can involve obstacles and misunderstanding created by both people. Finally, along with some negative experiences, I think most people have also had very positive experiences with doctors and I also examine the significance of these experiences.

Purpose of research

The immediate purpose of my research is to determine, through in-depth, semi-structured interviews, women's perceptions of their interactions with doctors. I believe that this interaction has a profound impact on women's health since it may alter the way women feel about themselves, affect their health care, and change the course of their illnesses. It may also affect other people in women's lives (children, partners) since women are often the ones who are "in charge" of their family's health (Sargent & Brettell, 1996).

In my research, I focus on one patient characteristic, level of formal education, and explore the differences and similarities in perceptions of the doctor-patient relationship in two groups of women with varying levels of education. I am aware that there are many other characteristics such as race, income, age, sexual orientation, and body size that may affect a woman's treatment in a doctor's office and her perception of that treatment. This should also be recognized and addressed. There has been little work done examining how education may affect the doctor-patient interaction. Socio-economic influences on health are often examined, only in terms of the kinds of barriers people living in disadvantaged circumstances face in access to health care. There is also some discussion about how the quality of food and housing, and the stress of living in poverty, affects health (Frideres, 1988; Blackburn, 1991; The Working Group on Women's Health, 1994). There is little discussion about how negative attitudes surrounding lack of formal education, certain types of employment, and the possible status difference between working-class women and doctors may affect doctor-patient interactions, and how women perceive these interactions in light of their socio-economic position.

Virtually absent is research that asks women *directly* what they like or dislike about their interactions with doctors. Many researchers judge the interactions according to their own standards and do not always give women the opportunity to discuss their subjective reactions or feelings or to theorize about why they were treated in a certain way. I feel that it is essential that women have an opportunity to talk about their experiences with doctors. The views of women with low levels of formal education are almost never solicited by health researchers or considered by the medical profession. A diversity of women's input is essential if medical education and health care policies can reflect a variety of women's experiences and needs. I hope that the information gathered in my research can be used to open up a dialogue in medical institutions, as a resource for policy makers, and other researchers. I would also like to deliver my research results to patients and I hope the community can benefit from the information generated by this project.

As a part of my feminist research project, I will not discount women's experiences because they are rooted in the personal or the subjective (Reinhartz, 1992). My goal is not to judge women's perceived experiences against some "objective" reality. By doing this research, I hope to give voice to women's experiences, involve them in the examination of those experiences, and, consequently, in their own emancipation.

Literature review

Introduction

Women's experiences in the health care system are not always positive. In fact, women are often mistreated, misdiagnosed, and misguided. Claiming objectivity and rationality, physicians often make judgements about women's desires and needs. These judgements are coloured by sexism, classism, homophobia, and racism present in our society. Often, doctors' interactions with women, their diagnosis, and their treatment, are influenced by factors that are not related to physical illness.

In my literature review I address two main themes: the treatment of women by doctors and the external factors which affect this treatment. I demonstrate that women's mistreatment by physicians has a long history, and that problems such as discounting women's experiences and/or excessively medicalizing them continue to affect women's treatment during the doctor-patient interactions and their health. My literature review reveals that a patient's treatment may vary depending on her age, body size, socio-economic status, ethnicity, and sexual orientation. It is important to examine the social, cultural, and economic factors which influence help-seeking behaviour and women's treatment. My literature review also explores the larger problem of how the construction and privileging of modernist, "objective" knowledge, as manifested in traditional medical education and bias in research, works to discount women's experiences and perceptions. I explore how power accorded to the physician by the patient, the medical system, and North American society in general, can hamper the development of an egalitarian doctor-patient relationship and may lead to harmful treatment. Finally, I address some methodological problems with past studies that have examined doctor-patient interactions.

The (mis)treatment of women by doctors

The historical mistreatment of women patients and the disease of femininity

Male doctors' mistreatment of their female patients has a long history. In the early-to-late nineteenth century, when allopathic medicine already had a psychological and financial grip on North America, femininity was well on the way to becoming a diseased state. Femininity refers to the stereotypical expectations and qualities that are associated with being female. Paradoxically, although women were (are) expected to have feminine qualities to avoid pathologization, femininity itself was (is) pathologized (Nicolson & Ussher, 1992).

An upper-class woman's natural condition was seen as that of illness. Almost every aspect of a woman's life that distinguished her from a man was pathologized. Menstruation or the lack thereof was a serious threat throughout a woman's lifetime. Physicians urged upper-class women to set aside at least one week per month as a period of bed rest and repose (Ehrenreich & English, 1979). Similarly, doctors believed in the pathological nature of the birthing process and insisted on a period of rest and confinement prior to and after birth (Ehrenreich & English, 1979). The uterus and the ovaries were also seen as a constant threat to a woman's unstable condition. Almost any medical problem appearing in a woman--backache, indigestion, tuberculosis, depression, and a variety of non-medical conditions such as promiscuity, hysteria, and disobedience were attributed to the effect of the uterus (Ehrenreich & English, 1979).

It is significant that these doctors' attention focused almost solely on wealthy, upper-class, women. Much of what was prescribed by doctors was simply not feasible for working-class or poor women. These women did not have the option of taking time off for pregnancy and menstruation. According to doctors, working-class and poor women were robust, coarse, and more animalistic. They stood in direct contrast to the refined, affluent, woman--sickly and frail as a result of her "civilization." The affluent woman's lifestyle was more compatible with lengthy, expensive medical treatment (Ehrenreich & English, 1979). The theory of innate female illness was skewed to account for class differences that, in turn, affected the patients' ability to pay for doctors' services.

Two ends of a spectrum: medicalizing or discounting women's experiences

The medicalization and pathologization of women's experiences still affects women today. Events such as menstruation, childbirth, and menopause, which most women experience as part of a healthy life, are made into "medical events," or at least events laden with the possibility of complications and problems. Rarely do doctors or researchers consider how the social construction of these events affects women's perceptions or their perceptions of the events. This is misguided since the social and cultural construction of experiences such as menstruation, childbirth, and menopause are perceived differently in a variety of cultures and they are not automatically defined as sources of emotional stress, stigma, or depression (Sargent & Brettell, 1996).

A good example of how women's common experiences are medicalized and pathologized is the case of premenstrual syndrome (PMS). PMS did not exist as a medically defined category before the 1930s. Bio-medicine has taken the bodily changes of women over the period of a menstrual cycle and has sold them to women as a disorder or problem that needs medical treatment and attention. Although the recognition of PMS as a real problem is comforting to some women whose experiences were discounted, feminists warn of the dangers of this kind of medicalization and categorization of PMS as a debilitating disease (Sargent & Brettell, 1996). Davis (1996) argues that attention and concern over PMS grew when women started entering the work force in increasing numbers. She says that when women were seen as a threat to the social order of society, menstruation became a liability. PMS has been used as a method of social control to keep woman out of positions of power.

It is also important to consider the political economy or the business of PMS and menopause. Books, drugs, seminars have sprung up all over North America to help (rich) women deal with their "debilitating disease." Menopause is an extremely lucrative business with over 460 million dollars in estrogen sales in the United States alone (Sargent & Brettell, 1996). As in the 19th century, it seems that the targets for these treatments are middle and upper class women who have enough money to buy the books and drugs that keep the industry alive.

On the other end of the spectrum, women's experiences are often dismissed. Paradoxically, doctors often believe that a woman's symptoms result from her emotionality or hysteria. For example, Martin (1988) notes that in hospitals women's symptoms of cardiac distress are often perceived as stemming from "other factors." This study indicates that there is a sex bias in the decisions to refer women for coronary bypass surgery.

The protracted mistreatment of women patients and the pathologization of women's experience can potentially influence women's encounters with doctors. If doctors believe that women's everyday experiences are pathological and if they believe that this pathology is determined by their biology, there is a possibility that women will be treated with unnecessary medication and procedures, without a consideration of external factors (such as stress, nutrition, and social relationships) that may influence and contribute to the experiences of PMS, childbirth, postpartum depression, and to women's illnesses (Gurevich, 1995). Conversely, if doctors believe that women's illnesses are "all in their heads," women may not feel as if their concerns are being taken seriously and may not be given life-saving medical options (Smith, 1992).

Doctor-patient interactions

On the doctor's terms

Several problematic issues are specific to interactions during the medical interview. Not only does the doctor have power and knowledge sanctioned by society but the whole medical interview is often done on the doctor's terms. The patient is received at the doctor's convenience. Often the doctor does not introduce him or herself, assuming that he or she is known to the patient. Most often the patient is expected to call the doctor by his or her title and last name, while the patient is called by a first name. When an appointment is made for a certain time, the patient usually has to wait for extensive periods to see the doctor, while the actual doctor-patinet interaction only lasts an average of fifteen minutes (Todd, 1989). All of this underscores the fact that the doctor is the one with more power in the interaction.

Communication possibilities and problems

Good communication is the fundamental instrument of the doctor-patient relationship and influences the therapeutic goals of the doctor-patient interaction (Roter & Hall, 1993). Roter and Hall (1993) outline several principles that should guide doctor-patient interactions: 1) Communication allows patients to tell doctors the story of their illness. Doctors need to hear this story. Telling the story allows both doctor and patient to integrate and interpret the meaning of the illness and the disease. 2) The medical visit is a meeting of two experts. Each has a unique perspective and valuable insights into the patient's physical/mental state and quality of life. 3) Communication should facilitate the connection between a patient's physical state, mental state and experience of life. 4) Communication should maximize the value of the physician's medical knowledge. 5) Communication should make clear the expectations of both doctor and patient. 6) Communication should aid in overcoming stereotypes so that both doctor and patient gain a sense of power from the encounter.

Studies that have examined the discourse within doctor-patient interactions have shown some disturbing trends. For example, patients only have about sixteen seconds during the medical interview before they are interrupted (Jolly, 1987; Poulton, 1996). Further, physicians often avoid and dislike patient-initiated questions (Fisher, 1986; Katz, 1984). In one study, out of 773 questions asked, only 9% were asked by patients (Jolly, 1987). When physicians ask questions they are often specific and leading, tending to restrict the patient's informational response rather than encouraging the patient to describe problems completely. Todd (1989) reveals that once the initial complaint is stated, most doctors do not allow for further patient-centred concerns to be introduced. Yet, when patients are given adequate time and opportunity, they are able to pinpoint their exact symptoms and convey them to the practitioner (Jolly, 1987).

Open-ended questions provide doctors with more information about a patient's condition than closed questions. Closed questions tend to procure incomplete information (Gordon & Sterling, 1995). Fisher (1986) says that in ordinary conversation, people can expand on a topic, change it, amend it, or argue. In the case of the doctor-patient interaction, the rules are far more rigid. Patients are expected to answer all questions and provide any information that is requested. Female patients, particularly, are taught that it is expected that they do not expand, amend or disagree with the topic of discussion. Fisher found that when a woman tried to expand on the information given by the doctor, if she challenged what the doctor said, or tried to gain control over the conversation, the doctor often started using "morality talk" which asserted his position and implied that the patient's (inappropriate) behaviour could have caused her condition (Fisher, 1986; Fisher & Groce, 1985).

Gordon & Sterling (1995) outline several behaviours employed inadvertently and intentionally to prevent patient talk. These include clock watching, mumbling (to convey that the doctor is thinking and should not be interrupted), leaving quickly without indicating that the visit is finished, interrupting, ignoring the patient's questions and concerns, showing unreceptive body language (i.e. frowning), and using technical language. The use of medical jargon can be very problematic for the patient. Jolly (1987) notes that doctors often rely on scientific terms to describe symptoms and disease.

"Med-speak" is a disregard for different levels of familiarity with medical terms and procedures, and indicates the doctor's inability to be flexible and accommodating. There is a reluctance to demystify language and procedures. A study found that 95% of doctors did not ask a patient whether she or he understood the treatment the doctor was prescribing. They said that they *would not ask*, stating that it was not significant (Jolly, 1987). Jolly (1987) describes the results of this obscure language. She says that when patients do not understand language, they may respond in a vague and inarticulate manner. This may reinforce the stereotypes that doctors may have about certain groups in society (women, people of colour, the poor) and discourage doctors from offering meaningful information and explanation because they assume that patients will not understand.

Many of these problems may be exacerbated depending on who the patient is. Doctors, like other people, are likely to be influenced by stereotypes regarding (for example) the poor, people of colour, people who are over-weight, and women. Based on these stereotypes, doctors may make assumptions about the kinds of illnesses certain people have, the causes of these illnesses, and about appropriate treatments. These assumptions can direct the course of a doctor-patient interaction and may affect a patient's experience of the medical encounter.

Stereotyping of patient characteristics

In this section I discuss how patients' treatment may be affected by physicians' notions about gender, age, weight, social, economic status, race, and sexual orientation. I have already discussed how gender can influence the doctor-patient interaction. Other characteristics, however, may have an equally significant effect.

Age

A patient's age may be important since doctors can make judgements about what a person of a certain age wants or needs. It is important to realize that age, like gender, is more than a biological category. It too operates like a cultural and social construct. Aging is often viewed by physicians as a physiological condition requiring medical intervention. This conceptualization has a profound effect on health care and medical treatment. Women who are going through menopause may be confronted with negative attitudes and physicians who tell them that they are ill. Many women "buy into" Hormone Replacement Therapy (HRT) because they have been told that menopause is ovarian failure, estrogen deficiency, and the onset of aging (Sargent & Brettell, 1995). The negative attitudes toward aging make HRT, along with other surgical and medical treatments, systematically recommended and sought after.

Some research indicates that older women may be at a disadvantage during their interactions with doctors. One study showed that doctors ask younger patients more questions, given them more information, and provide them with more support than they do older patients. Another study found that doctors tended to be less egalitarian, less patient, and less engaged with older patients (Roter & Hall, 1993).

Adolescent girls also experience some barriers to receiving adequate care. One large study of the health of adolescent girls showed that girls who want to see a female doctor do not always have their preferences met. Twenty-five percent of girls surveyed who wanted to see a female doctor did not get to see one. Further, many girls do not have the opportunity to speak to their doctors privately (Louis Harris and Associates, Inc., 1997). Young women may also be susceptible to mistreatment in the doctor's office. Not only can a large age gap between physician and patient contribute to a power differential, young women may not be aware of their rights when it comes to confidentiality and informed consent. Doctors may also have preconceived notions about teenage sexuality and "appropriate" behaviour for that age group and gender. These preconceptions may influence the options presented to the patient during a medical interview. Teenagers may not know about the health resources that are available in their communities or they may feel uncomfortable inquiring about clinics providing anonymous HIV testing and free birth control. Young women can be vulnerable to sexual abuse because they may not know what is normal for certain procedures (The Committee to Investigate the Process Of Reporting Sexual Misconduct by Physicians Toward Patients, 1993). They may have little experience with medical examinations, especially gynecological ones.

The Commonwealth Fund Survey of the Health of Adolescent Girls (Louis Harris and Associates, Inc., 1997) that surveyed over 6,500 adolescent girls in grades five to twelve found that one in four of the girls said there had been a time when they did not receive the care they needed. Major barriers to receiving care included concerns about doctor-patient confidentiality and not wanting to discuss particular problems with parents. Since girls see health care providers infrequently, the need for effective communication and development of trust is essential during doctor-patient visits.

Unfortunately, there seems to be a discordance between girls' expectations and experiences with doctors. For example, over half of the girls said that doctors should discuss topics such as drugs, eating disorders, sexually transmitted diseases, pregnancy prevention, sexual abuse, and violence with patients. However, only one-fourth of girls said that their doctor had ever brought up these topics. Only ten percent participants said their doctor had ever brought up the topic of sexual abuse, incest, or violence. Thirty-five percent also said that there had been a time that they did not bring up a specific problem with a health care provider because they were embarrassed, scared, or uncomfortable.

Body size

Overweight or obese women may also have negative experiences with doctors. Many physicians equate thinness with health and as a result can urge an overweight woman to go on diets which may cause her immense harm. Being overweight in our society is a value-laden state. Obese women are seen as lazy, disgusting, and stupid (Poulton, 1996). Their obesity is often seen as resulting from gluttony or neglect of their body. Consequently, many obese women are treated with general disrespect and may be given inadequate medical attention.

Socio-economic status

The amount of money, resources, education, and status a woman has often affects her treatment by the medical system. Women who have the time and resources to educate themselves about procedures, different health alternatives, and their rights as patients are more likely to demand ethical treatment and question a doctor's orders and authority. There are many interactions among the effects of gender, race, and class on health and health care. Women in Canada are more likely than men to live in disadvantaged circumstances during the course of their lives. For example, Statistics Canada reports (1995) that the average income for a woman in 1988 was just over 22,000 dollars a year, while for a man it was over 28,000 dollars a year. Single mothers' income was almost half that of single fathers'. Further, women of colour are more likely to live in poverty than are white women (Blackburn, 1991).

Since most doctors come from a middle-to-upper class background, any patient not from a similar background may be at a disadvantage. Many practitioners do not understand or share the language, attitudes, choices, or lifestyles of working-class patients and are ill-prepared for behaviour that does not conform to middle class values (Frideres, 1988). They may make assumptions about the intelligence and knowledge of patients who are of a certain socio-economic level, occupation, culture, and race. This is especially true when the patients' knowledge does not correspond to what the doctors have been told (by society and by medical education) constitutes "real" knowledge and intelligence.

Several studies have shown that doctors talk less with patients that have a lower socio-economic status and that they give them less information (Roter & Hall, 1993). Doctors give less explanations to patients with lower levels of formal education. Ironically, patients who are better educated and come from higher socio-economic backgrounds are given explanations using language that is more clear, comprehensible, and non-technical than are patients with less education (Waitzkin, 1985). Waitzkin (1985) concluded that a patient's level of education has the greatest impact on the quality and quantity of information that she or he receives from a doctor. Several researchers have suggested reasons for disparities between the treatment of patients with high levels of education and patients with low levels of education. Investigators suggest that doctors may perceive less educated patients as disinterested in information about their treatment and condition. However, patients from different classes do not differ in the amount of information they say that they want from their doctors (Roter & Hall, 1993). Patients who have low economic and educational levels may be hesitant about asking questions, not because they do not want to know about their condition or treatment, but rather because the social distance between them and their doctors inhibits verbal assertiveness (Roter & Hall, 1993).

Middle-class and upper-class doctors may not be aware of limitations that living in disadvantaged circumstances places on individuals' lives. Working-class people may not have enough money to buy nutritionally balanced food. There may not be any athletic facilities in poor communities, and affording memberships at gyms or exercise equipment can be impossible. Working-class women may not have the means to take time to relax and concentrate on their well-being if they have children, partners, and jobs. It may not be financially feasible to leave one's job, even if it is the cause of pain and illness.

Working-class women may also be treated poorly by physicians because poverty is a value-laden state in our society. There are several conditions, for example, poor nutrition, addiction, and depression that can result from the physical and mental stress of not having enough money or resources. However, the blame for these conditions is often placed on individual "flaws" such as laziness, stupidity, and apathy, while social factors are ignored (Blackburn, 1991).

Race and ethnicity

A woman's ethnicity can also affect her treatment. Women of colour and immigrant women are often discriminated against, within the context of the doctor-patient interaction. Given the correlation between social class and ethnicity, it is not surprising that doctors' treatment of patients from different racial backgrounds and ethnicities parallels that for different social classes (Roter & Hall, 1993). A study conducted by Shuy (cited in Todd, 1989) reveals that black patients tend to get worse treatment at a doctor's office and have to wait longer to see a doctor. Shuy also found that people of colour were considered to be more ignorant by doctors and were *told* what to do rather than *asked* what they wanted to do. White patients also tend to receive more information than non-white patients and the care that they receive is more personal (Roter & Hall, 1993).

Sterilization without consent is one way that those in power can abuse poor and non-white women's bodies and disrespect their choices. Sterilization has been performed on those who society and the medical establishment sees as unfit to reproduce or raise children. The definition of "unfit" can be extended by those in power to include people deemed socially undesirable, for example, poor women and women of colour (Carey, 1998; Chater, 1991)

Stereotypes of people living in disadvantaged circumstances as a result of their social class or ethnicity can have an affect on the doctor-patient relationship. However, it is important to note that most doctors are probably not aware of their differential treatment of patients. If noticed at all, differences in behaviour are probably attributed to a patient's aptitude, personality, or the mood of the physician at the time of the consultation. It is important that doctors become sensitized to how stereotypes regarding minorities and patients with low incomes and low educational levels affect their own attitudes and interactions.

Sexual orientation

Although there are gay and lesbian physicians who serve the homosexual community and are conscious of the health problems most often encountered by gays and lesbians, many women will not have access to these doctors or know how to find them. In small cities and rural communities such doctors may be non-existent or at least not "out" to the community. There is very little motivation for gay and lesbian doctors to make their sexual orientation public in their professional life, and chance facing discrimination from their colleagues and patients.

Lesbians and bisexual women may encounter problems that are related to a (heterosexual) doctor's homophobia and heterosexism. Some doctors will be hostile to gay patients. Most doctors will assume that a patient is straight and others will be misinformed about the health needs of lesbian or bi-sexual women. For example, doctors may recommend the use of condoms for women who say that they are sexually active, assuming that they are sexually active with a male partner. Although most lesbians would like the option to discuss their sexual orientation with a physician, in one study, 40% felt that their health care would be adversely affected if their sexual orientation was known to the doctor (Burns, 1992). Across numerous studies, lesbians have reported hostility, demeaning jokes, anxiety, and excessive curiosity on behalf of health care providers (Hart, 1995). Further, a study by Mathews, Booth, Turner, & Kessler (1986) showed that 40% of doctors hold negative attitudes toward gays and lesbians and feel uncomfortable treating them (cited in Hart, 1995). One consequence of these beliefs and attitudes is that many lesbians will choose not to visit a doctor. Infrequent medical check-ups can lead to later diagnosis when a health problem exists, delayed treatment, complications, and even earlier death (Burns, 1992).

External factors affecting women's (mis)treatment

In the following section I will explore how the construction of knowledge and what is seen as valid knowledge leads to the discounting of women's experiences. I will also examine the effects of traditional medical training, physicians' power, and paternalistic attitudes on doctor-patient interactions.

The construction of knowledge

Women's treatment during the doctor-patient interaction is influenced by what is considered knowledge in our society and who is responsible for the production of accepted knowledge. One of the ways in which the status quo of male power is maintained is through women's exclusion from the production of knowledge and culture, an exclusion rooted in a tradition of men listening to men. That which is produced by men and important to men--men's thoughts, words, and writing--is supported by men and attended to by men (Smith, 1987). This "malestream" knowledge is seen as both legitimate and objective.

Our society is based upon a set of binarisms which have persisted since (at least) the Enlightenment era. Dichotomies such as rational/irrational, objective/subjective, culture/nature are fundamental to western civilization and each of these oppositions defines a hierarchy in which the privileged side is associated with the masculine and the devalued side with the feminine. Some feminists argue that man/woman is the ultimate binarism informing all others (Hekman, 1990). Women have been, and continue to be, associated with irrationality, subjectivity, emotions, superstitions, the body (as opposed to the mind), and so on. These binarisms influence what is viewed as "valid knowledge", prizing the objective over the subjective, the rational over the irrational, and natural science over social science. Woman is viewed by masculinist knowledge, constituted by nature to be an "essentially subjective species" (Faith, 1994, p. 41).

The doctor-patient relationship can often reiterate, reflect, and reinforce the hierarchical dichotomies and prejudices present in society (Armstrong, 1994). Studies have shown that doctors have very different ideas about what is healthy and normal for women and men. Characteristics said to be male resemble social definitions of normal behaviour and health, while characteristics said to be female are associated with sickness and instability (Doyal, 1995). In our society doctors are told that they have the objective, "real" knowledge (the knowledge privileged by modernist thought) and that the patient is the emotional, subjective, vulnerable *other*. This power differential is amplified when the doctor is a man and the patient is a woman--especially a woman with a low level of formal education, a woman with a disability, a woman of colour, or a poor woman. It is not only the doctor who is taught that her or his knowledge is superior, but the patient is also taught that her subjective experience is of little concern and actually interferes with the way "real" medicine is done (Oakley, 1993). During the doctor-patient interaction, women often realize that what they are feeling is only deemed true if it is verifiable by medical, scientific, observable facts. If no physical pathology can be found, then it is assumed that none exists. Because different women's experiences may not always coincide with that of white, middle class males, they can be seen as less important, deviant or simply non-existent.

Bias in research

Ideas about what is valid knowledge often dictate what studies are conducted, what is identified as a problem, and the kind of methodology used. This in turn affects how doctors interact with their patients. It is necessary to question what kinds of assumptions emerge out of studies which are congruent with modernist, masculinist ideas and ideals. It is clear that what is often being studied is the white, middle class, male experience. The exclusion of women from the circle where "valid" knowledge is produced is replicated in many studies, especially in the natural sciences. This is most evident when large studies on the effects of a certain drug or the progress of a disease are done without including women as participants. The results are then generalized to the entire population (Rosser, 1994). Further, the bulk of the mainstream research done on issues directly relating to women, such as menopause, uses only Caucasian, middle-class women as participants and then extrapolates results to *all* women. This is dangerous since there is evidence that Black and Asian women experience osteoporosis, breast cancer, and heart disease at different rates (Sargent & Brettell, 1996; Boston Women's Health Book Collective, 1992).

As well, research that shows no significant results is seldom published and rarely accessible to doctors. For example, research which finds that the majority of women do not experience difficulties with menopause or research which indicates that there are no differences between males and females in mental ability, is virtually ignored by medical journals and the media (Gurevich, 1995). Consequently, this kind of research is not widely known by researchers and physicians. As a result, beliefs about many behaviours or experiences of women may be misinformed or inaccurate.

It should be unacceptable to perform drug trials or studies which map the development of diseases on male subjects only. It is equally unacceptable to perform studies on women's health issues which systematically ignore minorities and working class-women. These studies are sexist, homophobic, classist, racist and they prevent women from getting adequate diagnoses and treatments for illnesses. They also further normalize the white, heterosexual, upper-to-middle class, masculine experience, so that anything outside of that experience is pathologized.

Medical training

The bio-medical model of education can also contribute to the systematic discounting and pathologizing of women's experience by placing value almost exclusively on physically discernible pathology and scientific "objective" knowledge and by ignoring the individual experience of illness. The bio-medical model of medical education became popular with the emergence of new subjects like biochemistry, microbiology, pharmacology, genetics, and immunology (Shorter, 1985). Internal medicine became the dominant form of medicine, influencing both the education and the practice of doctors. Doctors were (and to a large extent continue to be) sold to the public as scientists. Today, medical schools are concerned with training a student to be a "temporary storehouse of miscellaneous information collected in textbooks and lecture notes and retained for long enough to be reproduced at the moment of examination" (Pickering, quoted in Shorter, 1985, p.187). This technical information is almost immediately forgotten (Shorter, 1985). Shorter argues that this kind of knowledge is almost completely useless to a general practitioner who will largely be dealing with people complaining of colds, coughs, stomach aches, and depression. This extreme emphasis on technical, scientific knowledge diverts doctors' attention from the psychological, social, cultural, and economic causes of disease.

According to the bio-medical model, illness is envisioned in terms of physiological pathology such as abnormal cell tissue, diseased organs, and genetic malfunction. Further, the meanings of disease and illness are collapsed, although the two represent very different things. Disease is something that everyone with a certain condition has in common. For example, women who have breast cancer all have a cancerous tumour in their breast. Illness, however, is experienced differently depending on many social, economic, cultural, and personal factors. Even when disease is present it may not adequately explain a person's suffering since the amount and kind of distress a patient experiences refers not only to the amount of tissue damage but also to the personal meaning of the illness (Stewart, Belle Brown, Weston, McWhinney, McWilliam, & Freeman, 1995).

According to Gabe, Kelleher, and Williams (1994), patients' lay knowledge poses a threat to allopathic medicine. Lay knowledge challenges the (mostly) quantitative methods with which medical science is comfortable because it is not easily accessible by these methods. Lying outside of the convention of positivism, lay knowledge about health and illness challenges the search for abstract facts understood independently of patients' interpretations. If lay knowledge constitutes a challenge to expert systems of knowledge, a patients' non-compliance may be better understood as a subversion of medical dominance and of physicians' authority (Gabe, Kelleher, & Williams, 1994).

The discounting of social factors involved in illness and healing and the technocratic governance of medicine help foster doctor-patient interactions that contribute to the disempowerment and demoralization of patients. Mishler (1995) advances that many doctor-patient interactions are doctor-centred and that they are governed by the technocratic perspective described above. Because it is largely believed that the doctor's role is to make the diagnosis, he or she tends to only attend to the voice of medicine and ignores the patient's struggles and experiences of the illness. What is necessary is an approach that would give value to "patients' lifeworld contexts of meaning as the basis for understanding, diagnosing, and treating their problems" (Mishler, quoted in Stewart et al., 1995, p.32).

Female doctors

Some women feel that they will receive better quality, more suitable, care if they go to a female doctor. Some feel more comfortable going to a female physician for gynecological exams (Roberts, 1985) and women going to female physicians are less likely to experience sexual abuse or harassment (The Committee to Investigate the Process of Reporting Sexual Misconduct by Physicians Towards Patients, 1993).

There have been several studies done that indicate doctor-patient interactions with female doctors are more patient-centred. In general, female doctors spend more time with their patients, give them more information, are better at partnership building, ask the patient more questions, and engage in more positive talk with their patients (Roter & Hall, 1993).

Although there are many female physicians committed to improving the state of women's health care through the organization of women's health clinics and well-woman clinics (The Boston Women's Health Book Collective, 1992), going to a female doctor does not necessarily ensure considerate and just treatment. Despite the fact that women are entering the medical profession in increasing numbers, they are still constitute a minority of faculty in medical schools and 89% fall below the rank of full professor (The Feminist Majority Foundation, 1995). Usually, women are not in positions where they can determine medical school curriculum and policy. This is even more the case for women of colour. Women training to become doctors are faced with a number of obstacles. The arduous routine of medical school, initially set up for men who had a woman at home to take care of them, does not consider the fact that many women may be expected to perform the majority of housework and childcare in addition to their studies. Women also face discrimination that (white) men do not encounter. Many women are determined to prove that they are "as good" as their male colleagues according to the criteria of most medical schools, which include "clinical competence, emotional detachment, and financial success" (The Boston Women's Health Book Collective, 1992, p.668). For this reason a patient may encounter similar problems with female and male physicians. Both female and male doctors are socialized to believe that they have more knowledge than their patients and that their knowledge is more valid. Most doctors are white and middle-class (The Feminist Majority Foundation, 1995). If they are coming from a working-class background, their education, the financial rewards of medicine, and the prestige associated with being a doctor imposes a power differential between them and their working class-patients. It is important to judge each doctor individually. Good doctors, female or male, will be those who are knowledgeable, take a patient's concerns seriously, treat all people respectfully, and communicate effectively with patients about their needs.

Changes to medical education

There has been some progress made in educating doctors to be responsive to patients' needs, the contexts of patients' lives, and in educating doctors in the development of a mutually involving method of medicine. In 1995, six clinicians at the University of Western Ontario wrote a manual to be used in educating doctors in patient-centred care (Stewart, Brown, Weston, McWhinney, McWilliam, & Freeman, 1995). Patient-centred medicine is based on the notion that patients should be active participants in their health care and that there should be a sharing of power in the relationship. This requires a renouncing of the control that has been traditionally held in the hands of the physician. There are six interacting components in patient-centred medicine: 1) In discourse, diagnosis, and treatment the practitioner must understand both disease and illness. It is necessary for the doctor to understand how the patient is experiencing her or his illness, what she or he expects from the doctor, and how the illness affects the patient's life. 2) The physician needs to have an awareness of the context of the patient's life and where she or he is in the life-cycle. 3) A common ground needs to be found between physician and patient with regards to the definition of the problem, management goals, and the roles of physician and patient. 4) Each visit should be used as an opportunity for prevention and health promotion. 5) The doctor-patient relationship should include empathy, trust, caring, and healing. 6) The physician should be realistic about time, availability of resources, and the amount of emotional and physical energy that is required (Stewart et al., 1995).

It is possible that a model of patient-centred medicine can lead to a more egalitarian relationship and to better care, health, and satisfaction for all patients regardless of gender, race, class, or age.

The power of the physician

Many power dynamics hamper the development of the kind of healthy, egalitarian relationship that could foster increased agency in women's own health care and increase satisfaction with the doctor-patient interaction. As stated previously, doctors are told that they have objective, "real" knowledge. Not only does the doctor have power and knowledge sanctioned by society and by the medical establishment, but she or he is in a position to decide what knowledge will be imparted to the patient and when. What a doctor decides to tell a patient is often influenced by what she or he believes about certain groups in society. For example, a lesbian who is having problems conceiving may not be told about fertility treatments if the doctor holds negative attitudes toward lesbians having children (Rosser, 1994). The doctor can also make decisions based on his or her views on certain issues. In a 1998 interview, Peggy Keats, the coordinator of the Morgentaler clinic in St. John's, Newfoundland stated, that she repeatedly encounters patients who have been misled by doctors about their reproductive options, who have been refused abortion referrals, and who have been told by doctors that they had to wait several days or weeks before an abortion referral would be given. This is unacceptable since abortion is legal in Canada and because it denies women our fundamental right to control reproduction.

Fisher (1986) also states that often it is the doctor, not the patient, who decides, on non-medical grounds, what would be best for the patient. For example, Fisher says that in her study doctors were much more likely to recommend hysterectomy as an option if a woman already had children and if she was older. Many older patients have hysterectomies not warranted on medical grounds alone, while younger, childless patients are given more options that included information about less invasive procedures. I am not arguing that doctors maliciously decide that patients should undergo unnecessary procedures but rather that their judgements are not based solely on medical criteria. If women are not given all their options with regards to treatment and if they are not told about all possible side effects openly and honestly, they will not be equipped to make informed, well-thought out choices about their health care.

Medical paternalism

The self-perceived and patient-perceived power held by physicians can result in paternalistic treatment of patients. Medical paternalism refers to physicians making decisions on behalf of their patients, without their full consent or understanding (Sherwin, 1992). Supporters of the paternalistic medical model argue that paternalism is necessary since illness or fear of illness negatively affects the reasoning powers of patients. Further, it has been argued that adequate medical decision-making can only be done by those who possess highly advanced, technical knowledge acquired through scientific, medical training. Finally, some also believe that a patient's trust and faith in the power of the healer (the doctor) is an essential part of the doctor-patient relationship. This trust can only be fostered through the mystification of the healing process and of health care (Sherwin, 1992).

Medical paternalism affects women patients far more than men. Society still endorses and expects passivity from women and women are often taught not to question authority. Further, women are in the patient position more frequently than men. They are most often responsible for the health of their families--bringing the young and the elderly to receive medical attention (Sherwin, 1992). Sherwin offers some critiques of medical paternalism. She says that it is necessary to consider the gendered assumptions that are implicit in the assertion that patients are unable to make rational decisions as a result of their illness or fear of illness. Women (ill or not) are told that their knowledge is not real knowledge and that it is merely subjective. Women are told that they are not able to speak objectively or with any sort of authority about their experiences--including what they are experiencing mentally or physically. Further, given the wide-spread pathologization of women's experience, women are often patients when they are healthy--for example during pregnancy or menopause. These women are not ill, yet they still may be dismissed as not being capable of making the right decisions, because they are coming to the doctor as patients (Sherwin, 1992). Even if a patient's reason is diminished and paternalistic intervention can avert some clear and present danger, it is not obvious that physicians alone are in the best position to decide what is in the patient's best interest. Considering the distance that is maintained in many instances between physician and patient, would these decisions not be in better hands with someone who cares about and knows the patient?

The argument which maintains that the physician is the only person who has enough technical skill and knowledge to make medical decisions is also problematic. Medicine has restricted its focus to objectively measurable symptoms and has, to a certain degree, not identified patients as complex and integrated people (Sherwin, 1992). It is important to note that technical instruments are often flawed and that doctor objectivity is a fallacy. Rather than serving as neutral social instruments doctors have often been party to continued patterns of oppression. Doctors are not justified in claiming a uniquely privileged position for decision-making by clinging to their scientific knowledge (Sherwin, 1992).

The final argument sometimes used in support of paternalistic treatment is the notion that the physician's authority is an essential element for healing. However, patients in general and women in particular, have good reason for not putting blind faith in physicians (Ehrenreich & English, 1978; Foster, 1995; Roberts, 1983). Dangerous and unwarranted procedures are carried out on female patients at alarming rates. Women's reproductive organs are especially vulnerable to "the knife." Fisher estimates that if current trends continue, half of the women in the U.S. will have their uteruses removed by age 65 (Fisher, 1986). Further, the assumption that physician authority is a necessity for healing goes against evidence which indicates that patients tend to fare better when they are active participants in their health care than when they are passive recipients of authoritative treatment (Freund, 1982; Sherwin, 1992; Worcester & Whatley, 1988).

Some studies have suggested that certain groups of people (for example, older people, those with low levels of income, and those with little formal education) *prefer* more paternalistic relationships with their physicians (Roter & Hall, 1993). However, The President's Commission for the study of Ethical Problems (1982) (cited in Roter & Hall, 1993) concluded that even when patients agree to a paternalistic relationship, doctors and patients are often at such different social and economic levels that patients may not be aware of alternatives that exist and may not be able to negotiate a more "active stance" in the relationship (Roter & Hall, 1993, p. 26).

Gaps in research

There are several deficiencies in the current research about the doctor-patient relationship. These shape the questions I am pursuing. There have been relatively few studies done to evaluate the doctor-patient interaction with regard to patient satisfaction. Many of the existing studies examine the quality of the doctor-patient relationship and patients' satisfaction by watching and interpreting doctor-patient interactions (Fisher, 1986; Fisher & Groce, 1985). Rarely are women asked for their perceptions of the interaction. This is perilous since observations are based upon what researchers find problematic and may not reflect how the actual patient feels during the process. For example, a study by Hooper, Comstock, Goodwin & Goodwin (1982) concluded that women had better experiences with doctors than men without actually talking to any of the patients. Further, although researchers obviously approach the analysis of the interview with certain biases, their interpretations of the interview and what they consider to be problematic are often taken as objective truth by the medical system and by society. It is possible that researchers do not identify aspects of the interview that are problematic or identify elements that are not significant for patients. This even more likely to occur when participants are of a different race, age, or class than the researcher. Roberts (1992) warns that questionnaires examining women's experiences of their health care can be problematic when interviewers and interviewees come from different backgrounds. Researchers may get responses that do not reflect a patients' actual experience. One participant in a study of experiences of pregnancy said: "I felt that the answers I gave were not a true reflection of my attitude because the questions themselves did not fit my experience..." (Roberts, 1992, p. 185)

Similarly, studies that examine patient satisfaction often use written questionnaires with pre-determined questions that do not allow participants to comment on aspects of the doctor-patient interaction not represented in the questionnaire (Rowlan-Morin & Carroll, 1990). Like doctors who, when taking a history, may discard certain parts of a patient's story that does not fit into a disease pattern, researchers often create questionnaires that will induce a minimum amount of participation from their respondents (Roberts, 1993). It is easier for researchers to have patients' rate their interactions on a scale of 1-5 then discuss the complexities of their feelings and experiences. Written questionnaires do not allow for participant elaboration that is often needed when dealing with complex issues surrounding discourse, authority, and control.

In her study (1986), Fisher says that she suspected that poor women and women of colour sometimes felt that the way they talked or dressed affected the way the doctor interacted with them. Yet, Fisher points out the difficulty of identifying this as a problem from her transcripts. She notes that doctors never verbalize the fact that the way a woman's shoes look, her skin or her disposition, signal to them that she is a welfare recipient. Similarly, women patients usually do not say out loud during an interaction with a doctor that they feel disrespected.

Some studies that explore the doctor-patient relationship only focus on the "generic patient's" experience without examining how gender, race, or class may shape that experience. For example, Williams & Manace Borrins (1993), randomly selected articles in the New England Journal of Medicine and reviewed them for gender bias and sexism. They found that, overall, researchers ignored the effect of gender in the presentation of research results. The gender of research participants was often unreported and researchers often conducted research studies with only one gender and later in the discussion applied it to all people. The researchers also found that in the majority of articles, health was conceptualized as unaffected by any social, cultural, or economic factors.

There is a marked absence of studies examining the role of a woman's socio-economic level in the doctor-patient interaction. Although several studies have explored the health hazards associated with being a person of colour or one living in disadvantaged circumstances (Blackburn, 1991), few studies try to determine what these individuals see as problematic or positive in the doctor-patient relationship. Finally, I did not find any literature indicating that women patients were asked about their experiences and then were asked to speculate about why they were treated in a certain manner and about their reaction to such treatment.

Summary

In this chapter I have outlined my reasons for conducting research on women's experiences with doctors and how this study can add to the existing research on women's health care. I have provided an overview of the literature on the problems facing female patients in the health care system, especially during their encounters with doctors. The information presented in this chapter has also underscored the importance of many broader issues - such as the construction of knowledge, doctors' medical training, gender stereotypes, racism, and classism - to the interactions women have with physicians. The gaps I have identified in the research on doctor-patient interactions and my literature review shape the kinds of questions I have posed in this study.

Methodology and Research Design

Chapter Two

Introduction

This chapter addresses the methods and methodology I employed for this research. I outline my research goals and the research questions I hoped to answer in the course of my research. I also provide a summary of my preparations for the research and the questions that I used as guides during the research interviews. Finally, I discuss the ethical issues of conducting interview research and possible problems resulting from social, economic, and cultural differences between the researcher and the participants.

Overview

As part of my research, I talked to women about their interactions with doctors and about how they perceive these interactions. I conducted in-depth interviews with twenty women about their positive, negative, and ideal interactions with doctors. I asked women about the specific aspects of their encounters they found negative or positive. In the course of the interview, I involved the participants in self-reflection and in an analysis of their own experiences. I also asked all participants questions about their health-related behaviour and about their sense of well-being. These questions allowed me greater insight into a woman's relationship to her health and the health care system, and in turn contextualized her doctor-patient interactions. Finally, I wanted to get a picture of each participant's "personal profile" so I asked participants to provide me with some demographic information such as age, number of children, level of formal education, employment, and income. The information I collected also allowed me to separate participants into two groups according to their level of education.

There is a void in the literature concerning the experiences and perceptions of women disadvantaged as a result of their educational level. There is also some indication that the educational level of a patient and the differences in educational levels between physicians and certain patients may influence doctor-patient interactions, including communication, treatment, and patient satisfaction (Roter & Hall, 1993). I chose to interview one group of women who had no more than a secondary school education. I also interviewed a group of women who had completed at least four years of university. The aim of this research was to uncover these women's perceptions, thoughts, and feelings about their doctors, health, and health care. I was guided by certain questions I had about women's experiences with doctors.

Questions

1. How do women perceive their health and well-being? How do they care for themselves and what part does the medical system play in a woman's well-being?
2. What are the most common problems that the women in my study have with doctors?
3. What *aspects* of the medical interactions do women name as positive and negative?
4. Are there any marked differences in the two groups in the kinds of experiences women describe as negative and positive? (Note that it is not necessary that I find differences between the two groups of women. I realize that many of the problems may over-lap)
5. To what do the participants attribute their treatment? Are there any differences in the two groups?
6. What kinds of reactions (external reactions, i.e., walked out of the office, and internal reactions, i.e., felt angry) did women have in response to the interaction?
7. What factors do these women see as most affecting their health and as most important to their interactions with doctors and to their health?

I expected that there would be other issues that became important or clear during the course of the interviews. I did not want to limit myself to answering only these questions and ignoring other issues that arose unexpectedly. There were several goals and objectives that I kept in mind during the course of my research. These were guiding principles that helped me stay focused and put my research in context of other research on women's health.

Goals and objectives

- Get a deeper understanding of the problems that different women have with their doctors.
- Identify what women want in a doctor-patient relationship and what makes for a satisfactory doctor-patient relationship.
- Give voice to women's experiences and theories about their interactions with doctors and about the health care system.
- Make information available to medical students, health care providers, community groups, and other researchers about Newfoundland women's experiences with doctors and give some insight into how formal level of education may affect perceptions and experiences.
- Present medical students, health care providers, and the Memorial University Faculty of Medicine with information about patients directly from patients' point of view. Open up a dialogue about avenues for change.
- Communicate the importance of designing health care services with the consideration of women with different health care needs resulting from their economic and social circumstances to policy makers and health care providers.
- Make a contribution to the community and present some possible methods of improving doctor-patient interactions that women can use.
- Do methodologically rigorous research that is egalitarian, participatory, and serves to improve the quality of health care for all women
- Accumulate information that can be used in the construction of larger scale studies, both qualitative and quantitative, in the area of women's health care and health determinants.

Research methodology choice

Qualitative methods

Qualitative research methods have become increasingly important for doing research in the social sciences. Qualitative research is difficult to clearly define because it has roots in many disciplines, where the roles of the researcher, the participant, and the data analysis methods used are diverse (Whitt, 1991). Whitt (1991) uses this definition by Van Maanen:

> [Qualitative Research is] ... a term covering an array of interpretive techniques which seek to describe, decode, translate, and otherwise come to terms with the meaning, not the frequency, of certain more or less naturally occurring phenomena in the social world (p. 407)

Usually, qualitative methods yield large amounts of in-depth, rich data from a limited number of informants. The context of the data gathered is important because it affects the experience of the informants (Whitt, 1991). Rather than generalizability or the identification of cause and effect relationships, understanding is of paramount importance (Whitt, 1991). In my research I use qualitative methods because an enormous amount of knowledge that is valid and reliable can be gained from in-depth interviews with women. Once rich information is known about my informants' perceptions of their interactions with doctors, this qualitative data can provide an empirical foundation for further, larger scale research. Analysis of qualitative data is meant to produce understanding and theory through the information found and not deductively, proceeding from assumptions and hypotheses (Whitt, 1991). As a researcher, I come with pre-conceived ideas and opinions about doctors and their relationships with women. Some of these ideas are influenced by my personal experiences, while others have been shaped by my studies and literature review. My experiences have helped shape the topic of my study but the questions I asked participants were open-ended and allowed for a diverse set of responses. Inductive analysis is important in my research because I do not want to set out to prove or disprove certain ideas *I have* about doctor-patient interactions. This is not useful for uncovering meaningful findings that are true to the *experiences of the women in my study.* Consequently, my theories about different informant's perceptions of doctor-patient interactions will be formed after my interviews and data analysis have been completed.

Feminist methods

Qualitative interviews are a suitable method for many feminist researchers who want to conduct in-depth investigations of women's experiences that have been overlooked, misconstrued, or investigated in unsatisfactory ways in the past. The methods that I used reflect my aim, as a feminist researcher, to allow women to speak for and about themselves. By "feminist researcher" I mean, someone whose choice of study questions and ultimate goal of research is the achievement of emancipatory goals and positive change for women. Regardless of the subject matter, feminist research includes attention to the process of research, not only to the final outcome. The methods of feminist research recognize the plurality of women's experiences, and reject the notion that there is only one truth, one authority, or one objective method (Reinhartz, 1992).

Giving credence to what women say, in their own words, names the personal as part of the human science methodology and directly challenges the modernist assumptions of what constitutes knowledge. Listening to women's realities, as they perceive them, challenges the notion of "objective knowledge" and its paramount position in society (Reinharz, 1992). As a feminist interviewer, I do not discount women's experience because they are rooted in the personal or emotional or "merely subjective" (Langellier & Hall, 1989). My goal was not to judge women's perceived experiences against some other reality. Instead, women's consciousness of their subjective experience is what was important to me as a researcher and a feminist.

Data collection

Preparations

Many of the questions that I asked in my research grew out of my reflection upon my own experiences with doctors and from discussions I had with other women during my involvement with women's centres in Montreal and St. John's. Once I had a preliminary set of questions I did two pilot interviews with two women. I interviewed each woman about her experiences with doctors and about her experience as an interviewee. We talked about the structure of the interview, the kinds of questions that I asked, and if I had omitted anything. I incorporated some of the suggestions that the women had into my final interviews. At this time my study received ethical approval through the Faculty of Arts Ethical Review Committee at the Memorial University of Newfoundland.

At the beginning stages of my interviews I asked a colleague of mine to interview me using the same questions that I would ask women in my research[1]. This was a tremendously revealing and useful experience. Although I had obviously contemplated the questions that I would be asking, I had never articulated the answers out loud in the same way that participants in my study would have to. During my interview, I found it difficult to answer some of my own questions! It was difficult not to focus on the running tape recorder. I felt pressured to answer quickly because the tape was running. Further, when the interviewer asked me about a negative experience I had with a doctor I did not feel comfortable telling her about the experience that was most negative because I was too embarrassed. This exercise allowed me to experience the interview as an interviewee. It was valuable because I became sensitized to how an interviewee may be feeling during the interview. I realized that when a woman wanted some time to think about an answer, I should turn off the tape recorder because she may feel pressure as a result of the running tape. I also understood that sometimes, maybe often, women would not tell me about their most negative experiences, regardless of how open, friendly, and understanding I was.

Finding and choosing participants

In order to explore a broad spectrum of women's experiences, I tried to make the option of participating in this research project available to a diversity of women within St. John's. I did this by contacting over twenty-five different community groups and centres around St. John's and posting ads about my research at the university and in the community. I received several direct responses from the ads posted around Memorial University of Newfoundland. These responses were from women who were currently attending the university. There were several ways that community groups became involved in my study. Some groups put up posters advertising my study around their community centres. Other groups told their membership about my research and those who wished to participate were encouraged to contact me. These two methods were not very successful in attracting participants to my study. Telling one's story about a demoralizing, embarrassing, or painful experience to a stranger probably did not seem all that attractive to many women. Women who only saw a poster about my research or who were told about my research by someone in their group (but not by the researcher), did not get the opportunity to ask me questions about the study or get a sense of who I was as a person. About a quarter of the groups that I contacted permitted me to come and talk to them about my research and about who I was. After an information and discussion session, those who were interested put their names down of a piece of paper. I told women that they could decide not to participate at any time and that they could call me with any questions or concerns. I also told potential participants that if I had more women interested than I could interview, I would choose names randomly from each centre or group. Although the nature and length of these interactions varied, I was able to address many issues that were important to participants and to have a discussion about health care issues important to women at a particular group or centre.

Several women had questions about the research process. For example, some women were concerned that I would ask them very specific and embarrassing questions. I assured them that my questions would be general, about their positive and negative experiences with doctors, and that they would choose what stories to tell me. Some women also wanted to know if I was from the medical school or if I was planning to become a doctor. I told them I was a women's studies graduate student and my research was not connected to the medical school. These sessions gave me an opportunity to tell women about who I was, why I had come to Newfoundland, and why I was interested in women's health.

During the course of my research I was given approximately forty names of women interested in my research. As a result of financial and time constraints I could only interview twenty women. I made the choice to interview only pre-menopausal women, living in the St. John's area. Most researchers must answer questions (to themselves, to the community) about why they choose to involve one group and not another. The most difficult question I had to answer was about why I did not interview rural Newfoundland and Labrador women. In Newfoundland, rural women often do not have access to the health care they need (The Working Group on Women's Health, 1994). In the community where there is only one doctor, a woman is put in a precarious position when a doctor will not give her birth control information, an abortion referral, or if she has a negative experience and wants to go to a different doctor. I chose to do my research in an urban centre where I was already living since I knew it would not be as costly as doing research in rural Newfoundland. I also suspected that some of the women that I would interview had lived in out-ports prior to their arrival in St. John's and would speak to their experiences in rural Newfoundland and Labrador.

The interview

Out of each list of names from a community group or centre, I randomly chose two women to interview. I called them and asked whether they were still interested in being interviewed. If a woman agreed to be interviewed, we arranged a convenient time and location for both of us to meet. I conducted most interviews at a woman's home or at the community centre where she had volunteered to be part of the study. Several interviews were conducted at coffee shops.

At the start of the interview, I reminded the participant about the nature of the interview and the types of questions that I would be asking. I told each participant that the interview would be in three parts. First, I would ask some general questions about their health and well-being. Second, I would ask about a positive and negative experience with a doctor, and finally, I would ask some questions about their "personal profiles." These would be questions about their age, income, education, and so on. Next, I reviewed the consent form with each participant. I stressed that her participation was voluntary and that she could withdraw from the study, or refuse to answer any question at any time. I asked each participant if she had any questions or if she wanted me to clarify anything about the study. Each participant then signed a consent form (see Appendix A).

The interview was semi-structured and participant-centred. Although I had a set of questions that I wanted to ask, women's stories and interjections often led us down a path that was non-linear. The interview often digressed from the questions that I asked when a participant mentioned something that I felt should be followed-up or pursued. During the course of the interview, I used active listening techniques such as reflective voice and tone and sending back messages to the participant for confirmation or disconfirmation.

I first asked women about their health and health-related behaviour. I asked each woman about what she does when she is not feeling well. I wanted to know whether women go to see a doctor immediately or whether there are self-care techniques they use in order to feel better. I asked each participant how often she goes to see a doctor, whether she goes to a male or female doctor, and what are the most common things she goes to see a doctor about. I also asked if she had ever been to an alternative health practitioner (for example, a chiropractor, a massage therapist, a naturalist, a herbalist, a psychologist) and why she had or why she had not decided to go to a alternative health practitioner about a particular problem. I asked about alternative medicine to gauge whether it was a care option for women from different educational and income backgrounds. Perhaps women who had access to alternative health services had a broader range of options to choose from when it came to their health care and they did not necessarily have to rely on allopathic medicine as the only option for health care. Women who use complementary health care may also have a broader, more holistic view of their health and health care. These questions were asked first because they were least threatening and least personal. I hoped that each participant would feel more at ease by the time she started talking about her experiences with doctors.

Next, I asked each woman to think of a positive experience with a doctor and how it made her feel. I wanted women to tell me about aspects or parts of that experience that made it positive. I then posed the same question about a negative experience. I also asked the participant to speculate about why she was treated the way that she was. I wanted to know the factors to which she attributed her negative experiences. I asked each participant how she reacted to a negative experience (both internally and externally). Also, I asked each woman if she felt that a past experience had affected her interactions with doctors, for example, how she feels about going to the doctor, or how she perceives doctors. I asked women if there was something that could be done (a change involving the practitioner or the patient, or a systemic change) to improve doctor-patient relationships. I told participants that this question referred to the doctor-patient relationship in general and also to their particular circumstance. I also asked the participant to describe what an ideal experience with a doctor would be like since it is plausible that a woman's positive experience may not represent an ideal one. Perhaps a "positive experience" is simply one that is less negative than the others, but not what a woman would optimally like it to be. I ended the second section by asking each participant if she had any questions or anything she wanted to add or comment on.

During the last part of the interview, I told each participant that I would ask her some questions about her "personal profile." I asked women about their age, household income (the combined income of all family members in the household), and the highest level of formal education they had attained. I asked about the number of children they had, since more dependent children, in relation to income, can add strain on family resources. I also posed a question about occupation because it is an important determinant of health and there are health concerns specific to certain work that doctors may not recognize during the medical interview (Zeytinoglu, 1996). (See Appendix B for list of questions)

I am aware of the importance of unspoken gestures, body language, and the woman's comfort level to the comprehensiveness of the story conveyed. I believe that my initial impressions of the interview were helpful to my analysis and to the understanding of a woman's experience. For these reasons, I immediately followed up each interview with a write-up of my impressions and any details that could not be conveyed through an audio tape.

The Participants

I chose my participants according to two levels of formal education.

High school educated group (9 participants): All women in this group had no more than a high school diploma. Five women had completed grades nine or ten. These women were all working toward their high school diploma. Three women had their high school diploma, while one woman did not have a high school diploma but was taking some university courses as a mature student. Although these women did not have a great deal of formal education, several had gained knowledge about their illnesses, chronic conditions, and certain health issues by talking to nurses and friends, and by reading magazines, newspapers, encyclopedias, pamphlets, and medical journals.

University educated group (11 participants): All women in this group had finished at least four years of university study. Three women in this group had completed a graduate degree. Seven women had one or more undergraduate degree and one woman had completed more than 4 years of university and was working toward an undergraduate degree (she had switched programs). Most of the women that volunteered for the study gave me their names after hearing a short presentation about my research or after seeing a poster. I approached four women myself after hearing from others that they would be interested in my work. All of the women that I approached were in the university educated group.

Although I tried to write about difference without assigning value laden labels to different groups, sometimes I caught myself privileging the words of women who had high levels of formal education. Perhaps because I was used to how they spoke and I had been taught that the words and grammar they used were (for the most part) correct and proper, their voices seemed to be more valuable and seemed to carry more credence than the voices of women who had less formal education. Throughout my research I tried to challenge the assumptions I had about education, knowledge, and worth. I think it is important to recognize that the amount of formal education a woman receives depends of a variety of personal, social, cultural, and economic variables. Each woman I spoke to made a positive contribution to my study and helped me gain insight into her experiences and perceptions of health care. I hope my research was true and respectful to every woman's story.

Personal profiles of the women

Age - The women's ages ranged from 21 to 54. The average age in the high school educated group was 32 and in the university educated group it was 38. One reason that the women in the high school educated group were younger could be because most heard about my study through adult education classes or community groups offering programs for young children.

Children - Eight women in the group of interviewees were childless. Four women had one child, four had two children, and four had three children. Six out of the nine women in the high school educated group had children, five of those were single mothers (not raising their child with a partner). Six out of the eleven women in the university educated group had children, two were single mothers.

Employment – None of the women in the high school educated group were employed outside the home on a full time basis. One woman worked seasonally and took care of her children and another woman took care of her children and was unemployed. The rest of the women in this group were going to school and some were also taking care of their children. Seven women in the high school educated group were on Social Assistance. Four women in this group reported that they did some sort of volunteer work, for example, helping organize a community centre program, crafts, or babysitting. Five women in the university educated group were employed outside of the home full time (some were also taking care of their children). Four women worked part time; out of those, three were also attending school. One woman was a homemaker. Ten out of eleven women in the university educated group reported that they did some sort of volunteer work, for example, working at community centre, sitting on committees, and other community activism.

Income – In the high school educated group, five women reported a household income of $10,000 and under. The rest of the women in that group reported an income between $10,000 and $14,999. All of the women in this group were living below Statistics Canada's low income cut-offs (see Appendix C), when number of children was taken into consideration. In the university educated group, the household incomes varied greatly. Three women reported household incomes of over $100,000, four women reported incomes between $69,999 and $39,999, and four women reported incomes between $29,999 and $14,999. In this group, two women were living below Statistics Canada low income cut-offs when number of children was taken into consideration.

Urban or rural - Ten of the women grew up or had lived in rural areas or in areas with a population under 30,000. Six women were from St. John's and four women grew up outside of Newfoundland but had been living in St. John's for a minimum of two years.

Current living circumstances – Most of the women were happy living in their present neighborhoods. They reported feeling safe and they said that they had access to places where they needed to go, for example, hospitals, doctor's offices, community centres, and grocery stores. One woman in the university educated group said that she occasionally found it difficult to get satisfactory health care in her community but she has a car and is able to drive into St. John's when necessary. Three women in the high school educated group reported that they did not feel happy or safe where they lived. Drugs, alcohol, noise, and disturbances are problems in their communities. One woman reported violence against women as a concern.

Race – Two out of the twenty women that I interviewed identified themselves as non-white. I hoped that the group of women I interviewed would be more racially diverse but St. John's is more racially homogenous than other urban centres across Canada. I repeatedly tried to make contact with the Multicultural Women's Network in St. John's but I was unable to set up a meeting with the members of the group.

Disability – Two women that I interviewed were living with a permanent disability. Several others were living with a chronic condition that restricted their activity periodically. Again, I made several attempts to contact the Disabled Women's Network in St. John's but was unable to set up a meeting with the members of the group.

Sexual Orientation – I contacted NAN (Newfoundland Amazon Network) and NGALE (Newfoundland Gays and Lesbians for Equality) and informed representatives about my research. I encouraged members to participate. Since none of the women stated their sexual orientation, I do not know if there were any lesbian or bi-sexual women in the group of participants.

Data analysis

The analysis of qualitative data involves the identification and interpretation of themes in the participants' lived experience. It often requires the noticing and exploration of patterns, themes, irregularities, and differences (Whitt, 1991). Qualitative data analysis can help gain a greater understanding of the material studied by focusing on the quality of responses in a small number of interviews (Glaser & Strauss, 1967). Steinar Kvale (1996) has outlined six steps of data analysis. Kvale illustrates that data analysis occurs concurrently with data collection and involves input from both the researcher and the informant. Analysis begins when participants describe their experiences and feelings, as related to the themes of the interview. Next, participants discover new relationships and meanings in the course of the interview. The interviewer absorbs the information and messages sent by the participant and sends them back for confirmation. The aim for the interviewer is to determine whether she understands what the interviewee is saying or implying. Often, a participant may have several and contradictory feelings and interpretations of their experience and the researcher tries to integrate all the information that she is given. In the next step, the transcribed interview is analyzed and interpreted by the interviewer. The researcher first clarifies her data by removing non-essential superfluous information. What is non-essential will depend on previously decided upon themes and the priorities of the study. Kvale (1996) describes several methods of performing data and meaning analysis. These include meaning condensation, meaning categorization, narrative structuring, meaning interpretation, and a variety of ad hoc methods that combine different approaches. In the next step, the researcher re-interviews her participants to give them an opportunity to comment on her analysis and elaborate on anything said. A final step may be an extension of the description and interpretation to include action by the participants and/or the researcher. This action will be based on the insights and information generated by the research.

The analysis of my data

My data analysis was loosely structured around the steps proposed by Kvale (1996). Specifically, as participants described their experiences, I used active listening techniques to send what I was understanding back to them in order to clarify what was being said and what was meant. I transcribed one fourth of the interviews and I received a small grant from the Maritime Centre for Excellence in Women's Health to have the rest of the interviews transcribed. To analyze transcribed data, I used primarily meaning condensation and meaning categorization. First, I examined two interviews very thoroughly. I read the transcripts and I condensed longer passages into smaller phrases using my own vocabulary. This method is similar to Kvale's (1996) method of condensation that requires the taking of "natural meaning units," extracting the central theme of the unit, and stating it was simply as possible. Through a close reading of the transcripts and meaning condensation, I discovered several dimensions specific to different sections of the interview. Although I recorded every dimension I discovered during the first two interviews, some dimensions became more or less important during the remainder of the interviews. When I discovered a new dimension that did not appear in the first two interviews, I integrated this dimension into my analysis and re-examined the preceding transcripts and summaries. I evaluated the relative importance of each dimension by examining how much emphasis was put on a dimension during conversation and how often the dimension was mentioned within one interview or across all of the interviews. Every dimension consisted of several sub-categories.

2.1 Participants' discussion of doctor-patient interactions

Main Dimensions	*Subcategories*
Appropriateness of interaction	-Response to patient, professionalism, dismissing, amount of time spent, judging, reactions, follow-up, sexual misconduct
Balance of power	-paternalism, racism, classism (income, education), sexism, homophobia, ableism
Communication between doctor and patient	-Questions, listening, talking, nature of language, dismissing, giving information, body language
Convenience	-Time spent waiting, access, appointments
Doctor's personal manner	-Caring, cold, rough, patient, calm, honest
Personalization of the interaction	-Individual treatment, holistic approach to individual, concern, follow-up, involving patient in care/decision making
Treatment given to patient (i.e., prescription, medication, recommended regime)	-Clinical competence, appropriateness of treatment, holistic treatment, personalization of treatment

2.2 Participants' analysis of factors contributing to negative treatment and negative doctor-patient interactions

Main Dimensions	*Subcategories*
Clinical skills	-lack of experience, incompetence, inadequate detection skills
Education	-Medical education, socialization
Money	-Overbooking, pressuring patients to buy products, not considering patient's financial situation

Personal manner	-Personality (cold, impatient, bossy, inconsiderate, uncaring…)
Power imbalance between doctor and patient	-Gender, age, class, race, education, sexual orientation, ability
Situation	-Overwork (doctor) , time of the day, volume of patients

2.3 Participants' response to negative treatment

Main Dimensions	*Subcategories*
Emotional response	-Anger, fear, frustration, outrage, disappointment
Inaction	-Acceptance, compliance, not questioning, patient's justification of negative treatment
Resistance	-Leaving, non-compliance to treatment, getting a second opinion, not returning
Subversion	-Yelling, swearing, name calling, telling others, arguing, challenging

2.4 Information about the participants and their lives

Main dimensions	*Subcategories*
Feelings toward being a patient	-Empowerment, vulnerability, satisfaction, frustration
Life experience	-Personal stories, anecdotes
Self knowledge	-Self-education, passed down knowledge, traditional knowledge, personal coping/healing techniques

2.5 Other (miscellaneous)

Main dimensions	*Subcategories*
Interviewer/interviewee relationship (my impressions)	-Comfort, rapport, quality of interactions
Social theme	-State of the medical system in Canada, sexism, racism, medical education

I coded my data using the dimensions above. For example, if a woman talked about a doctor listening to her, I coded that as **communication (+)**. The positive signed indicated that there was a presence of communication. If, she did not feel that her doctor gave her ample opportunity to ask questions, I coded that as **communication (-)**. The negative indicated an absence of communication. Some dimensions did not require a positive or negative symbol. For example, when someone talked about a problem associated with the health care system, I simply coded that as **social theme**. After a transcript had been coded for all dimensions, I noted the frequency of occurrence of various subcategories and the emphasis with which a woman talked about a subcategory. Some subcategories were mentioned throughout the interview, while other subcategories were only mentioned once, but the participant indicated the subcategory's importance by talking about it at length or telling me what an impact the occurrence had made. In one instance, importance was also based (in part) on my judgement of the issue. Whenever a participant discussed an interaction where she stated a physician's conduct was sexual in nature, I noted this as important even if the woman did not seem to attach great significance to the experience. Whatever effect the sexual misconduct had on the participant, it was a major violation of the patient's rights and clearly against the medical code of ethics.

In the course of the interviews, I asked women to theorize about their experiences. In this way the participants themselves were involved in analyzing their experiences with doctors. In my data analysis I included women's explanations for why they had been treated in less-than-desirable ways.

My final write up, after each interview was coded and analyzed, consisted of a list of significant dimensions and subcategories, a synopsis of the interview, and any other notable quotes, facts, or impressions about the interview. I decided to write a synopsis of the interview to get a sense of the overall story of the participant's experience. Sometimes when analyzing such small sections of text, the larger story can become lost. I did not want women's narratives to become "dead text." Writing a story out of each participant's interview helped keep each narrative alive and personal.

It is important to note that not all meaning is conveyed through words. As significant are things such as tone of voice, loudness, repetition, laughter, silence, and body language. I noted both verbal and non-verbal meaning in my interview transcripts. Every effort was made to indicate when there was a change in tone or emotion by writing in a woman's laughter, using italics when something was stressed and using capitals when something was said with force.

Ethical concerns: interviewing and the interviewer-interviewee relationship

Constraints

At the conception of my research, I had a commitment to doing research that fully involved the participants in every stage of the study. This included the involvement of participants in research design, the formulation of questions, and data analysis. I believed that the involvement of participants would make my research more ethical by giving participants a certain amount of control over the direction of the study and by adding to the validity and reliability of the data I would present. Quickly, I realized that conducting the sort of research project that strives to be completely participatory in nature is very difficult when one is a new researcher and when one is faced with the time and financial constraints particular to graduate work. Further, without having the practical know-how that comes from first-hand research experience, I did not know what type of research methods would or would not work. (See Limitations section, Chapter four)

The interviewer-interviewee relationship

In many instances, the interview is a hierarchical, power relationship and it can involve some of the same problems inherent in the doctor-patient interview. Often the interviewer has more power than the interviewee since she is asking the questions and the interviewee may be discussing embarrassing, painful, or personal things, while the interviewer does not reveal anything about herself. I did not want to reproduce the same sort of power dynamics inherent in many negative experiences women have with doctors. I wanted women to be able to speak about and interpret their experiences because this kind of exploration is often empowering. Throughout the interview, I also hoped to provide a space for any questions that women may have about *my* experiences. I was open about my experiences with doctors and I always tried to solicit questions from the participant. Self-disclosure by the interviewer prevents the interview from being completely uni-directional, can put the informant at ease, and helps to produces a more egalitarian relationship (Reinharz, 1992).

Socio-economic differences between the researcher and the participant can have an impact on the quality of the interview. The issue of being a mainlander - not a Newfoundlander, was often mentioned by myself or the participants during my initial visits to the community centres and during the interviews. However, I did not find my "outsider status" as large of an issue as I thought that it would be. Although I came from outside of Newfoundland, I felt accepted by the women that I interviewed. When asked, I told participants that I had come to St. John's to study at Memorial and that before coming here I had lived in Montreal, Toronto, and that I had immigrated to Canada as a child. Perhaps women felt that I belonged in Newfoundland as much as anywhere else. I had moved around a lot so maybe I was not seen as having any strong prior allegiances. Perhaps I did not seem like a complete outsider because I had lived in Newfoundland for two years and I was faced with some of the same issues that the women who I talked to were faced with. I was not a researcher who had only come to St. John's to conduct her interviews. I felt immersed in the culture, atmosphere, and problems of St. John's by the time I did my interviews.

Being from the mainland was only one difference between me and the participants. More than half of the participants had either higher or lower levels of formal education. I interviewed women who had completed 2 years of high school and women who had several graduate degrees. Many women came from socially and culturally diverse backgrounds. Upon reflection I noticed that the interviews that were most open, comfortable, and informative were those where there was a common ground found or formed between the researcher and the participant. For example, during one interview one women and I talked about how difficult it was to maintain a good diet during the winter months in Newfoundland when vegetables were very expensive. The woman was a single mother on social assistance. I do not pretend that my problems or my situation is the same as hers, but somehow the gap between us was bridged.

Summary

Using qualitative, feminist methods, I hoped to contribute to an understanding of the problems within the doctor-patient relationship and give voice to women's personal experiences. This chapter outlined the methods that I used in my study. I presented my research questions and goals, then gave a detailed account of my preparations for the interview. I summarized the questions that I asked participants during the interviews and how I conducted my data analysis. Finally, I discussed some of the ethical issues of conducting interview research. The next chapter will discuss the data that emerged out of the interviews I conducted.

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1. Unfortunately, I did not have someone interview me until after some of the interviews had been done. I did not think of the idea at the start of the interviews.

Findings

Perceptions of Health and Health Care: A Holistic Outlook

Chapter Three

Introduction

The story that emerged out of the interviews I conducted was that women regarded their health and health care in a broad and holistic manner. For them, health was not simply the absence of disease, and health care was not simply a doctor prescribing medication for a patient. Many factors such as personality, communication, and the current structure of the health care system, influenced women's perceptions of their health and health care. In this chapter, I first present women's responses to questions about their general well-being, self-care, and health seeking behaviour. I then discuss women's narratives about their health care. These narratives encompass three different levels of experience: the **relational**, the **personal**, and the **social**. Finally, I outline women's interpretations and explanations concerning their negative interactions with doctors.

Women's well-being and health seeking behaviour

Current health

Most women reported feeling very good or good about their current health. They usually qualified these statements, however, by referring to an illness or event that was negatively affecting their health. The two most common complaints in both groups were stress and chronic, longterm ailments. The women attributed their stress to school, work, and family pressures. Many women discussed various chronic problems such as back pain, persistent respiratory/bronchial problems, asthma, arthritis, re-occurring digestive problems, and diabetes. Almost all of the women talked about various coping techniques that they have for dealing with their chronic problems and it is possible that these coping techniques help women define themselves as healthy *despite* the problems they are experiencing. Several women mentioned health problems often associated with life in economically strained circumstances like poor diet, smoking, and lack of exercise. For example, Aimee (names have been changed to preserve confidentiality) talked about smoking, being over-weight, and not having a good diet:

> **Aimee (high school educated group):** The doctor I have now, he's forever telling me to cut down and not so much to go on a diet but start eating heathier foods and to quit smokin', he forever trying to get me to quit smoking. But, like I said, I tried before and every time I tried, I went back to smoking again...when I quit for probably for 2 or 3 days and when I started again I smoked even more. I said the only way you're getting me to quit is putting me in the woods for 6 months. That's the only way *(laughs)* Cuz it's so hard. And I mean I'm only on social assistance and trying to buy them patches and they say their not all good, they only work for so long...but the thing is I don't have the will power, plain and simple.
>
> **Agnieszka:** Do you find the patches expensive? I don't know how much they cost.
>
> **Aimee:** Oh yeah! They're $60 dollars for 2 weeks so that's like $120 dollars in a month. I don't spend that in tobacco. So, it's cheaper for me to smoke than go on the patch! *(later in the conversation)*... Well, I try *(talking about eating right)*. I only eat once a day but when I eat, I eat the wrong foods...like french fries and hamburgers and stuff like that...But I like a lot of fruits and vegetables...I love pasta and stir-fry, rice. If I could afford to eat salad, I could live on salad. Lettuce and tomato and green pepper and stuff like that.
>
> **Agnieszka:** It's expensive though...
>
> **Aimee:** Yeah, it's very expensive...I mean $1.99 is the cheapest you can get a head of lettuce, $2.69 for 5 little tomatoes..it's wicked. It's unreal.

Most of the participants' health varied over the course of their lives. Several women reported childhood diseases and occasional gynecological problems. Other women mentioned periods in their lives that were marked by repeated illness or severe stress. It was repeatedly made clear to me that stress had a profound impact on mental and physical health. Some women talked about feeling healthier when they were younger and they expressed the need to exercise and take better care of themselves as they age.

When you are not feeling well, what do you do to feel better?

By asking this question I was trying to determine what the women that I interviewed do when they are sick. Do they promptly go to the doctor? Do they try to heal themselves? What kind of remedies do they employ? At what point do they decide to go to the doctor? Some literature (Miles, 1991) suggests that women's higher frequency of visiting doctors (women go to doctors more frequently than men) can be attributed to female patients going to see a doctor about trivial matters or at the first sign of illness. Surprisingly, only one participant said that she went to the doctor as soon as she was not feeling well (without any self-treatment). All of the other participants described various coping techniques and remedies:

> I would try and establish why I wasn't feeling well, whether it was due to injury, whether it was due to fatigue - general fatigue - or diet or, you know, something environmental, you know, stress or overwork or something clinical. And then if it was something.... an injury, I would take steps to heal it. Usually, myself first and then.... I think in general, unless, you know, I actually fell down and broke my leg, my first step *would not* be to go to the doctor. I would, you know, start drinking herbal tea. If I had headaches or if I had period pain, it would be to walk more and increase my fluid intake, you know. So I think, like many other women, I would go through that regimen of.... my own personal body history and experience and then all the home remedies that you build up over a lifetime of living in your body, and going to a doctor would be the last resort. **(Phyllis, university educated group)**

* * *

> Well, well usually I'll go to a pharmacist, like if I have a sore throat or something that... you have lozenges or cough drops or whatever and most of the times - home remedies like soups and stuff like that, often makes your.... clears out... you know...your sinuses and everything so... I don't know but usually I'm not.... I don't

> go to a doctor a lot. I try to limit how many times I go to the doctor because it seems like, you know, a lot of people do take advantage of the fact that where we sort of have a free health care, that they go quite a bit; but myself - I only goes when it's really necessary (**Geena, high school educated group**).

What are the most common problems you go to see a doctor about?

Several women in both groups stressed that they went to see the doctor only when it was ***absolutely necessary*** (see two quotes above). I sensed that women were trying to impress upon me that they did not overuse the system and that they did not rush to the doctor at the first sign of trouble. They would go to the doctor when they had a persistent problem that they could not get rid of, if they were in a situation that they had difficulty coping with, if they incurred a serious injury, when their children were ill, or when they had to get a required check up, like a pap smear, STD test, or during pregnancy. Women with children said that they often go to a doctor when their children are sick. Sixteen out of twenty participants reported doctor visits for gynecological reasons, for example, pap smears, pregnancy, and infections. It is interesting that although pap smears and pregnancies are not illnesses, many women listed them as such in response to my question about problems. Possibly, they had internalized the medical profession's and society's pathologisation of women's reproductive functioning. Another possibility could be that they associate going to the doctor with illness and hence label their gynecological exams as problems. Finally, it is possible that some of the women misunderstood or misinterpreted my question as "What are the most common *things* that you go to see a doctor about?"

Three women in the high school educated group and one woman in the university educated group said that they had gone to talk with a doctor to get help when they had been in a bad and unhealthy relationship[2]. This underscores the fact that doctors will have to deal with situations where a pill is simply not an adequate solution. It also perhaps speaks to the need for support staff and complementary health care providers (for example, psychologists, social workers) who would work together with doctors and patients.

Frequency of doctor visits

The frequency of consultations varied greatly from woman to woman. One participant reported going to the doctor only once a year while another reported going about twenty-four times a year. The average number of visits per year was between three and six, although pregnancy and having young children increased the frequency. Not surprisingly, changes that occurred in the frequency of consultations mirrored changes that women reported in their health.

The gender of the doctor

Eight out of eleven university educated women and five out of nine high school educated women stated that they preferred a female doctor. Most often, women said they felt more comfortable with a female doctor but other reasons included being better able to relate to a woman, having a bad experience with a male doctor, and supporting female professionals. Although these women preferred female doctors, they did not always see female doctors. If a person had to go to a doctor right away she would usually see whatever doctor was available. Three women reported that when they were living in small communities outside of St. John's, they had to see a male doctor because there were no women doctors working in the community. Also, some participants would see a woman doctor only if she met certain criteria (for example, she also had to have good communication skills). Amanda (high school educated) found her experience with a female gynecologist different from her experience with a male gynecologist. Not only did the female doctor know from personal experience the kinds of feelings she was having in the course of a pregnancy, but the doctor also had a open, consultative style of interaction.

> Oh, with the.... when I switched the doctor to a lady doctor.... well, she knew what I was going through with the pregnancies and everything so I mean, you know, you could talk to her more one on one. Like I said, she knew everything you were going through and she just made you feel more comfortable, more relaxed with it. You know, she would explain everything more thoroughly. I mean a man can't tell you what's it like to go through labour. I found it like that way.... it was excellent...She made me feel really comfortable. Like I said, I did better on my second pregnancy with her than I did with a male. It's just like.... she could explain everything clearly to me. Like okay, you could have this and you could have that but, like I said, I did feel more comfortable with a woman.

Anna (university educated group) said that, although she prefers a female doctor because the doctor-patient relationship is a personal one, she also wants a doctor who has excellent clinical skills.

> Quite a long while ago, I made a very conscious decision to get a female doctor. You know, I just came to the conclusion that I'm a woman and your doctor is a very.... you have a very kind of personal relationship with and you just ask things that are personal and I just felt that a doctor who has the same body as me and, you know, and not just a body but experiences, also would be a better doctor for me. But even after I made that decision I had male doctors because I couldn't always find a female doctor that I wanted to see. So I did... I have one now, but before this one I had two male doctors before that and a female before that. So....I want a female that I also am confident in professionally...

Samantha (university educated group) said that she had usually gone to see female doctors. She told me about a negative experience with a male doctor. This experience strengthened her resolve to only see female doctors.

> I like to give women the business (laughs) also because I'm not in this town for very long and the first doctor that I started to see happened to be a woman doctor…umm...but also I had a choice of seeing a male doctor at the same place, and I did have to go see him once because the female doctor wasn't working that particular day that I had to *absolutely* go in and he confirmed my reason that I should keep going to female doctors. He's like a big orthodox, religious person…

Participants who did not say that they preferred a female doctor chose their doctor based on the doctors' interpersonal manner, their clinical skills, a combination of the two, or some other criteria that they felt were important. One reason for not choosing a female doctor was satisfaction with a current male doctor. Finally, some participants chose their doctor out of convenience ("whomever was available") more than any other reason.

> **Agnieszka:** Okay, do you usually go to a male or female doctor and why?
>
> **Andrea (university educated group):** It doesn't really matter to me.
>
> **Agnieszka:** So how do you decide? How do you decide on the doctor?
>
> **Andrea:** I decide on the doctor based on conversations with friends about their doctors. A friend of mine also has this Scottish doctor, Dr. B and the kinds of things she was saying about him to me made me think, well, maybe he's the kind of...because the doctor I had previously moved to Nebraska so....
>
> **Agnieszka:** So you decide on recommendations of friends.
>
> **Andrea:** Especially female friends. I don't.... yeah, I think I would seek out the advice of a female friend because men are so.... you know, they don't take notice of things and you would want to know how he treats women or how he thinks of women and so on like that. But I've had male doctors and female doctors.

* * *

> **Agnieszka:** And do you usually go to a male or female doctor?
>
> **Dorothy (high school educated group):** Mostly male [...] It just.... I think it just happens that way. Yeah. I don't know. I don't think I've ever seen a female doctor - except the podiatrist... oh, about eight years ago now. That's the only female doctor I seen [...] I moved to St. John's and phoned the Medical Clinic and asked which doctor is taking on new patients. At that time, it was just my family doctor so....

* * *

> **Agnieszka:** And do you usually go to a male or female doctor?
>
> **Geena (high school educated group):** I have gone to both actually. On some occasions I've went to a female - usually when I want to get a pap smear or whatnot but recently, I've changed my attitude about that. I've just sort of think, well, you know, the doctors are very mature and professional about it so I have went to male doctors but it's usually I'll prefer going to an older doctor because, I don't know, I find that he has more years and a lot of time they have better bedside manners sort of thing [...] More experience and you feel more comfortable around them and if it was a really young man, you'd feel a little more awkward (laughs), right?

There didn't seem to be many differences between the two groups of women in terms of gender preferences in their doctors (a similar number of women in each group went to female doctors). The only difference was that many of the women who had a higher level of formal education reported more time-consuming and complex methods of finding the "right" doctor. This included interviewing many doctors and talking to friends and colleagues.

Alternative medicine

University educated group:

All of the women in this group have gone to at least one alternative health practitioner in the course of their lives. They gave a variety of reasons for going to an alternative health practitioner. Some felt that they had a problem, stress for example, that would have been dealt with inappropriately by a medical doctor. Others sought a more holistic method of treatment that could not be provided by the medical system. Some felt that going to an alternative health practitioner was a way of subverting allopathic medicine and its reliance on drugs to treat problems and disease. Women in this group, especially those who were students or living in economically strained circumstances, said that they would use alternative medicine more often if it was covered by their health care plan or if they could afford it. Besides going to an alternative health practitioner, some women also talked about taking herbal remedies (usually on the advice of friends) to ward off illness or to alleviate certain symptoms like PMS or congestion. Hannah told me why she has gone to many alternative practitioners:

> I've seen psychiatrists. I've seen psychologists. I've seen massage therapists. I've seen lots of people from more of a homeopathic approach, meaning nutritionists, spiritual guidance, people who take different approaches to healing, you know, specialized doctors [...] I believe.... (laughs) I think the main reason [I have gone to see them] is I believe that... not necessarily that that's a better alternative to medicine - the medical framework - although I think at times that may be the case but I think it's a real complement; and to be quite honest, if I could get it covered by MCP, I would be doing it more often. That for me is the drawback. It just costs far too much. And, you know, the same with psychiatrists versus psychologist: if.... psychologists were covered by MCP, I'd probably see the.... I would DEFINITELY see psychologists over psychiatrists.

Caroline said that she went to a massage therapist for stress relief. She does not want to become dependent on taking pills for problems such as stress or depression. She feels that this is good modeling for her children:

> Well, I didn't go to the massage therapist for a health reason. I went to the (chuckles) massage therapist because I love getting massages and I think that is a really nice stress reliever. I can't imagine going to a doctor and saying, you know,

> "I'm aware of how much stress I have in my life - what can you do to help me" .... I'm so nervous about taking pills. Like I just can't see that.... like that's kind of like a band-aid effect so I would go...you know, if the opportunity presents itself, I would go and have a really, really nice massage for an hour and I would rather use that than use a doctor.[...] I am concerned - just about the long-term effects that those [pills] have on you and getting addicted to something like that... I would also like to raise our kids - our children - to find other alternatives as well and I guess partly to model coping techniques - you know, because it's not going to be an easy world for them out there either and I would hope that they would be able to have some coping techniques instead of asking for pills.

High school educated group:

Only two out of nine women in this group have ever used an alternative health practitioner and then only when it was recommended by a medical doctor. The three most common reasons that women gave for not going were: *financial reasons*- alternative medicine is expensive and not covered under MCP, *lack of necessity* - some women did not feel that they had problems that warranted going to an alternative health practitioner, and *absence of recommendation* - if a doctor did not recommend an alternative treatment or medicine, the participant did not feel that it was necessary or important to go.

> **Agnieszka**: Why do you think you have never gone to see these people? Is it that you don't think you want to go see them...or...what are the reasons?
>
> **Tina**: No I don't. If the doctor asks me, prescribes me to go to one, I will go to one, besides that, no.

* * *

> **Agnieszka**: And why [haven't you ever tried] alternative medicine?
>
> **Dorothy**: Well, I've had no need for a psychologist and I don't think I can afford a massage therapist or natural healers...It's not covered under....By the social services or the MCP so.... yeah.

The relational

Women's positive and negative interactions with doctors

Health and health care do not only involve the individual. An important relationship influencing health and health care is the one that a patient has with her doctor. In this section, I discuss women's positive and negative experiences with doctors, what women attribute their negative experiences to, and women's reactions to negative experiences.

Experiences with doctors

When women talked about their health care, they most often talked about their experiences with doctors. All of the women I interviewed were able to identify at least one positive experience that they have had with a doctor. Some women told me about a specific experience that stood out as positive while others described their interactions with a particular doctor that, in general, could be described as positive. All of the women in the university educated group were also able to identify a negative experience with a doctor and several women talked about many negative experiences. In the high school educated group, most women also had a negative experience with a doctor. Some women initially said that they did not have any negative experiences with doctors but during the course of our conversation told me about several experiences that they were not happy about and that they clearly labeled as negative.

Interestingly, several women in both groups were perplexed by my questions about positive and negative experiences. They suggested that doctors' visits were neither very positive nor very negative, rather, the visits were simply a necessity. Some women also told me that all medical encounters were anxiety provoking and, by nature, unpleasant, regardless of the quality of the doctor or the interaction.

> In general, I think doctor visits are kind of tiresome because they always take longer than it seems they should have because you always have to wait. And I think even when it's just for.... I find, even when it's just for something sort of routine, I always feel a bit anxious even... you know, especially for pelvic exams. I always feel a little freaked out even when it's the just the regular old thing. So I guess generally, I find them kind of anxiety producing - doctor visits. **(Hilary, university educated group)**

* * *

> **Agnieszka:** I want you to think of a positive experience that you had with a doctor and that could mean...anything about it can be positive, and just tell me about the experience and tell me what made it positive, you know...what aspects of it made it positive?
>
> **Tina (high school educated group):** So these were good, positive things with a doctor? Oh, I haven't had that many of them... (laughs)
>
> **Agnieszka:** Well, if you could think of a *more* positive one...
>
> **Tina:** No, I really, besides like waiting, you know what I mean, like nothing happen', you know I haven't had no bad experience, or anything like pretty good experiences...like basically it was all the same...like I went there and he did what he had to do...basically.

Although the women I interviewed talked about a variety of different experiences, almost all of the women mentioned at least one experience related to reproductive health. Women often discussed doctor-patient interactions during gynecological exams, births, abortion referrals, and hysterectomies. Perhaps this focus on reproductive health highlights the medicalization of these experiences--during all of these experiences women are expected to be examined by a doctor. Further, since most women probably feel vulnerable during gynecological exams, a particularly negative or positive experience will probably be extremely salient.

There were seven characteristics of doctor-patient interactions that were frequently discussed by both groups of women. These were ***communication, information, balance of power, quality and quantity of time spent, valuing the patient and her time,*** and ***personal manner***. The absence or presence of these characteristics determined whether an experience and/or doctor was labeled as "good" or "bad." Many women also mentioned these characteristics when they talked about what an ideal encounter would be like. Often, women cited a number of themes when they talked about their positive and negative experiences. For example, a positive experience may be one where there is communication and the doctor spends a lot of time with the patient. For another person, a positive experience may entail getting in to see the doctor without waiting, the doctor offering information about her illness, and the doctor being friendly, honest, and compassionate.

Some women also talked about ***sexual misconduct*** by a physician. Some women's encounters with doctors were negative as a result of sexual harassment and abuse. A physician's sexual misconduct obviously had a harmful effect on the doctor-patient relationship.

Communication

Women talked about communication in a variety of different ways. I picked out the different characteristics of positive and negative communication mentioned by the participants and grouped them into several categories. Communication entails both doctor and patient behaviour and is manifested verbally and non-verbally. *Positive* *doctor communication* involves listening to patients; giving patients an opportunity to ask questions; asking patients questions; not interrupting patients; explaining procedures, treatments, or options; using language that is clear and straightforward; and positive body language that indicates attentiveness, concern, and interest. *Negative doctor communication involves* not listening to patients; not developing an atmosphere conducive to the asking of questions; not asking patients questions; interrupting patients; not explaining procedures, treatment, or options; using medical jargon; and negative body language that indicates impatience, irritation and dismay. *Positive patient communication* involves being able to ask questions and for clarification, understanding what the doctor is saying, feeling understood, and feeling listened to. *Negative patient communication* involves being afraid to ask questions or for clarification, not understanding what the doctor is saying, being intimidated, feeling misunderstood, and feeling ignored. Women in both groups stressed the importance of communication. Breakdown of communication can affect the amount of information that the patient has about her illness and the amount of information that the doctor has about the patient. It can influence the patient's confidence in the doctor's competence. In general, women in my study who felt they were being listened to, who were able to ask questions, and who felt that the doctor was adequately explaining procedures, treatments, or options, described their doctor-patient relationship as positive.

The tale of (almost) three hysterectomies: communication, decision-making, and patient satisfaction

The impact of positive and negative doctor-patient communication was well illustrated by the narratives of three women (Phyllis, Andrea, and Beatrice) who described choices surrounding having a hysterectomy. All three women suffered debilitating uterine bleeding and, as a result, went to see a physician. Phyllis (university educated group) and Beatrice (high school educated group) eventually had hysterectomies, while Andrea (university educated group) did not. The two women who had hysterectomies felt very differently about the events preceding their hysterectomies and about the doctors that treated them. Andrea went to several doctors before she found a doctor with whom she jointly made the decision *not* to have a hysterectomy. She told me about her positive and negative experiences.

Phyllis' experience with her doctor was almost life-altering. Their relationship was characterized by continuous communication and consultation. Phyllis was able to ask for information about her condition and discuss different options with the doctor. Phyllis said that their open communication and collaboration allowed her to have a great deal of trust in her doctor's opinion and medical competence.

> The reason that experience was positive was because he was very verbal. He addressed me as an intelligent, highly educated woman who needed and wanted a complex level of information about what was going on with my body - and delivered it - recognizing at the same time that there was terror afoot so that I would need some comfort at the same time. He recognized that I would want an equal role in the decision-making process about what was going to happen to my body and shared his power with me, alright? It was tremendous! It was absolutely tremendous! [*later in the conversation*] He was everything I had ever wanted a doctor to be. He spent all kinds of time trying all kinds of different things. He was non-interventionist. When we did decide to go for surgery, it was very much my decision. He told me EVERYTHING that could go wrong and how everything that could go wrong could be fixed. When I said, "Okay, well.... sometimes in hysterectomy surgery, we might clip the bladder," right? And he would say, "Okay, this is what would happen if we clipped the bladder. We'd do this. We'd do this." I said, "Okay, how many times have you ever clipped a bladder doing a hysterectomy?" He said, "I've never done that." I said, "How

> many hysterectomies have you done?" He said, "About 622," right? "Alright," I said, fine." Good numbers for me! Okay, let's move to the next one."

Beatrice also went to a doctor about her uterine bleeding. She saw her doctor for several years and although he also tried different options to stop her bleeding, she became extremely frustrated and was very unsatisfied with the treatment she received. She said that after having three D&Cs (scraping of the uterus) she could not understand why he would not "just give her a hysterectomy." She did not feel listened to, and she felt that her doctor was not taking into consideration what she wanted or the pain and inconvenience she was going through. She finally switched doctors and had a hysterectomy.

> The negative part with that doctor was the fact that he wasn't there to listen to his patients. That's what I found with him. He had a bad bed-side manner, let's put it that way…to me, it was just that he did not take the time with his patients. That he was always in a rush, rush the person in and rush them out. [*later in the conversation*] I think that doctors like him should be taken aside and showed some manners and be more patient with their patients and be able to talk to them and not rush them in and rush them out. It's like it's a money thing. Don't explain anything. They just do what they got to do and it's all over. So I think they need to be...told (laughs) […] That they need to spend more time with their patients and explain things to them.

Andrea had gynecological problems since she was an adolescent and developed fibroids on her ovaries. She told me about the many different diagnoses she received throughout her life. From the time she was twenty five years old, doctors had told her that she should have her uterus removed. She told me about some of her negative experiences and about how enraged she felt at the many violations she had to endure.

> …I've had several D&C's, you know, and I had several other procedures and I had built up over the years such a rage against having an internal examination. I built up such a rage that if they touched me, I mean I could just barely control myself

> long enough for the examination to take place; and when it was over, I was just... really enraged at the violation of your privacy and your body and the whole attitude that, you know, they.... I think they were trying to be impartial and clinical but it comes across as being disinterested and unaware... *[later in the conversation]* And if you do get the chance to discuss it [alternatives to having a hysterectomy] with them, they ...sort of (long pause).... they don't take your feelings into account and they make you feel like.... you know, they dismiss you with a kind of....if you want to kill yourself, go right ahead, lady - you know what I mean? - that kind of attitude. If you don't want my superior advice, then don't come to my office, you know?

Andrea juxtaposed her negative experiences to her relationship with Dr. R, a gynecologist that listened to her and with whom she had a very good relationship. She told me that his ability to communicate and form a partnership with the patient made him unique.

> And that was one thing about R-- he always involved you in your own health care. He always involved you in.... he'd say, "I think we'll try this. Now what do you think about that?" And you could argue with him about, you know, "Well, I've heard the side-effects of that" or "blah blah blah" and he'd say, "They are in some cases, blah blah blah." And then, you know, you could have a dialogue with him about your own treatment, whereas most doctors take a real patronizing attitude. [*Talking about the same gynecologist and another doctor*] They've no problem in referring you to...giving me references to do some reading, you know, Internet references or whatever. They have no problem talking to you about what the procedures are going to be and what's going to happen: Step A, Step B, Step C. That to me is a real physician. Like... but I haven't encountered very.... like I say, I've only ever encountered two of them like that.

These women's narratives highlight some of the communication problems discussed by many women in my study. Communication may affect how women respond to their doctors and their treatments. Phyllis and Andrea, the two women who had a relationship with their doctor characterized by open, clear communication, felt satisfied by the treatment they received. They were glad that their doctors recommended and explored different options to stop their bleeding and pain. Conversely, Beatrice was frustrated and angered by her gynecologist who recommended D&Cs and birth control pills to stop her bleeding. She did not understand why he was suggesting these treatments. She felt that he did not adequately explain his rationale, instead he rushed her out of his office. Effective communication between doctor and patient is a vital component of a satisfactory doctor-patient relationship.

Information

When women talked about communicating with a doctor, they also often talked about the importance of information. Positive communication between doctor and patient often led to the understanding of information a doctor provided to the patient about procedures, diagnoses, different options, and treatments. Negative communication offered little information. Patients were often left feeling frustrated, confused, unsure, and vulnerable. Some literature (see Roter & Hall, 1993) suggests that women with low educational levels prefer more authoritarian interactions with doctors where little information is exchanged and the doctor makes decisions about procedures and treatments without fully informing the patient. I did not see any evidence of this in my study. Women in both groups wanted to know what was happening to them (and to their children) and wanted to be given information in a clear and honest manner. The following quotes indicate an interaction between communication and the receiving of information. Pauline (university educated group) told me about her views on the information doctors give:

> Well, oddly enough, I think my experience would be better than most people's because (long pause) I would ask questions.... at least ask questions. That's another thing.... now I'm jumping but there is a tendency on the part of doctors to give you the quick answer with a lot of very technical jargon to intimidate you so

> you shut up and you stop asking the questions. I've seen them do that time and time again and you really have to push them and not be afraid to say, "I don't understand." You know, "I don't know what you're saying. Say it in another way!"

Geena (high school educated group) told me about a time when she went to a gynecologist about her occasional yeast infections. When she asked if it was normal for women to have yeast infections from time to time, he told her that it was *not*. He would not give her any more information. This interaction left her feeling frightened and confused. She said that she felt "shook up" by the doctor's manner and the interaction. In response to her negative experience, she contemplated whether this doctor was really "addressing her health issues." This experience made her wonder "whether or not doctors tell you everything." It also made her temporarily concerned that she had done something wrong that caused this situation.

> **Agnieszka:** So when he said "it's not normal," did he say why it's not normal?
>
> **Geena:** No he didn't! And I tried to push him, you know. I tried to, you know....and he just wouldn't say anything more about it and I was sort of.... I left the office thinking, my gosh, do I have a more serious problem I'm not aware of?... Why did he act this way?... And then I was wondering if I had done something wrong or, you know, or if it's just a normal thing that happens or whatnot so it made me feel very sort of inadequate at the time because I was thinking to myself, you know, did I do something wrong? I mean, did I, you know, did I put the question to him wrong or something - to the other doctor that was the specialist or whatnot and I just... I don't know, even up to this day, I wonders, you knows, if there might have been more to it, right? So I think that that is sort of a very negative experience, not so much in the examination or anything but just his attitude.

Martha (university educated group) talked about an experience that left her feeling empowered. A gynaecologist gave her detailed information about the procedure that was being performed and also about what options were available. Martha felt that she had a partnership with this doctor. She felt that as a result of her doctor's openness and willingness to give options, she had a choice. She felt like an active participant in her own health care. The decision about what to do was hers.

> For the first time in my life there was somebody who took the time to listen to me, to explain to me what she was doing and to outline as she went and what she was finding and what that meant and giving me what appeared to be genuine advice and reflecting an approach that indicated that she cared. And she also sort of threw the ball in my court and said these are your choices-you decide. That was 2 years ago and that was the first time in my life that I had that experience and I'm 54 [...] I felt empowered. One of the things that we talked about is whether I should take hormone replacement therapy for menopausal symptoms and you know she gave me all the information to read she told me about the pros and cons and she really helped me see that it was my decision and that I would sort of live with any side effects that result from my decision. But it was a first time that I felt like I really had a choice. Before that I think all of my experiences with doctors, pretty much all of them were male...it was, I tell them my symptoms and they write out a prescription when I am half way between telling them what's wrong with me, and I go get the prescription and that's it, you know?

Balances of power: recognizing vulnerability

Many women recognized a certain amount of vulnerability in their patienthood. Some women recognized that doctors have power because society often sanctions their words and labels. Lisa (high school educated) went to a psychiatrist because of stress as a result of living in a "bad environment." Lisa said that she just needed to get a lot of things off her chest and wanted "someone who would listen in a non-judgmental way." When her doctor was out of the room, she looked at her chart and read that the psychiatrist had labeled her a "Histrionic." He wrote that she needed medication for her mood swings. Lisa was very upset by this label. She thought that her stress was normal given the situation that she was in and that the doctor could not possibly "diagnose" her in the course of a forty-minute encounter. Lisa talked to me about how she felt about the interaction and about the doctor's power:

> I was very rational. I was in a bad situation. I was trying to get out of it. I explained the circumstances that led up to it. I explained that I needed to get it off my chest, talk about it... and then to be told I was sick and not functional and needing medication. If I had less education and less maturity - if I was younger or something and I believed this - he could have me in his hands and the power he exercised, he could keep me locked up or anything, you know. Very scary. Frightening. [*Later in the conversation*] ...[I am] extremely angry. He's lording his power over me. He has all of the cards in his hand and he has...in the eyes of society, he's qualified. I'm nothing. What he says.... he's.... he has a lot of power. I mean he could say I'm blue and green and made of swiss cheese...and society would believe him!

Doctors often have information and services that women need and this sometimes puts women in a vulnerable position. Several women talked about having (or trying to have) abortions and the problems that they had as a result of the limited access to abortion in Newfoundland. Until 1998, there was only one location (a hospital) in the province that provided legal, state-funded abortions. Women also need a referral from a doctor to get an abortion at the hospital. Two women, Kristine and Samantha (university educated group) told me about their experiences with abortions. Samantha talked to me about a doctor who refused to give her abortion information or a referral. This caused her great inconvenience because Samantha was having difficulty walking and she had to search for another doctor who *would* give her a referral. She talked about how the doctor exercised his power over her:

> I had to prove to him that I knew what I was talking about. I had to prove that I knew what I wanted. He would not just accept that on face value...that I knew what I wanted. He felt that he had to teach me something. You know? I thought he was doing a little of the authority thing, where he was getting off on him being the source of knowledge and me being the one who needs the knowledge...He was an asshole. And he was trying to take out his personal issues on my body...

Kristine talked to me about her abortion. She told me about how the doctor at the hospital asked her questions, she felt, were inappropriate. He asked her about her religion, if she had a boyfriend and if she had a job. He wanted Kristine to explain why her and her boyfriend were not getting married and keeping the child. She said that she sensed that the doctor did not think her reasons for wanting an abortion--she was young, she was not ready to have a child, and the pregnancy was an accident--were legitimate. She was angry about having to answer those questions in order to get a medical service she was entitled to. She said, "I answered all the questions, mostly because a) I was young and b) you feel like when you're in that situation you need something from this person, you know? How could I stand up to him? When he has a service that I need..."

Many women talked to me about times when they felt that there had been a power imbalance during interactions they had with doctors. Interactions characterized as equal--where power and knowledge was shared--were seen as unusual and as exceptionally positive. Women talked about power or powerlessness in two different ways. First, some women talked about being empowered or disempowered because of circumstances in their life or because of something they did for themselves. For example, Dorothy (high school educated group) talked about being empowered by the knowledge she gained through reading about her illness. Ann (high school educated group) talked about being in a disadvantaged position because of her child's illness. Although she was treated negligently at a hospital, she felt that she was in no position to argue or complain because she was scared that her child would die. This power narrative primarily focused on the woman herself and/or her social or economic situation. Second, women talked about being empowered or disempowered as *a result of* certain interactions with doctors. For example, Phyllis (university educated group) the woman who talked about the positive interactions she had with her gynecologist prior to having a hysterectomy, was empowered by the relationship she had with her doctor. Conversely, Pauline (university educated group) felt disempowered when she went to a doctor with her child and was made to feel like her child's illness was due to her neglect.

Balances of power: resistance and subversion

Although many participants had experiences that were negative and disempowering, it is not accurate to label them as victims. Most women did not simply accept negative treatment unquestioningly, but rather they showed a great deal of **resistance** in reaction to what was happening to them. Since doctor's authority often goes unquestioned, especially in mainstream literature and society, I considered women to be resisting when they questioned or did not comply with a doctor's recommendation or treatment for a number of reasons. *Non-compliance*, *not returning*, and going for a *second opinion*, were the most common ways that women showed resistance in response to negative situations. There were several reasons why women resisted as they did. Some did not understand why they were told to take a certain medication or go through a certain procedure. Other women judged the doctor's medical competence by how she or he interacted with them. If they did not like how they were treated, they did not have faith in the doctor as a clinician. Further, if a doctor did not take enough time, if she or he did not explain things, or if she or he was authoritarian, some women did not trust that the doctor had their best interest in mind or that she or he *knew* what their best interest was. Caroline (university educated group) told me about a doctor who was very patronizing to her and implied that Caroline was not knowledgeable enough to decide what was best for her child. She did not agree with the aggressive therapy that he suggested: "I wasn't agreeing (with the doctor)...I wasn't buying everything that he was telling me...I just felt like...oh! This guy's a loser, let's go somewhere else...we went for a second opinion-because I was NOT...I was not happy with that." Aimee (high school educated group) told me about a doctor who insisted that she change the medicine that she was used to taking. She did not understand why he would not give her the kind of medicine she usually used. She reacted by simply deciding, "That's it. I am never going back to him again."

Some women reacted in very **subversive** ways to negative interactions or doctors that they did not like. As opposed to resistance, subversion occurred when a woman did something *actively* to undermine the doctor's treatment, recommendations, or authority. There were many subversive acts that women participated in. Often they made an effort to tell other women about negative experiences they had and warn other women about "bad doctors." Samantha (university educated group) told me: " I have never seen him since and I told everybody I know not to go to him..." One woman hid from a doctor who wanted to perform surgery on her. Another woman told me that when she had to get blood work done, she checked off a few more boxes in addition to what the doctor already checked off, because she wanted more "in-depth information" than he was willing to ask for. A few participants told me about arguments and shouting matches that they had with doctors over waiting time, treatment choices, and negative interactions.

Remarkably, I felt that some women were being subversive in the way they talked to *me* about doctors with whom they had negative experiences. Some women called doctors they did not like or who treated them badly derogatory names. They referred to them as "assholes," "alcoholics," "jerks," "idiots," "losers," and so on. I think this name-calling allowed women to express their anger about the way they had been treated. It was also a way of subverting the reverence that women are often taught to have for doctors and for the medical profession.

Several women mentioned that they wanted to report a doctor's inappropriate conduct, or some negative interaction to the medical board; however none of the women filed a report. Most women who thought about filing a report did not do so because they felt that "it was no use," they were "one person in a mass of many." They did not feel that the report would have any effect or that their complaints would be taken seriously. One woman was concerned that she would have to tell a humiliating story over and over to the medical board. She did not think it was worth her embarrassment. Another woman said that the doctor who had sexually abused her was so old that he would be retiring soon and would not hurt other women. Hannah (university educated group) talked to me about what she thought prevents her (and others) from formally complaining: "I don't even know how I would report a doctor. Maybe if there was more of an awareness of a process where if you do have a complaint, this is where you go. You go to the Medical Association. You go to an independent body. If they had feedback sheets [in their office] and read the feedback sheets, and changed their behaviour accordingly..."

Quality and quantity of time spent

The amount of time a doctor spent with her or his patient was very important to both groups. Although women did not specify how much time was enough time, many were frustrated by doctors who rushed them out of their office and did not seem to have time for them. Feeling rushed or pushed out of an office often contributed to a negative experience. On the other hand, doctors who took their time and did not rush patients were held in high regard. When patients felt that they were not being rushed, they were better able to explain their symptoms, they did not feel like they were forgetting to ask important questions, and they felt more confident that the doctor was diagnosing them correctly. It was especially frustrating for them to wait for extensive periods of time in the waiting room, only to be rushed out a few minutes later. Although, most women talked about time in terms of quantity, it seemed that equally important was the quality of time spent. Related to the idea of spending time with a patient was investigating different options. It seems that when the women felt their doctors were spending enough time, doctors were taking the time to explore different reasons for a particular condition and trying to find the best possible (most appropriate) treatment. Fiona (high school educated group) talked to me about her positive experience with a family doctor:

> **Fiona:** I find that, like when I go back to her now, I feel a lot more comfortable being with her and I can sit down and I can sit there and I can talk with her about anything; and she'll sit there and she'll listen to me. I am her patient and I think she takes time out for me. I don't know if you consider that a positive interaction with a family physician plus patient.
>
> **Agnieszka:** Well, do you think it's positive?

> **Fiona:** Yes. Yes. Because I mean, you know, I've been seeing her now for years and she's always taken time out for me. You know, it's not a big rush all the time. You know, it's a busy day or something, she'll sit there and she will listen to me.

Caroline (university educated group) was upset when a doctor applied what she called "pressure tactics" to get her out of his office. She felt that one reason that he recommended such drastic treatment for her child's illness was because he did not take the time to explore other less invasive treatments:

> ...literally, within maybe two to three minutes, he had Noah diagnosed with asthma and had him on puffers and steroids and the whole bit and was starting to shuffle us out the door and said, "Well, we'll see you in six months. Oh, by the way, do you have any questions?" [*later, talking about the same experience*] . What I saw was that it was (pause) that it was...it was a business! Like people were just in and out of there. Oh, the other thing he did which just.... my jaw just dropped.... is when he said, "Well, do you have any questions to ask" and I started to ask him some questions, he stopped me and called his secretary to the door and in front of us had said, "How many clients do I have waiting for me?", which I felt was extremely tactless - a very tactless thing to do. Well, it's kind of this pressure tactic. Like, "Well come on lady. Hurry up, you know, because there's four other clients waiting..." and it's such a.... it's kind of like a.... just a REAL.... you know, get 'em in, get 'em out, get 'em in, get 'em out. And instead of like quality care, it's just.... it's just a matter of numbers for some of these people.

Geena (high school educated) said that being rushed makes her anxious because she feels that she may be forgetting to tell the doctor something or ask important questions:

> ...they're there writing down on their little pad and "Now let's do a quick little examination or whatever", you know - check out your heart and whatnot and the you're pretty much out of the room and half the time, you're thinking to yourself, is there anything I forgot to ask. Is there something I forgot, right? You know, because I mean they're so quick at doing their job, right, that you're wondering, you know, did I cover.... did I mention the things that I was gonna mention that I was concerned about, right? But that's pretty much how you feel after you leave, right. You're wondering, you know, did I ask what I was supposed to ask...

Participants repeatedly used the phrases "she/he took the time" when describing a medical encounter where they felt enough time was spent during the interaction. It is interesting to speculate what exactly is meant by "she/he took the time." Certainly, it does not only mean the physical time spent in the office. I think that "time spent" is so important because, to the patient, it represents the amount of effort that a doctor is willing to exert when dealing with a person and a problem. It is easier and more time efficient (at least in the short term) to give a patient a pill and send her on her way. It requires more labour, effort, and caring to examine different possibilities and to find one that both patient and doctor can be happy with. Communication, information, and "time spent" can also attest to a doctor's competence. Although this was only implied in some interviews, it seems that some patients have more confidence in their doctor's diagnostic ability when she or he has spent an adequate amount of time with them and when she or he has explored different treatment options.

Valuing the patient and her time

For the women that I interviewed, the amount of time they spent waiting in a doctor's office and how accommodating a doctor was to their needs impacted on the degree of their satisfaction with the medical encounter. There were three characteristics that made up the concept of convenience. Time spent **waiting** in the waiting room was mentioned most often by women in the high school educated group, although some women in the university educated group mentioned it also. Some women saw this as a necessary inconvenience while others were indignant that they had to wait for so long. For them, waiting was not simply an inconvenience, but rather a devaluation of their time. More than with any other doctor-patient problem, women speculated about the causes of this problem. Although some women thought that the doctor was simply busy and the wait could not be helped, many others attributed the problem to over-booking. The issue of money was often raised and some women stated that doctors who repeatedly made their patients wait for extended periods of time were often those who were motivated by money more than anything else. Several women thought that being made to wait for extended periods of time was an indication that their time was not seen as valuable by doctors. This underscored the social inequality and power differential that existed between the patient and the doctor. Pauline (university educated group) wants a doctor to consider her time valuable:

> And so I was shopping around here for doctors and I was appalled at the level of service that you got and how long you would wait in people's waiting rooms and never, never any sort of an apology or even an acknowledgement of the fact that your time as valuable as their time (laughs) or even that it might have any value at all. I find it.... for somebody not to make any comment when you've been sitting for two hours in the waiting room (laughs), I find amazing...

Tina (high school educated group) was also frustrated with how long she has been made to wait in a doctor's office. She feels that waiting often leads to other problems like being rushed out and doctors doing "a sloppy job":

> They call you into the office and you think you're gonna be there like 5 minutes but actually, you're waiting there probably an hour [...] and you're waiting and waiting and you don't think you gonna be that long but you be's forever. Just be in the other room waiting, you know what I mean...till she comes in...so that's the only bad experience that I had with my family doctor...just waitin', that's it. [*later in the conversation*] Yeah, Ok, yeah...I thinks that there should be more doctors down there to give you the right treatment. Cuz, I finds that when I goes down there there's only like one doctor on and there's a room full of people down there and then you're there waiting for hours and hours and hours and he kinda rushes

> ya and so you get a sloppy job, I find. And that's why they treat you the way that they...you know?

Convenience for several women meant having a doctor who would do **home visits.** Sometimes it is difficult to get around because of small children or a disability. Some women could not understand why, at a time of illness and weakness, *they* were the ones who had to get out of bed, go to the doctor's office, and wait in a waiting room full of other sick people. These women thought that, ideally, a doctor would come to their home when they were ill. Other women simply appreciated some **accommodation** that took into consideration their personal lives. Aleksandra (high school educated group) told me about how difficult it is getting around with her disability. She wished that a doctor could come to her home when she or her children are ill:

> I think for my concern....like where I got a disability...I'd like for a doctor to come to my home, which would be great because where I got the disability it's hard to get around. That's the only thing really I would like to see happen - doctors coming to their homes if they can't get out. [*later in the conversation*] Especially like in the middle of the night if there's something wrong with the kids or me, they can come to your house there and then, right? But some doctors don't do that.

A doctor's personal manner

For many women, a doctor's personal manner was very important. I think that the importance of personal manner for the women I spoke with also attests to their longing for a holistic approach of health and health care. If women were only concerned about treatment of disease, clinical skills would have been mentioned far more frequently than personal skills. This did not happen. Often women used the phrase "she/he made me feel comfortable" when talking about a doctor who had a good personal manner. For a patient to feel comfortable, a doctor had to create a certain environment in her or his office and had to respond to a patient in a particular manner. The creation of a comfortable environment involved many of the things previously addressed: not making patients wait for long periods of time, being considerate of the patient's feelings, and not rushing the patient out of the office. But the doctor's personal manner or personality also helped to create a comfortable environment. Women reported that doctors would make them feel comfortable if they asked about their lives (kids, family, work), when they asked them how they were doing in general, when they looked them in the eye, when they smiled, and so on. Personality or behavioural traits such as being patient, caring, and calm were also important. Doctors who were cold, rough, impatient, unprofessional, or dismissive were not considered to have a good personal manner and they did not make patients feel comfortable.

Anna (university educated group) talked about a doctor who she went to who was unprofessional and made her feel very uncomfortable. She told me that he was simply "too friendly" and her interactions with him "felt inappropriate." She told me why she did not report him to the medical board.

> Maybe...you know, his style was inappropriate for his profession...so maybe there was something there to complain about--professionally. But sometimes it's hard-that line between a personality trait and a real professional mispractice. I felt that in his case with me that it was more of his personality was not what I wanted in a doctor.

Lisa (high school educated) talked about her present doctor. She said that her doctor has a personal manner that inspires trust: "She's very nice. She's very friendly and seems to care. She seems professional and honest. I would say honest. I think I trust her."

Boundary violations: sexual misconduct

Reports of sexual misconduct by physicians were quite common in my study. Six women (two from the high school educated group and four from the university educated group) labeled certain incidences as being sexual in nature and I grouped these under the category of "sexual misconduct by a physician." According to the Newfoundland Medical Board (1993, p.2), sexual misconduct is: "Conduct of a verbal of physical nature that assails the sexual integrity of a patient and breaches physician-patient trust. Conduct means action or behaviour that is under one's voluntary control or direction. Sexual integrity refers to the privacy, completeness or wholeness of a person's sexuality." Sexual misconduct includes sexual assault, sexual harassment, or sexual impropriety[3]. None of the women in my study filed a formal complaint about the sexual misconduct they experienced to the medical board. (See section on "subversion" for possible reasons why.)

Although it is possible that women who had been abused by their doctors would be more likely to participate in my research in order to tell their story, I do not think that is why there was such a high rate of reported physician sexual misconduct in my study. First, only one of the women who was sexually abused approached me to be in the study. I approached two women and I did not know prior to talking to them that they had been abused. Second, because of time and financial constraints, I did not interview all women who volunteered to be interviewed. I chose women randomly from the lists of names I had. For this reason, I do not think that the women I interviewed chose to be interviewed for the sole reason of telling their stories of abuse. All of the women who had been sexually abused by a physician also talked about other negative and positive experiences. It is remarkable that none of the women who had been sexually abused reported the abuse to the police or the medical board. Although the group I interviewed does not constitute a representative sample, perhaps the participants' silence speaks to the presence of certain barriers that prevent women from formally reporting sexual abuse.

Conclusion

Women's experiences with doctors are varied and several important factors discussed above are pivotal to the doctor-patient relationship. A doctor's ability to communicate with her or his patients, the amount of information the patient is given, and the amount and quality of time a doctor spends with a patient has an impact on how most participants in this study felt about their visits to the doctor. Equally important is the doctor's personal manner and ability to see the patient as a complex individual with a variety of social and economic forces acting on her health and life. Some patients also recognize that the power difference resulting from education, money, and status have an effect on their interactions with some doctors. This section has outlined some of the problems that occur during doctor-patient interactions and the elements that contribute to a positive doctor-patient relationship.

Women's holistic perceptions of their health and health care are not always relational and do not necessarily always involve doctors. Next I will discuss the impact women's self-concepts and personalities had on their experiences with doctors.

The personal

"Who I am"

Personal experiences can influence perceptions of health care. The participants in my study revealed their personal lives and feelings to me. They told me their personal stories. How women feel about themselves, what they know, their internalized fears and expectations, can affect health care perceptions and outcomes.

Personality

Several women in my study attributed some of their negative and positive experiences to their personalities and personal outlooks or attitudes. Personality also seemed to affect women's reactions to negative situations. Amanda (high school educated group) told me about her fear of asking questions. She said that she didn't always feel confident asking the questions that she should. She talked to me about how she was dealing with this problem:

> Well, the doctor I'm with now.... like I said, I feel a bit more comfortable with her. I'm starting to get my confidence around myself now that I can go in and ask them anything. Like when it comes to my kids, I will ask them anything; but when it comes to myself, forget it. I just... like okay - I'll agree with you and walk away; but I'm getting to the point now.... well, I ask them, "Okay, what does this mean" and "how long.... what are the side-effects" and stuff like this. I'm starting to open up to being able to ask questions - slowly but surely. It'll take me awhile.

Amanda's ability to ask questions is not only based on her personality but also on the manner or personality of her doctor. Although Amanda told me that she became more confident while going to her parent-child group, it was also the comfort she felt with this particular doctor that allowed her to ask questions.

Pauline (university educated group) also talked to me about her experiences with doctors and how her confidence and life circumstances have influenced these interactions.

> I don't mind doing that at all [*asking questions*] and I have the confidence to do that and generally, I think my feeling.... MY treatment by doctors would be a lot better than other people simply because I have a fair level of confidence when I go into an office and don't mind asking questions and another thing, a lot of people know I'm married to a lawyer and, you know, they are more.... I think that they're more careful for that reason...

Anna (university educated group) talked to me about going to a doctor who made her feel uncomfortable as a result of his lack of professionalism. When she later found out that he had been sexually abusing his female patients, she was not surprised. She felt that her personality had protected her from becoming his victim.

> Now this man never molested me in any way. But there was this underlying something and, you know, as soon as I heard this thing [*about the doctor molesting other women*], you know, I thought yeah.... and I thought I'm not much..... I don't think I am and I've been told - I'm not much of a pushover. Like if you were a doctor and you had to choose between.... these girls if I remember were very young - an 18-year-old, you'd molest her - not me because I'm the type of woman who would be screaming bloody murder before you even.... you know what I mean to say? I'm not an easy target.

A woman's personality can also affect how she reacts to negative treatment. When I asked Tina (high school educated group) how she reacted to a situation where she had to wait a long time at a hospital while bleeding profusely, she told me that she was upset but, "I could not bring myself to say anything to him cuz I'm not like that…I's keep it all in".

The influence of past events and experiences

I asked the women in my study if they had any past experiences (not necessarily medical) that they feel have affected how they feel about doctors, certain medical procedures, or health care in general. Some women found this question somewhat unclear and in most cases I gave the following example: "If at a young age your friend or a family member told you what a gynecological examination was, what it was for, and what to expect, gynecological examinations may not seem very frightening to you. On the other hand, if you heard horror stories about painful, embarrassing procedures, you may be frightened about going for a gynecological examination." By asking this question, I wanted to determine how women incorporate their experiences into personal beliefs and how these may affect their perceptions of doctor-patient interactions. The answers to this question were varied. Several women said that their past (negative) experiences with doctors affected their perceptions of doctors in general. Some women said that their negative experiences with male doctors convinced them to only see female doctors. This is what Hilary (university educated group) said:

> I guess having that one experience with the gynecologist affected the way I sort of view male doctors in general - which perhaps is not the most fair thing (laughs) but I don't.... you know, I try to avoid them whenever possible even just for regular things to tell you the truth.

Other women talked about being reluctant to go for a pap smear because of stories that they heard about gynecological examinations. Aimee (high school educated group) told me about what happened when a friend told her a frightening story about getting a pap smears:

> She was telling me all kinds of stuff that they does to you and everything. And I was frightened to death and I said no way, I don't care, and you know... and a few of my old friends were sayin' you can get ovarian cancer and you can get this and you can get that and I said I don't care, I'm not going. She had me frightened to death when I went to...when I got pregnant with my son. About the internals and things that they do and I wouldn't go and I didn't go to a doctor from the time I got pregnant up until I went in labour.

Knowing a doctor personally, because they are part of the family or because they are in the same social circle, made doctors appear more human and fallible. It made women less intimidated when going to the doctor. Andrea (university educated group) talked about how knowing a doctor personally affected how she perceived doctors' treatment of patients in general:

> ...it became for him a kind of a tedium and a routine, you know, because he had so many patients to see and he wanted to see so many patients because the more you saw the more money you made and so on. I just knew that he didn't, you know, didn't remember things about people. I mean he didn't have time to give any personal attention to someone so I extrapolated from that to other doctors...

Having children also had an effect on women's interactions with doctors. Several women said that they were very concerned about getting the best possible care for their children and this made them into more assertive patients. Caroline (university educated group) said:

> If there was any experience that would have an effect, it would be having children - that because when you have children and if you do have any sort of health problems with your children, that you want the best care for your children that's possible. And so I think what I have learned vicariously is that I need to inform myself before I go to the doctor so that I can ask intelligent questions. I know the terminology that's used. I'm not intimidated and that I can make an informed decision with the doctor about the best treatment for the child. And it's like a consulting process. I'm going and asking, you know, for him to consult me and to help me out with what I know and let's work together and definitely, definitely, get the best treatment for the kids.

Personal stories

Many women told me about personal experiences in their lives. This disclosure did not come as a result of a question I posed. It occurred spontaneously. Women talked about problems that their children were having at school, their families, problems at work, and successes at school. The stories that women told were not *directly* related to health or health care. They were part of what constituted a woman's personality, and what contributed to her present situation, and life trajectory. If health and health care are to be considered in a holistic manner, these women's personal stories make up one part of a complete picture.

The Social

Health care in a larger context

Women's discussions of health and health care included more than personal narratives and discussions about doctor-patient interactions. Women often contemplated social problems affecting their own and other people's health and health care. Depending on what was important to them, they referred to a variety of issues.

Power, privilege, and choice: women's perceptions of doctors and the health care system

Many women talked about the state of Canada's health care system. The most often mentioned topics were access to services and financial issues. Gail (university educated group), who grew up in rural Newfoundland, talked about patients' lack of choice and her frustration with doctors who do not want to practice in rural areas. She felt frustrated that doctors felt entitled to work anywhere their pleased, yet other professionals, like social workers or teachers, would take any job they could get:

> ... you need more doctors; and then they all get on about how doctors want more pay and they want to.... if they go to isolated communities, they want to be able to pick their community and they want to have more pay in that community and they wanna have and... you know, all this stuff they wanna have. Well, that's fine. Everybody should get good pay for their jobs; but hell, you know, there's people out there saving lives every day in volunteer capacities - saving people from committing suicides who get nothing.... It just makes me ill. (laughs) It just makes me frustrated.....if you look at every other profession or just about every other profession, if people want employment, they have to go away, right? You know what I'm saying? Like, when I graduate, chances are I'm gonna have to move. Teachers - you wanna be a teacher, you gotta move. You might have to go as far as Korea. Be a doctor you can go anywhere you want and then they're sitting back complaining because they might have to go to Labrador - you know, when someone coming out with an Education degree has to all the way to Japan. You know? Like what are they complaining about? No, but I mean really. I mean that's unfair - and they get really good pay so it's not like they can't make a life for themselves...I'm not saying that these people shouldn't have a choice either but I guess what I'm saying is the consumer should have choice.

Several women thought that if doctors were put on a salary, patients would receive better quality care. Participants believed that patients were made to wait and were being rushed through medical visits because doctors were over booking. Some women felt that doctors over booked because they billed on a per patient basis. It was suggested that if doctors were paid a salary instead, they would be more likely to "take their time" and not over book. This is what Caroline (university educated group) had to say:

> What about the idea of putting doctors on a salary instead of a billing per patient. And, you know, doctors might have a different....it would slow them down a bit. Would they not be so concerned about running their practice as a business. Would they.... if they're just getting a salary, maybe it wouldn't be so important to get 30 people through in a day as opposed to 15 because the salary is not going to change. So I think seriously we need to look, as a society, that.... and I know it

> will never ever happen because they're one of the most powerful lobbying groups in this country and that they would never ever hear about it whatsoever. I mean they won't even go to a rural place without putting up a huge stink; but I think, yeah, maybe let's look at putting them on salary and giving them more time with a patient...

Holistic health and health care

After listening to women talk about their health and health care, it became clear that most women saw their health in a very holistic way and wanted their health care providers to respond to a variety of physical and emotional needs. Several women described the detrimental effects of financial difficulties, stressful situations, or relationship problems on their physical health. Andrea (university educated group) sees her health being influenced by a variety of factors. She thinks that doctors would be better attuned to the causes of certain problems if they were familiar with the context of a woman's life:

> I think your health is a matter of.... it's a matter of.... like a lot of people and a lot of things have an input into it. You can't fix something with a pill because you don't know whether.... you don't know what the circumstances are that causes the symptom to appear; and until you know that.... and that takes a long time. I mean it takes.... you have to, you know, be observing your own habits and looking at what you're eating and what is different in your life - what kinds of stress you're having or not having at the moment or whatever and all of those things go to making up a picture of your health, especially your diet. I think that's.... and to tell you truth, I've only ever met two doctors who ever made a question to me about what I ate. [*later in the conversation*] Most of the time, they don't know your circumstances so there's nothing they can go on. For fourteen years.... fifteen years, I was a single mother and trying to go to school and having to do a university degree - well, once you know those two simple things, you might be really well equipped to figure out that I was under some kind of stress or pressure, you know?

Many women felt that doctors should understand and be taught about the connection between emotional well-being and physical health. They also thought that doctors should be sensitive to patients' emotional health and not dismiss it as a non-medical problem. Several woman said that doctors should be prepared to deal with patients who are upset or depressed. Others also proposed a broadening of health care services to include psychologists and dietitians, for example. Fiona (high school educated group) talked about the importance of paying attention to a patient's physical and the emotional problems:

> I think that the doctors out there today should be more sympathetic when it comes to a patient. Sit down and listen to them and just don't have them in the office and rush them out the door as soon as they came because they happen to be behind or something like that. You know, that's what they're there for, even if they do have a busy schedule and they're behind - whatever. If a patient comes in and they're upset or they're sick or whatever the case might be, at least have time with them - not just come in, okay check you out and "Here's a prescription. Go get better." No. I think there should be some changes in that area...

Caroline (university educated group) believes in broadening health care so that both physical and psychological needs are met.

> I think that they should have psychologists on the staff because they don't have the skills and the training with the people and they don't have the time and they're so.... and it's such a medical model that they're under and like, you know, I said before, I think you've got a lot of people that, you know, come in and it's not that they need Valium or that they need any sort of drug per se. You get a lot of people that come in to your physician, who for example, have just lost their partner; and I mean they're.... they're grieving and what's the first thing that the doctor does - nine out of ten times - puts them on Valium and I think, you know, if doctors had psychologists on staff, they could say to this client.... they could say, "You know, I think what you're feeling.... what you're going through is grief and that's pretty normal stuff" and "how would you like to go down the hall and see Dr. So-And-So" and have a psychologist there who can help these people in the way that they need to be helped.

Several participants said that if doctors took into consideration some of the social and emotional causes of illness and mental distress, they would not be so quick to prescribe medication that obviously does not deal with the root of a problem.

Some women also thought that community-based health care was important. Health care should not take place in a isolated setting where patients are not supported and "healed" by the community:

> I think the communities should have a lot more say and I think it's terrible that old people have to die in hospitals instead of at home and that they suffer of at home and that they suffer through all this pain in their last week or two and all these really expensive procedures and I think everything is so *alienated.* The community is not involved anymore. **Lisa (high school educated group)**

Issues of power

Although I expected that many women would identify sexism as a factor in their negative interactions with doctors, few did so. If a woman had a negative interaction with a female doctor, it was unlikely to be interpreted as sexist. Even though some women recognized that medical education was often sexist and portrayed female patients and their complaints in a problematic manner, few participants explicitly recognized that female doctors could also "buy into" sexist assumptions. Although it is difficult to compare incidences that occurred with different doctors, it seems that participants were more likely to label a behaviour as sexist if it came from a male doctor. The same behaviour with a female doctor would probably be attributed to other causes.

Although they did not directly related it to their own experience, several women did talk about issues of power surrounding race and gender. Some women felt that sexism and/or racism had an effect on how the medical system was structured and how certain patients were treated in hospitals and in doctor's offices. For example, Fiona (high school educated group) was concerned about how aboriginal people were being treated by the health care system:

> I will speak on the Native people out here...I know they find it difficult when they come out to the doctor's here because they don't really understand...So that's pretty hard there for Native people when they do come out - aboriginal people actually - from Labrador. And I think there should be some changes in there. They should have someone there.... well, what they do have here in St. John's is an interpreter and stuff but it's just like it's always rushed. You know, get you in - get you out and that's it and then forget about you, you know.

Phyllis (university educated group) told me about a psychiatrist who saw her as ill and dysfunctional because she was not acting in an "appropriate" manner in her new marriage. She attributed her doctor's behaviour to sexism:

> **Agnieszka:** Can you think of a reason why you were treated the way you were treated?
>
> **Phyllis:** Of course! Oh yes! The history of medicine for one. You know, the history of gender power and the history of how medicine has treated women [...] It's not surprising to me that that psychiatrist thought he was doing a great job. I mean, here's a young, married woman who's running into some problems with the socializing expectations suddenly being put on her, which she was told wouldn't happen when she got married, and the best thing I can do for her is to socialize her better--not say that the marriage sucks, the society sucks, the neighbourhood, the community expectations SUCK but... it's easier to fix her to fit into the screwed-up cultural situation than it is to fix the screwed-up cultural situation.

Over-prescription

The fear that doctors are prescribing medication too easily was also seen as a problem. Several women thought that doctors often prescribe drugs for problems stemming from stress, abusive relationships, financial difficulties, and so on. Prescribing a pill for this sort of problem was seen as a band-aid solution that did not examine the root of the problem, much less attempt to solve it. This is illustrated by what Gail (university educated group) said about survivors of sexual assault:

> A lot of women especially who have gone through, like sexual assaults and things like that and they go to psychiatrists and what do they get right away?.. A prescription. So now they have another problem. They're, you know, dealing with sexual assault and addiction! Yay! Now they've got two problems so it's.... and that's my beef. It's when the drugs are not monitored and when they're given as (pause)...an easy solution...

Some participants also felt that, even for medical problems, alternative or natural treatments should be tried before prescribing a pill.

Women's theories and interpretations of their treatment

Women had a variety of theories and interpretations about their treatment and about the negative situations they told me about. Once a woman told me about her negative experience, I asked why she thought she had been treated in a particular manner. I wanted to see how women interpreted their experiences. I also wanted to know women's theories about the causes of their negative treatment. The answers to this question were varied and were given throughout the interview (not only when I asked the question). Attributions also changed depending on the particular negative situation and women often gave more than one attribution. There were three common attributions. Participants often attributed negative interactions to a doctors' greed for **money**. Many women felt that doctors who rushed them or made them wait for extended periods of time in waiting rooms without justification were overbooking. The reason they were overbooking was to make more money. Hannah (university educated group) talked about a doctor who constantly made her patients wait for over an hour: "With Dr.O! - well, I just think it's.... I'm sorry, I think it's greed. I think it's a lack of professionalism and I think it's lack of respect for her client. You know, there's no other explanation in my mind other than she wants the billable hours!"

Some women also attributed their negative interactions to a doctor's **education** or training. There was a consensus that doctors did not receive enough training in patient care. Participants thought that medical education should underscore the importance of "people skills." Some participants felt that paternalism and power imbalances are built into medical education. Future doctors learn by observing other doctors or through course content that a power difference is natural between doctor and patient. Andrea (high school educated group) said that this would account for the fact that both female and male doctors sometimes wield unnecessary power over their patients: "I think they're taught to do that because female doctors as well as male doctors do it. I think it's part of the system of training that they have. It's, you know, the patient.... in order to trust them, the patient must feel inferior or something. I think that's a misguided approach myself."

Some participants attributed their negative interactions to a doctor's **personality**. A patient felt that she was treated poorly because the doctor was a "jerk," "an asshole," a "cold person," and so on. Women who attributed their negative experiences to a doctor's personality usually felt that they had simply stumbled upon a "bad" doctor and did not put their problem into a larger social context.

Other reasons given for negative interactions included sexism, racism, cultural differences between the doctor and the patient, a doctor's lack of experience, the nature of the situation ("The doctor was busy with an emergency"), and the nature or the patient's complaint ("The doctor was uncomfortable because I went in for a pap smear"). Several women had mixed feelings about why an interaction with a doctor had been negative. Some partially blamed themselves, the situation, and the doctor. For example, Tina (high school educated group) tried to figure out why she had been neglected at a hospital: "...it's like they weren't experienced enough to do what they were suppose to do...they were pretty busy too probably... I wasn't very important...there were lots of people there that night it happened. Still, I think that I am the same as anybody else..."

Comparison of the two groups

Certain themes involving doctor-patient interactions were only mentioned by one group. Only women in the university educated group talked about the importance of doctors personalizing interactions to fit their individual needs. Several women in the university educated group also wanted doctors to trust their self-diagnosis of certain problems. The theme of honesty was specific to women in the high school educated group. Several women in that group mentioned being worried that doctors were not being honest with them. Overall it seemed that women in the high school educated group were less confident during their interactions with doctors, especially when it came to asking questions and speaking out against negative treatment.

University educated group

The personalization of interactions

For many participants in the university educated group, it was important that a doctor shape her or his interaction and service to fit the individual needs of the patient.

This involves taking into consideration the context of a woman's life, for example, her financial or family situation, when recommending treatments. It also means that these women expect a doctor to make, what women considered to be, common sense judgements about what would make someone feel unnecessarily uncomfortable and what are appropriate (or inappropriate) responses to certain situations. For example, Hilary described an incident where a doctor did not take into consideration her age and inexperience with gynecological procedures when performing a pelvic exam:

> Anyway, I think I was 13 or 14 anyway. The reason I was going was because I'd had my first period. Anyway, I was having a pelvic exam - first time ever - and there was a nurse in there with him and he was sort of looking around and hadn't really done anything that I could tell - yet. And then he got up and he went to the door of the exam room and he yelled down the hall, "Could someone get me a small speculum please!" And I didn't know what that meant but I was mortified, you know. I was so embarrassed because, you know, I didn't know what that meant. I didn't even really know what a speculum was but just that he would be screaming down the hall, I knew it was related to me. I thought, "You asshole!" You know. Anyway, so he went on with the exam and it was very uncomfortable - like it would be - and I just couldn't believe it. And then he went on to tell me that I was very small and that, you know, before I had sexual intercourse - you know, and I'm just sitting there and I'm sure my face was bright red because of the whole thing - that before I had intercourse, I might want to have my hymen clipped. Otherwise, it might be unreasonably uncomfortable. Then I thought, unreasonably uncomfortable! (laughter) There's something somebody's not told me about this whole SEX thing! Anyway, I was just mortified and I couldn't wait to get out of there and I never went to see him again. [*later on in the conversation*]...I thought it was unprofessional of him to be yelling down the hallway like that [...] I just felt like he wasn't very sensitive to my sort of, you know.... this is in retrospect, I don't know that I thought this at the time. I think at the time I just thought he was a jerk - very insensitive to my age and my situation. I thought that if he.... well, it seems like a physician wouldn't want someone's first pelvic exam to be traumatic, any more than, you know, than the usual anyway.

Personalized care also means treating the patient as a person and not just like a disease or case to be studied. It requires the doctor to be sensitive to how the patient is feeling during an uncomfortable procedure, when hearing bad news, or when they are not feeling well. Gail told me about her doctor's small gesture of kindness:

> That big, cold metal instrument that most doctors don't consider it to be cold. And it is, usually. She used to keep it on a heating pad and whatever she needed, it was there and it was always warm. And that just kind of made the experience... because it's such a horrible experience - it kind of made it a little easier to go through.

Pauline could not understand why it is so difficult for some doctors to respond to their patients with respect and courtesy. She thinks that doctors should be taught the importance of "basic people skills".

> It's just very technical education and they're no people skills involved, just some basic.... some of it is just courtesy and making people feel good and putting people at ease and being careful the way they say things so that they aren't unduly alarmists. Sometimes they're very flippant about the way they will say things without giving any thought to how that might be received or assessing the person that they're talking to in terms of their education level or their level of ability to grasp and cope with something. But that's all pretty basic stuff that most people do in their daily lives but often.... I don't know, our doctors are so rushed. It's very much an in/out, putting people through a mill - a system type of thing. (pause) That's all - some of that basic people stuff - interpersonal relations.

Anna felt that some doctors do not see the person behind the disease. She talked to me about getting the personal element back into doctor-patient interactions:

> ...You know, he goes into the hospital and he became a disease and he's not a disease. He's a person with a body that has a history; and you know, if you have a long-term, if possible, relationship with a doctor AS a person and as much as possible that doctor be involved with your medical care as much as possible, I think it's better. You're not.... you don't go to this specialist because it's this disease and you're this disease when you see this specialist and that as much as possible, you're treated as a person and not this..... some doctor out there knows you as this person. That's not to say that at some point you might not have to go see a specialist. There is this continual rapport with someone who knows YOU as a person and your physical foibles, let's say, (pause).... yeah, I feel sometimes that going to see a doctor - you just walk in there and you.... today, it's Pneumonia 404 and tomorrow, you know, it's Flu 102 or something like that and (pause) there's something.... I feel sometimes that medical practice has lost the human element and it would be nice to get back.

"Take my word for it": trusting the patient's judgement

Several women in the university educated group did not understand why doctors could not simply accept the fact that they had a certain problem. Some women did not see the need for verification of every infection or illness through a physical examination. This was especially the case when a physical examination would cause a great deal of embarrassment or discomfort for the patient. For example, Kristine was getting yeast infections repeatedly as a result of some antibiotics that her doctor had prescribed. Despite the fact that the doctor had warned Kristine that she may get infections as a side affect to the medication, she still insisted that Kristine have an internal examination. Kristine said that she *knew* she had a yeast infection and she felt that the doctor should have "taken her word for it." She told me about another doctor (a homeopath) she went to see after having a negative experience with her medical doctor: "[The homeopath] trusted my knowledge of my body in terms of what I can feel comfortable with and what I can't feel comfortable with and what I consider bad enough or uncomfortable enough that I can't continue with something that I normally would do. He trusted that judgement and didn't just rely on I guess what would have been some sort of examination of me."

Women only wanted doctors to "take their word for it" in certain instances. All the women who wanted doctors to trust their own judgement also said that most complaints *should always* be verified by a physical examination. Only infections or conditions that some women got on a regular basis, such as yeast infections, urinary tract infections, or hemorrhoids, should not always have to be verified through a physical exam, especially since the drugs used to treat these problems are not addictive. Women stressed that doctors should not give addictive drugs to patients simply because a patient says that they need them.

High school educated group

"Tell it like it is": honesty

Several women in the high school educated group were concerned about doctors not being honest with them. They wanted doctors to tell them information about their condition and about treatment options. They did not want doctors to keep things from them "for their own good." Amanda talked to me about a gynecologist who did not inform her that her baby was in a breech position until a few days before her delivery. She thought that he waited to tell her because he did not want her to be "stressed out." Amanda had conflicting feelings about the interaction. The doctor had a lot of expertise but Amanda also did not feel he had been up front with her: "I mean he was a great doctor. I'd recommend him to anybody, but like I said, he should've been more up front with me and told me from the beginning..." It is interesting to speculate why only women in the high school educated group mentioned the importance of honesty. Perhaps, they are more often in positions where they feel that doctors are not telling them the "whole truth." Some literature suggests that doctors are less likely to explain things and give information to patients who have lower incomes and lower levels of education (Roter & Hall, 1993).

Speaking up, speaking out

When women spoke about doctors that they had a good rapport with, both groups seemed comfortable asking questions and asking for information. However, I noticed that several women from the high school educated group seemed to be less persistent and less comfortable asking for information when they where with a doctor who they did not know very well or who was treating them badly. For example, usually when a participant in the university educated group was confronted with a doctor who was not giving her information about treatment options, she would speak out, complain, or demand to know more information. Women in the high school educated group did not seem as comfortable in demanding information when it was not provided to them initially. Women in the high school educated group were perhaps less likely to stand up to doctors who were already treating them poorly. It is important to stress that the statements above are generalizations--there were women in both groups who were very assertive and confident with doctors. Further, how any woman reacted in a given situation depended on the particular situation and on a variety of factors including her mood the personality of the doctor. There are many possible explanations for this difference in assertiveness. Perhaps women who have less formal education feel less entitlement in the doctor-patient relationship. Maybe they feel that their doctor's time is more valuable than their own and demanding information is inappropriate. Perhaps they feel more vulnerable, and hence silenced, because lack of money or information or time or child care prevents them from going to a different *kind* of health care provider or simply to a different doctor. The feelings women have about their own self-worth are complex and I doubt any woman when asked would say that her time was less important than her doctor's or that she was less valuable than her doctor. However, for women who do not have a lot of formal education or a lot of money, it is difficult to be unaffected by a society that places enormous value on a university education and a high income.

Summary

This chapter outlined women's information gathered through my interviews about women's feelings about their health and their experiences with doctors. The women in my study saw many factors affecting their health and health care. Their perceptions were shaped by their personal beliefs, past experiences, current doctor-patient relationships, and the social, cultural, and economic climate that they live in. The women who participated in this research project provided a great deal of insight into the possibilities and limitations of doctor-patient interactions. They gave voice to experiences of vulnerability, neglect, and disrespect. They also described doctors who through their understanding of patient needs and effective communication skills created an environment conducive to learning and self-knowledge. The women in my study pointed to avenues for change for both patients and doctors.

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2. Although none of these women said that these relationships were abusive, I got the impression from their stories that they were all emotionally, and possibly, physically abusive.

3. The Newfoundland Medical Board (1993) also states that the following elements may be part of an act of sexual misconduct: disregard for a patient's privacy; rude or offensive remarks considered sexually demeaning by a patient; lack of informed consent; intrusiveness; psychological manipulation; coercion; exploitation; seduction; physical violation; sexual intercourse.

Situating my Research: Conclusions, Limitations, and Future Directions

Chapter Four

Introduction

This chapter situates my current research in what has already been written about women's health and about women's experiences with doctors and the health care system. I address some of the methodological issues and problems that have arisen in the course of my study and discuss the potential of positive and negative interactions in the context of women's reproductive health and health care. Finally, I address reactions to my research, the limitations of my research, and directions for further study.

Situating my research

As my literature review indicates, factors affecting women's health care, specifically their interactions with doctors, are complex and multifaceted. It is impossible to pinpoint one variable and conclude that it was that particular variable which determined the (positive or negative) course of an interaction. In my literature review I identified several themes that are important to the doctor-patient interaction. My research underscored the importance of some themes and I also discovered different themes. In this section I discuss the medicalization and discounting of women's experiences and some of the variables that help determine the quality of the doctor-patient relationship. I also consider the effects of stereotypes and bias on doctor-patient interactions. Finally, I explore how women's experiences were influenced by the devaluation of subjective knowledge and women's subsequent acts of resistance.

Two ends of a spectrum—medicalizing or discounting women's experiences

Although, some women I interviewed reported instances where doctors recommended treatment that was invasive and inappropriately drastic, many more women complained that doctors discounted their experiences. Although the literature suggests that doctors may not take women's medical conditions seriously, more often, the women in my research suggested that *they* were not taken seriously. As some women indicated during the interview, discounting or dismissing problems, illness, or circumstances manifested itself in a variety of ways. *Waiting:* Doctors who made their patients wait for long periods of time without an explanation or apology did not seem to value women's time or consider the affect of waiting on women's lives. *Rushing:* When doctors rushed women out of their office, women often felt like their problems were not being taken seriously. Doctors who rushed patients out were perceived as not caring enough about the patient, her illness, or her situation. *Looking for alternatives:* Doctors who automatically suggested an invasive or drastic treatment without explanation or exploration of other less invasive treatments were often seen as dismissive. Some respondents felt that such doctors "did not take the time" or did not care enough about the patient to look for or suggest alternatives.

Doctor-patient interactions

Communication

In my literature review I indicated that communication was one of the most important factors influencing doctor-patient interaction. This sentiment was echoed by almost all of the women in my study. Judging by what the participants said about communication, it seemed that it was the doctor who could best facilitate the development of a relationship characterized by clear, open communication. One reason for this may be that the doctor-patient interaction often takes place on the doctor's terms, for example, the patient is often made to wait for the doctor and the consultation is done in the doctor's office. The doctor is perhaps best able to set the tone for the interaction. For women, communication was also important as an indicator of a doctor's medical competence and personality. Doctors who were not good communicators were often not trusted professionally or "as a person."

Information

Participants in my research were eager to get as much information as possible about their conditions and possible treatments. Both high school educated and university educated women expressed a desire to be given information in clear, easy to understand, non-technical language. Hence, it is important doctors not assume that women who do not have high levels of formal education do not want to know about what is happening to their bodies or what is being done to them. This finding is congruent with information presented in my literature review.

Comfort

There is little written in the literature that indicates that making a patient feel comfortable is an important aspect of the doctor-patient relationship. Patients are expected to give doctors intimate details about their lives and health, yet doctors often do not even introduce themselves. Regardless of how professional a doctor is, this kind of exposure can be both uncomfortable and threatening for the patient. It was important for women to feel comfortable with a doctor and during a medical examination. It is difficult to pinpoint what a doctor must do or how an interaction must proceed in order for the patient to feel comfortable. Often a doctor's personal manner and communication style influenced how comfortable a woman felt. Sometimes small talk eased the tension. Women admitted that some procedures were uncomfortable regardless of how the doctor behaved. However, some doctors were able to lessen the level of discomfort by using clear, open communication, and by being patient, gentle, and friendly.

Waiting

I did not discover a lot of literature that discussed waiting for long periods of time for a doctor as a large concern, yet in my study this was one of the participants' biggest frustrations. Perhaps doctors do not recognize that waiting for an extended periods of time to see a doctor is not only inconvenient for women who have jobs and children, but also demoralizing. Being made to wait constantly (especially without justification) may indicate that a patient's time is not important and her pain or illness are not serious. The women in my study did not mention efficiency as a desirable characteristic in a doctor. Efficiency may be associated with speed and women, generally, wanted a doctor who took her or his time.

Women, children, and doctors

Women seemed to be more assertive around doctors when they were with their children. There were several instances in my research when women told me about standing up to their doctors and demanding better treatment for their children. Women seemed to ask more questions and ask for more explanations when they wanted information about their child's condition or problem. The same women were much more hesitant when the problems were related to their own health. I am not certain if this kind of behaviour speaks to women's devaluation of their self-worth or to women's dedication to their children. Some literature suggests that doctor-patient relationships are made up sets of carefully scripted social interactions that both doctor and patient have difficulty deviating from (Roter & Hall, 1993). For many women, the message that their children should be put ahead of themselves is firmly established in their psyches. It is a message that is reinforced repeatedly. As an example, governments and the public seem to have more sympathy for problems like child poverty and child abuse than problems of woman abuse and women's poverty. It is more acceptable (even expected) to fight for the care and just treatment of one's children than to protest one's own treatment. Although many women do stand up for themselves, perhaps some women feel more justified protecting the rights of their children. Ideally women would feel empowered enough to stand up for both.

Stereotypes of patient characteristics

In my literature review, I discussed how stereotypes surrounding a patient's gender, age, body size, socio-economic status, ethnicity, and sexual orientation can influence doctor-patient interactions. A few women in my study told me that sexism, classism, or racism had contributed to their negative experience with a doctor. In all of these cases the acts of racism, classism, and sexism were blatant. Many women did not attribute their negative experiences to gender (or in some cases racial) bias. There are many possible explanations for this. Both sexism and racism sometimes work in very subtle ways. As I wrote in my literature review, doctors who treat certain groups of patients differently, are probably not aware of this disparate treatment. Negative treatment may also result from a variety of interacting factors, of which sexism and racism are only two. Because sexism, racism, classism, and homophobia are inherent in many studies of health issues, it is inconceivable that this does not impact what doctors know and how they act toward patients.

As a researcher who has listened to many stories of women's negative experiences with doctors, I was able to see patterns of interaction and oppression that may not have been visible to a woman who was only considering her own personal experience. It is easy to dismiss one negative interaction as chance or bad circumstance. Further, the popular media likes to portray the fight for equality, especially gender equality, as virtually over. What effect does this portrayal have on women who have experienced sexism? Does it silence them into thinking that they are alone in their experiences?

External factors affecting women's treatment

Most women did not have a problem identifying how external factors, such as doctors' education or the structure of the health care system, affect their experiences.

Education and the broadening of health care

Although there have been several changes made to medical school curriculum to increase the focus on communication skills, many women complained that doctors are only being taught (or had only been taught) how to deal with diseases, not *people*. Since these changes to curriculum are fairly recent, it is probable that most of the women I talked to had not been seeing doctors who went through the medical school when this new focus was in place.

The women in my research painted a picture of health that was both holistic and complex. Their health was affected by the stresses of their social, cultural, and economic environment. These stresses often influenced both their mental and physical health. Many women, especially those living in financially strained circumstances, went to medical doctors with problems such as depression, anxiety, and stress. Given the largely technocratic nature of medical education, many doctors may not learn the communication, active listening, and counselling skills to effectively respond to these problems. Medical education should teach future doctors how to respond to people who have emotional problems or problems resulting from social or economic factors. But is it realistic or reasonable to expect that medical students learn how to become expert counsellors in addition to all the material they already have to learn in medical school? Maybe not. Doctors *should* learn empathetic active listening skills and how to respond to emergency situations (for example, when someone is suicidal). Further, medical schools should stress to students the importance of communication skills and "people skills." Perhaps, admission to medical schools should be dependent on applicants' ability to be effective communicators *as well as* a high grade point average.

Health care also needs to be broadened to include services and health care providers equipped to effectively deal with social-psychological problems. The health care system must address the needs of women of *all* social-economic backgrounds. As I found in my study, while women who are financially secure may be able to afford to go to a counsellor, psychologist, or dietitian, these services are not available to women who are students or to those with modest incomes.

Financial motives

I was surprised by the number of women who accused certain doctors of practicing medicine only for financial gain. One of the primary reasons for this accusation were the incredibly long waits women had to (repeatedly) endure at the doctor's office. Participants believed that waiting resulted from over-booking and over-booking resulted from a doctor's desire for more money. Participants blamed both individual doctors and the structure of the medical system. Some women felt that a fee-for-service payment scheme did nothing to dissuade doctors from overbooking and rushing patients out of their office. It is possible that some doctors make their patients wait because they have no choice. If they are working in a small community where there are only two or three doctors, overbooking may be the only way to meet the demand that exists. Regardless of the reality of why patients are repeatedly made to wait, the perception exists that it is because some doctors are greedy. This perception can have a negative effect on the doctor-patient relationship. Again, clear communication is the key to dispelling this myth (if indeed it is a myth). Several participants said that if doctors would explain why a patient had to wait, for example because there had an emergency or special circumstance, patients would understand. In fact, several women in my study said that although they did not like waiting in emergency rooms, they understood why it was sometimes necessary. They knew that they did not have an appointment and that some patients would be "higher priority" because of the nature of their illnesses.

The construction of knowledge

My literature review explored the hierarchical binarisms that define our society and how the discounting of subjective knowledge can have an effect on the doctor-patient relationship. Interestingly, the women I interviewed often depicted their relationships (especially the negative ones) as being very dichotomous. They often portrayed doctors as having the resources, information, and services they were seeking, while they were vulnerable as patients. This power difference was most apparent when women were in a position where they needed a service that only a doctor could give them. For example, since women could only get paid-for, legal abortions in one hospital in St. John's, they may have been more likely to tolerate negative treatment so not to jeopardize their access to the service. Lack of choice may exacerbate the differences in power between the health care provider and patient. However, some women did recognize the value of their own knowledge and they expressed frustration when doctors did not perceive this knowledge as important. Doctors could minimize the effects of this powerful doctor/powerless patient dichotomy by sharing with women information and options. Some doctors encouraged women to learn more about their illness and to actively participate in their path toward good health.

Women also gained power through their own acts of resistance and subversion. Although, on a large scale, the women's health movement has challenged male-centred, allopathic medicine, I have found very little research, surrounding issues of women's health, that explores how women resist or subvert doctor authority during day-to-day interactions. When issues of non-compliance are discussed, it is usually in terms of how to get patients to comply to "doctor's orders." In my research, it seemed that non-compliance sometimes had a positive effect on the women in my study. Not going back to a doctor, going to another doctor for a second opinion, and not complying with suggested treatment gave women a sense of control over their "destiny" as a patient and person. Perhaps patients could not control how a doctor treated them or how the interaction between doctor and patient developed, but they *could* (usually) chose to remove themselves from a negative medical encounter. This of course is often not a possibility for women living in rural areas where there are only a few doctors available. Finding a new doctor may not be an easy task everywhere. Women who are not fully mobile (because of disability, the presence of small children in the home, or lack of transportation) may also find it difficult to look for a new doctor.

Patients were sometimes subversive by arguing with doctors over treatment options or waiting time. Sometimes they would bring up information they read that was contradictory to what the doctor was saying. Sometimes speaking out made the doctor pay more attention to their needs as a patient. However, this strategy did not always produce a desired effect. For example, in one instance a woman confronted her doctor over the amount of time she always had to wait but the amount of waiting time never changed. The woman said she *was* empowered by the fact that she spoke up about her beliefs and made clear the expectation of decent, respectful treatment. Although women could not always act in resistant and subversive ways during the doctor-patient interaction, calling the doctor by her or his first name during our interview was one method of demystifying the power of the doctor. Further, insulting doctors by calling them names (during our interview) was a way to express anger and "get doctors back" for a negative experience.

Some of the things women did in response to negative treatment may not be easily identified as resistance or subversion. It may not seem that women who did not follow doctors' orders because they did not understand them or because they did not have time to follow them were necessarily being subversive. I would argue that even if the motivation for not following a doctor's orders is lack of time or lack of understanding, it is, nevertheless, an act of resistance. Not all doctors believe that patients need to understand a recommendation or treatment in order to follow it. Jolly (1987) cites a study that found a majority of doctors did not ask patients if they understood a prescribed treatment and stated that the patient's understanding was not significant. In general, patients are expected to comply with a doctor's orders regardless of understanding or other factors in their lives (for example, the amount of time they have or how a medication will affect their energy level). I have tried to outline in my literature review, ways in which patients' personal knowledge of their bodies and their illness, is devalued. Society sees doctors as experts not only on the physical mechanisms of disease, but also on the experience of illness and on what is an appropriate treatment for their patients. Whether it is father knows best, priest knows best, or doctor knows best, women have been told not to challenge authority. Not going along with a doctor's orders is resistance because understanding has not necessarily been seen as a requisite for obedience.

Women's reproductive health and gynecological experiences

About halfway through my interviews, I noticed that women discussed gynecological experiences and experiences connected to reproductive health in a different way than other, non-gynecological experiences. First, almost all of the women referred to gynecological or reproductive health experiences in their examples of a positive or negative experience with a doctor. They also talked about reproductive health issues, like reasons why they had waited so long to get a STD test or why they had never had a pap smear. Second, women's discussions of reproductive health seemed to be emotionally charged. For example, one woman discussed the rage she felt as a result of repeated internal examinations. There was little acknowledgement that the treatment that was suppose to "cure" her of her gynecological problems and alleviate her suffering was causing no small amount of discomfort and humiliation. Finally, when a gynecological experience was negative or positive it stood out as being either *extremely* positive or *extremely* negative. For example, positive gynecological experiences seemed to be almost life-altering. They were met with amazement and profound relief. On the other hand, negative gynecological experiences seemed to have a worse emotional toll on women than other negative experiences.

Perhaps the uniqueness of the gynecological experience comes from the fact that it is so personal. It requires a different trust than other kinds of examinations. In the case of a male doctor especially, the patient must trust that the doctor will not sexually abuse her. Not only must a patient trust the competence of her physician, but she must also trust that she or he is sensitive to the vulnerable position (both physically and figuratively) she is in. Maybe this is why most women preferred a female doctor for gynecological examinations. Perhaps women felt that a female doctor would appreciate how uncomfortable it is for women, both physically and emotionally, to go through gynecological exams. As one participant said, gynecological examinations are, by nature, violations.

I think that women's response to gynecological and reproductive health experiences also has to do with the relationship that women have with their bodies. Women's reproductive health, often medicalized, can come to be associated with disease and illness. Women's reproductive organs are laden (or so we are led to believe) with the possibility of failure and problems. Women's bodies, especially their reproductive organs, are also shrouded in secrecy and shame. The combination of this secrecy and possibility of failure can leave women in a vulnerable position. Although some doctors will tell the patient what they are doing during a gynecological exam, women are dependent on the doctor for that information. I think doctors have become the mediators between women and their bodies and this kind of dependence breeds vulnerability. Women may feel awkward asking for more information or to see what is being done to their genitals, because that knowledge is not considered their right. In the same way that one woman told me that she could not stand up to a doctor because he had the power to withhold an abortion that she needed, women may feel reluctant to stand up to doctors who have information about their reproductive organs. When women are denied services or information during their reproductive health care, perhaps their vulnerability is underscored. By contrast, when women go to a doctor who facilitates their comfort, knowledge, and learning about their bodies and reproductive selves, they may be especially empowered by that interaction.

Comparing the two groups of women interviewed

There were more similarities than differences in the two groups of women that I interviewed. For example, communication, information, and short waiting times were universally seen as important to a successful doctor-patient relationship. However, as I outlined in the previous chapter, in general, women who were university educated wanted their doctors to trust their judgement of what was happening to their bodies. It is interesting to speculate why most of the women with lower levels of formal education did not have the same expectations. As a result of the high value placed on formal education, perhaps those do not have a lot of formal education feel that the self-knowledge of their body's functioning in not as valuable as a doctor's many years of formal training. Women who have attended university may have a slightly different view of medical training. Being a university student may demystify medical school. Women with more formal education may feel that they have knowledge of their own that is different but not any less important than their doctor's knowledge.

Women who have high levels of formal education and high incomes may have higher expectations for treatment. They may expect to be accommodated in a way that women who are accustomed to dealing with the bureaucracy of social services or government programs do not. Maybe because women with higher incomes and higher levels of formal education are treated better in other (non-medical) domains, they transfer their expectations to health care providers.

Some women I interviewed who had no more than a high school education were concerned that doctors were not always being honest with them or telling them the "whole story" when it came to their illness, prognosis, or treatment options. It is possible that doctors and patients from different education and income backgrounds have problems communicating with each other. Doctors may assume that patients who only have a few years of formal education do not want or need as much information as university educated patients. Doctors may also not be comfortable talking to patients who come from different social, educational, and cultural backgrounds. On the other hand, patients with a high school education may feel less confident with doctors than patients who have a similar level of education as their doctors. High school educated patients may find it more difficult to ask questions and they may be less willing to demand that doctors give them information and different treatment options. A break down in communication may lead to the perception of dishonesty on the part of the patient or an actual omission of information on the part of the doctor.

Personal responses to research

There are implications of not hiding behind the label of "objective researcher" and sharing one's own experiences with participants. Because I had no pretenses about being distant or removed from my research and the participants, I could not ignore my reactions and feelings toward the conversations I had and the stories that I was told. To a certain extent, writing my personal response to each interview made me vulnerable and exposed my hidden prejudices and agendas. For example, when asked about a negative experience, a woman told me a story about a gynecological problem that she had. She said that her gynecologist kept trying different procedures instead of "just giving her a hysterectomy." After hearing her story I felt very uneasy because I thought that her gynecologist had been right. I thought about the many hysterectomies that are done unnecessarily and I suspected that her gynecologist was trying to save her from an often unnecessary and painful procedure. I almost had an argument with her about it. When I again listened to her taped interview, I finally understood that the experience with this gynecologist had been negative because this woman had not felt listened to. She told me that she always felt rushed out of the doctor's office. She said that she had little input into decisions that affected the amount of pain and inconvenience she lived with on a daily basis. I wondered why I had questioned and judged her feelings and experience. Was it because she was a woman who had less formal education than I did? Did I see myself as the expert, even about this woman's life? Had I been more distant from this research, these types of assumptions might have remained un-checked.

Because I shared my experiences with many of the women I talked to, I felt that often there was a mutual validation of experiences. For example, when one woman told me about her experiences with a doctor who constantly made her wait for long periods of time, I shared a similar experience that I had. Later in the conversation we realized that we were talking about the same doctor. During that interview I felt a sense of relief. I think sometimes it is easy to discount negative experiences and attribute anger or frustration to over-reaction or hyper-criticism. Somehow, hearing this woman's story validated my own anger and allowed me to recognize that I had a right to feel wronged.

Limitations of the study

Because I did not use a random sampling method and my group of informants was small, the results of my study are not generalizable to a larger population. My project has described, compared, and analyzed only the experiences of twenty women with different levels of formal education and income in St. John's.

There were several issues touched upon or discussed by participants that I did not pursue to the extent possible. For example, many women mentioned that medical education should be modified to teach doctors more "human" (as opposed to technical) skills, but only one or two women gave specific directions for change. I could have pursued some of these areas but I felt that I had to stay focused on the doctor-patient relationship. This was somewhat misguided since, clearly many factors, including medical education, affect the doctor-patient relationship.

Although I asked women about their positive and negative doctor-patient interactions and discussed both during the interview, there was a deeper exploration of women's negative experiences. For example, when women told me about a negative experience, I asked them to consider why they were treated in a negative manner. However, when women told me about a good doctor-patient interaction I did not ask participants why they thought they had been treated in a positive manner. One reason for this may be that at the inception of my research I spoke (informally) to many women about their negative experiences with doctors and perhaps this is the reason tended to focus on women's interpretations and explanations of negative experiences instead of the positive ones.

Although I involved different women from the community and local groups in my research, I regret not having time to do focus groups (especially during the pilot interview stage) and not involving those interviewed in different stages of my research. Involving more participants throughout my research may have made my research more participatory. Since I only interviewed each woman once, participants did not get an opportunity to validate my conclusions or interpretations. Throughout my thesis I have tried to make clear when I am directly quoting participants and when I am stating my interpretations and opinions. However, I recognize that meaning is created by the type of language used and the context created by the researcher. As I described in my methodology chapter, I tried to "send" meanings back to participants for confirmation during the interviews, yet it is possible that I misunderstood some things the participants were saying.

Although I read about researchers using an interview format that was very open and almost completely participant-directed, my lack of previous interview experience made me question my ability to successfully conduct such interviews. I opted for semi-structured interviews that allowed me to ask questions that directed the interview in certain directions but still allowed for flexibility and participant input into the direction the interview would take. After completing my interviews, I realized that a more open interview may have produced a greater variety of information from the participants and may have led to a more natural conversational style.

Financial and time constraints also affected the kinds of methods that I used. Certain compromises had to be made as a result of a lack of resources and pressure to finish my study in one year. For example, I did not feel that I could do a greater number of pilot interviews that would allow for larger participant input into the development of questions.

I also decided that I would not bring my analyzed data back to the interviewees for approval or elaboration. I did not have use of resources such as research assistants that would facilitate this process. A second interview would have almost doubled the duration of my study. A method that requires the researcher to re-interview participants is recommended by Kvale (1996), and although I followed several of the research steps he outlines, I did not follow this one because of time and financial constraints. Instead, I am planning a workshop where I will invite the participation of patients, community workers, and other researchers. During the workshop I will discuss the results of my study. I will also engage the workshop participants in a series of activities that produce responses to my work and serve to indicate directions for further research. The workshop is a kind of epilogue to my research and a way of reaching out into the community with information and resources. Although my research was egalitarian I realize that some researchers have gone farther to facilitate the involvement of their participants and the community. I recognize the methodological limitations of my study and I hope that I have made methodological choices that are justifiable.

Implications for patients

Judging by what some women involved in my research said, the interview process has made (at least some) women think more critically about their experiences with doctors. In some instances, as a participant spoke with me she had new realizations about the causes of her experiences and broader societal factors influencing her treatment. Instead of seeing the doctor-patient relationship as a discrete a set of interpersonal interactions, some women recognized some of the social, cultural, and economic factors influencing their experiences. This study has also provided women with an opportunity to discuss their negative experiences and have them validated. During the interview, I always tried to take the participants' feelings and experiences seriously.

Stemming from my research and literature review, I have identified several suggestions for patients. These suggestions may help women take control of their own health care and help establish a positive doctor-patient relationship. 1) It is useful to write a list of characteristics desirable in a doctor. These characteristics can be a guide when evaluating interactions with health care providers. 2) Although degrees, credentials, and affiliations are important, they do not tell a patient about a doctor's ability to listen or if she or he stereotypes certain patients. Women can talk to other women about their experiences with doctors. Is there a doctor that should be avoided? Is there a doctor that comes highly recommended by several people? Often a specialization in women's health can be predictive of positive rapport and attention to complaints presented by female patients. Some women's centres carry lists of doctors that have a history of mistreating female patients. 3) Patients who know their rights in terms of the doctor-patient relationship will probably recognize when boundaries are crossed and how to proceed if they would like to file a formal complaint. The Newfoundland and Labrador Medical Association has information about patient rights. 4) Patients can facilitate their visits by coming to the doctor with a list of questions they want answered and issues they want to discuss. 5) Patients can bring a note pad and jot information important to remember. It is also useful to keep a health diary that keeps track of changes in health and other issues to bring up with the doctor.

I hope the community workshop I am planning will generate further discussion and practical ideas for dealing with negative doctor-patient interactions and taking control of one's health care.

Implications for doctors

Because my study was small and I only talked to urban women, I do not feel comfortable advising doctors to change their behaviour on the basis of my study alone. However, given that several of findings are supported by preceding literature, there are some issues that doctors can consider. 1) Communication is vital to a good doctor-patient relationship and women may judge a doctor as more competent if she or he is a good communicator. 2) Women want information about their ailment, condition, or treatment in language they can understand. 3) Every disease is attached to a person. Doctors should not ignore the contexts of patients' lives. 4) Patients may not always want (or afford) the latest, most aggressive drug treatment. If possible, doctors should give patients different treatment options. 5) Patients may not always have access to mental health services. If a patient is upset or wants to talk, a doctor may be her only option. 6) Patients should be treated with the respect that doctors themselves expect. Doctors may want to consider the implications of making patients constantly wait on the doctor-patient relationship. 7) A patient's knowledge about their situation, body, and well-being is important and valuable in negotiating a treatment plan that fits a patient's needs and life.

8) Doctors should consider having evaluation or input forms in their offices or clinics. The solicitation of suggestions from patients will make patients feel that their input matters and doctors can learn how they can improve their practice to better suit patient needs.

Directions for change and implications for policy

The suggestions in this section come from the data gathered in my research. Some of the suggestions were given directly by participants. Others come as a result of my synthesis of the stated problems and suggested areas for change that emerged out of the interviews conducted.

Research:

1) Researchers from different disciplines researching health and health care issues need to share their knowledge and data. Research on women's health needs to be as holistic as women's health itself.

2) Research needs to be conducted that addresses the diversities of patients living in varied social and economic circustances.

Health care programs and resources:

1) Women of all income levels should have access to a variety of health care and well-woman services. These should include mental health services that do not heavily rely on drug therapy for healing, self-help programs, support groups, nutritional advice, information about drug-free cures for certain diseases/ailments, resource centres with materials written in non-technical language, alternative health services.

2) Health care services and resources should be structured so that women who have young children or disabilities are not barred from participating.

3) Each person should be made aware of her or his rights as a patient. All patients should have access to resources that will outline how to proceed if they want to file a formal complaint about a doctor's misconduct.

4) People should have the opportunity to evaluate their health care and health care providers. Patients should be given the opportunity to comment on the positive and negative aspects of their experiences.

5) Women should have the opportunity to attend educational sessions that teach them to incorporate their strengths in dealing effectively with health care providers.

6) The fee-for-service payment structure needs to be closely examined. What impact does it have on patient care, patients' perceptions of doctors, and the doctor-patient relationship?

7) Women should have access to female physicians when wanted, especially for gynecological examinations.

Education:

1) Medical education should not privilege technical knowledge over personal skills. The patient should be "present" throughout medical training.

2) Medical education should teach future doctors how to give patients information about their illness or treatment options in clear, non-technical language.

3) Medical education needs to acknowledge and address the myth of the generic patient. Patients are individuals with unique situations, needs, and problems.

4) Medical education should encourage a partnership in health and discourage paternalistic behaviour.

5) Future doctors should have the opportunity to interact and collaborate with other allied health care providers.

Future directions

There are several interesting and important directions and themes touched upon in my study that require further research. Since my research was small in scale there are also directions that I did not pursue that still need to be examined. Further research must be conducted on the health care needs and experiences of lesbian/transgendered/bi-sexual women, women of colour, women with disabilities, and women living with chronic illness. Women living in rural Newfoundland and Labrador do not have access to many of the resources and health services available to urban women and this may affect the quality of care that they receive. Their willingness to confront doctors who mistreat them may be thwarted by their lack of choice. Their experiences with health care providers should be known. Further research should explore women's experiences with doctors when they go to see doctors with their children. Are women able to assert themselves more fully when they are with their children in a doctor's office? Since several women in my research told me about experiences of sexual misconduct, research should be done to examine the barriers that prevent women from formally reporting physicians' sexual misconduct. Finally, since I only interviewed patients, it would be interesting to interview physicians about their experiences with patients and about their experience at medical school. Although some schools have changed their medical curriculum to include greater attention to communication and inter-personal skills, does this actually translate into changes in attitude and patient care?

Summary

In this chapter I have situated some of my findings within the current literature that exists on women's experiences with doctors. I have also discussed some findings that I did not encounter during my review of the literature. I included a discussion of my own reactions to this study and some of the reactions I received from the community and several medical professionals. This chapter concluded with some suggestions for policy change, a discussion of the limitations of my study, and possible future research directions.

Conclusions

Although women's experiences with doctors are often examined, analyzed, and critiqued, women have rarely been asked directly about their interactions with their physicians. This research has given women a chance to speak about their positive and negative experiences, in their own words, and to highlight areas where change is needed. Women's experiences and theories were of paramount importance in this study and that, in turn, helped to validate those experiences. Knowing women's perceptions of their doctor-patient relationships can provide an opportunity for health care providers, researchers, and policy makers to learn about the problems and possibilities surrounding this vital point of contact. There were several strong findings that emerged out of my research.

Holistic health, holistic health care: Many women in this study underscored the various economic, social, and societal factors that influence their well-being. These women wished for a health care system that was as holistic as their own health. However, as many women reported, the current health care system was not always apt at dealing with the diverse set of problems and situations affecting their health. Many doctors did not have the time, resources, awareness, or expertise to appropriately address problems such as stress, depression, violence, and poverty. Unfortunately, complementary health care providers who are equipped to deal with these problems were either not available or were out of reach for women living in strained economic circumstances.

As this study has shown, the health care system needs to consider women's self-knowledge and the context of women's lives. Doctors cannot discount women's intimate knowledge of how they feel, what influences their health, and what kind of treatments are congruent with their lifestyle. Although the women in this study did not have the same technical expertise as their doctors, they wished to play an active role in the managing of their own health and wanted the information necessary to make informed choices.

If patients counted: Because the women in my research went to doctors expecting care, it was particularly disappointing and demoralizing when they were treated with disrespect, inconsideration, and neglect. These women wanted doctors to treat them like human beings--not like diseases. They wanted doctors to make common sense judgements about the contexts of their lives. Women wanted to be treated with care and consideration during procedures that are known to be uncomfortable. They wanted doctors to take the time to look for options and explain procedures to them using comprehensible language. They wanted doctors to listen to their needs.

Negotiating power: The negotiation of power between doctor and patient was a complex issue that involved a multitude of factors. Differences in education, social status, and gender between some doctors and patients contributed to differences in power. Although most women did not readily identify sexism as a factor in their own interactions with doctors, many women found themselves in a precarious position resulting from the gendered assumptions surrounding reproductive health and women's lack of power in North American society. Denial of abortion services, pressure to have a hysterectomy, and sexual abuse were manifestations of women's lack of power in their relationships with doctors. The amount of power a woman had in a doctor-patient interaction also had to do with availability of choices, information, and options. Access to these alternatives was often dependant on a woman's social status, education, and financial situation.

Women felt they were able to regain some measure of control over negative situations through acts of resistance and subversion. Acts of rebellion and non-compliance were often responses to frustration with doctors and an inadequate health care system. Women whose doctors listened, respected, and consulted them were empowered by those interactions and even considered them to be life-altering.

This study has given women an opportunity to talk about their relationships with doctors and about their health care experiences and needs. By presenting women's narratives about their health care, I hope this information will open up a dialogue about avenues for change and subsequently have a positive impact on patient care, patient satisfaction, and health outcomes.

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Appendix A

Participant Consent Form

The aim of this study is to understand women's perceptions of their interactions with doctors. If you agree to participate you will be interviewed by Agnieszka Kosny, a graduate student at Memorial University of Newfoundland, about your experiences with doctors. The interview will be audio taped and then transcribed. The tapes will be stored in a locked, safe, place and will be erased at the end of the study.

The interview is confidential; only the researcher involved in this project will see *entire* transcripts of interviews. Her supervisors may also see *parts* of the transcripts. If part of the interview is quoted it will be done in a manner so that you, other persons (doctors you mention, for example) or places cannot be identified. This research may be published after completion and the results may be presented at conferences and workshops.

Your participation in this study is completely voluntary. You have the option to withdraw from this study at any time and/or refuse to answer any questions. If you wish, I can discuss the results and outcomes of the study with you once it is completed.

My supervisors are Dr. Joan Scott, 737-2301 and Dr. Elizabeth Church, 737-8874. I can be reached at my office at 737-2515 or 737-3322. My email is akosny@ganymede.cs.mun.ca. Please do not hesitate to contact me if you have any questions or concerns.

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Participant's Signature Date

Appendix B

Questions

I am a Master's student interested in examining women interactions with doctors. I am going to ask you some questions which relate to your experiences with doctors. I will also ask you some questions about your heath-related behaviour and personal profile which may have an effect on your experience of the health care system.

Health Related Behaviour

1) When you are not feeling well, what kinds of steps do you take to feel better? List them in the order that you usually do them.

2) Briefly describe how you feel about your well-being/health currently. Why do you feel this way? Have you always felt this way? If your feelings about your well-being/health have changed, how have they changed and why?

3) List some of the most common problems you go to see a doctor about.

4) About how many times a year do you go to see a medical doctor?

5) Do you usually see a male or female doctor? Why?

6) Has the frequency of your visits changed over the course of your life? If yes, why and how?

7) Have you ever gone to see any other kind of health practitioner besides a doctor, (for example a psychologist, a homeopath, a naturalist, a chiropractor, a massage therapist etc.)? Why have you or why have you not gone to see this kind of health practitioner?

Experiences with Medical Doctors

8a) Can you think of a positive experience(s) you have had with a doctor and tell me about it? How did you feel (or do you feel) about the experience?

8b) What aspects of the interview, situation or interaction contributed to your positive experience?

8c) Can you think of any reasons why you were treated in this manner?

9a) Can you think of a negative experience(s) you have had with a doctor and tell me about it? How did you feel (or do you feel) about the experience?

9b) What specific aspects of the interview, situation or interaction contributed to your negative experience?

9c) Can you think of any reasons why you were treated in this manner?

10) Did you react in any way to the negative interview, situation or interaction which you experienced? If yes, what did you do?

11) How have your past experiences affected your interactions with doctors? What experiences have had the most significant effect?

12) Describe what an ideal experience with a doctor would be like?

Personal Profile

13) How old are you?

14) Do you have any children? If yes, how many?

15) Did you grow up in a rural or urban setting? Approximately, what was the population of the place where you grew up? (categories from Statistics Canada, 1995)

a) 500,000 and over
b) 100,000 to 499,999
c) 30,000 to 99,999
d) under 30,000
e) rural area

16) Describe your living arrangements and "family structure" at this time. Are you: single, living with a family member, living with roomates, living with a partner, married, divorced, widowed etc.? Please explain.

17) Please indicate the level of your education. (categories from Statistics Canada, 1995)

a) 0 to 8 years (the highest grade of elementary school completed)
b) some secondary school
c) graduated form high school
d) some post-secondary school (attended a post-secondary institution, university, or non-university, or trades program through apprenticeship, vocational schools or private trade schools. Did not receive degree, certificate or diploma)

e) post-secondary certificate or diploma (includes trades certificate)
f) university degree (bachelor's degree or above)

18) If you are currently working, what is your job. Please include both paid and unpaid work (such as volunteering, going to school, child care etc) and both seasonal and year-round work. Please indicate which work is paid/unpaid, seasonal/year-round.

19) Please indicate the family income bracket which you fall under.
(explain to the participant that by family I mean anyone living in the household, for example, if the participant is living with a partner and a parent in one household, their total incomes would be counted,*
if the participant if living by herself, only her income would be counted, etc.)

Under 10,000
10,000-14,999
15,000-19,999
20,000-24,999
25,000-29,999
30,000-34,999
35,000-39,999
40,000-44,999
45,000-49,999
50,000-54,999
55,000-59,999
60,000-64,999
65,000-69,999
70,000-74,999
75,000-79,999
80,000-84,999
85,000-89,999
90,000-94,999
95,000-99,999
100,000 and over

Appendix C

Table 2.0 Canadian Low-Income Cut-Offs, 1996 (LICOs)

The LICOs are published by Statistics Canada. Families living below these income levels are considered to be living in "straitened circumstances." The LICOs are more popularly known as Canada's poverty lines.

1996 LICOs (1992 base)

Family Size	Population of Community of Residence				
	500,000+	**100,000-499,999**	**30,000-99,999**	**<30,000**	**Rural**
1	$ 17,132	$ 14,694	$ 14,591	$ 13,577	$ 11,839
2	$ 21,414	$ 18,367	$ 18,239	$ 16,971	$ 14,799
3	$ 26,633	$ 22,844	$ 22,684	$ 21,107	$ 18,406
4	$ 32,238	$ 27,651	$ 27,459	$ 25,551	$ 22,279
5	$ 36,036	$ 30,910	$ 30,695	$ 28,562	$ 24,905
6	$ 39,835	$ 34,168	$ 33,930	$ 31,571	$ 27,530
7 +	$ 43,634	$ 37,427	$ 37,166	$ 34,581	$ 30,156

Source: Prepared by the Centre for International Statistics at the CCSD using Statistics Canada's Low Income Cut-Offs. Cat. No. 13-551-XPB, January 1997. The URL for this document is www.ccsd.ca/fs_lic96.html