This article is based on results from a study of gender-sensitive medical practices in the western metropolitan region of Melbourne. It explored how women saw their experiences with medical practitioners through a survey, interviews and focus groups. However, it also included interviews with 12 general practitioners in the western region, eight of whom were men and four of whom were women. The doctors reported that their main anxieties in working with women related to issues which were on the borders of medical practices: domestic violence, child abuse, sexual issues, as well as specific issues such as gender differences between patient and doctor and sensitive areas of medical practice such as pap tests and breast examinations. Doctors reported on the constraints and difficulties they experienced in managing their own anxieties about these issues. They also discussed how they dealt with reports of inappropriate medical practice given to them by their patients.

BEING THE DOCTOR-JUDGE: Doctors and women sensitive medical practices

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We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the social worker-judge: it is on them that the universal reign of the normative is based; and each individual, wherever he [sic] may find himself subject to his body, his gestures, his behaviour, his aptitudes, his achievements.

FOUCAULT, a French philosopher and social theorist, argues that increasingly we are subject to the knowledge based power of professionals. This subject to power and knowledge has particular force in the relationship between patients and doctors. For example, in his book The Birth of the Clinic, Foucault argues that over the past 200 years the relationship between doctor and patient has changed radically from an active role played by the patient who provided the information to the doctor to one in which the patient is essentially a passive body which the doctor knows and explores intimately. The extension of medical knowledge and the subsequent power which doctors have in relation to their patients has led to a handing over of control to the medical practitioner who is assumed to know how our bodies should function and how to restore them to a scientifically established 'norm'.

When patients place their bodies in the expert care of doctors they do so on the assumption of a relationship based on, often, implicit and unquestioned trust.

The vulnerability of patients in relation to their doctors and the need to safeguard trust between the parties is exemplified in the fact that no other profession has such a long history of explicitly documenting the responsibility of the profession in relation to trust as the medical profession. For example, the Hippocratic Oath states:

In every house where I come I will enter only for the good of my patients keeping myself far from all intentional ill-doing and seduction and especially from the pleasures of love with women or with men be they free or slaves.

However, the commitment to ethical conduct is not without its problems. For example, The Victorian Medical Handbook highlights one possible dilemma for medical practitioners: a commitment to ethical conduct with patients and a commitment to loyalty to colleagues:

I will practise my profession with conscience and dignity
The health of my patient will be my first consideration
My colleagues will be my brothers [sic]
I will maintain by all means in my power the honour and noble traditions of the medical profession.

For both patients and doctors the Hippocratic Oath and its derivations provide a basis for an established and legitimised trust. Luhmann defines trust as:

the generalised expectation that the other will handle his freedom, his disturbing potential for diverse action, in keeping with his personality - or, rather, in keeping with the personality which he has presented and made socially visible.

The issues of trust and the power and knowledge of the doctor-judge raise questions about patient-doctor relationships. In this article we are concerned with how doctors see their role in relation to these issues and we seek answers to the following questions.

• What does it mean to occupy the position of the 'doctor-judge' in our society?
• What anxieties do doctors have about working with women patients?


THE FINDINGS

The doctors talked to us freely about their experiences of working with women patients and their anxieties and concerns. In this section we focus on the questions posed earlier in the article.

What does it mean to occupy the position of the ‘doctor-judge’ in our society?

The doctors to whom we spoke felt confident about their expertise and practice in relation to physical symptoms and illness. One doctor commented: I really like nitty gritty medicine.

As part of their role they sought to be reassuring and to try to reduce the anxiety of the women patients who came to see them. This was not always easy and doctors were conscious of the need to both maintain the trust of the patient and a ‘professional façade’ regardless of their own feelings.

I think if there is anxiety on the part of the woman you tend to get a little bit anxious yourself. But you try not to. You just try to maintain the professional façade. I might be anxious about it because they are anxious and then you start to get anxious. And you think ‘why am I getting anxious because this person’s anxious?’ Now if you get anxious and it shows, then they’re going to lose trust.

The need to maintain trust, power and knowledge put considerable strain on the doctors who attempted to deal with their own anxieties in a number of different ways and with little structural support from their practice. One doctor commented:

You just have to cut off. When a patient goes out the door, I just cut off. You have to be empathetic while they are with you but you can’t go overboard about it. Once you shut the door, it’s gone. If you worried about it you would go down in a screaming heap. Sometimes I just shut the door and sit for a few minutes if it’s been difficult. Then I go on. It’s a bit like being an actor. You switch on fully when they’re with you and then you switch off.

Other doctors used meditation between patients to release tension, two talked with other doctors. But there was consensus that in a busy practice there were few opportunities for doctors themselves to debrief or to obtain assistance with anxiety. One woman doctor had moved to a practice where the doctors employed a psychologist on a regular basis to provide opportunities for developing counselling skills and for personal debriefing.

Being the doctor-judge, holding the knowledge and power in relation to patients was perceived as stressful and anxiety provoking but inevitable by the doctors. Currently there seem to be few ways in which doctors can obtain assistance with these issues.

What anxieties do doctors have about working with women patients?

The doctors interviewed in Project Hippocrates were aware that for some women, medical practices which involved intimate examinations or which dealt with sexual or emotional issues might be difficult to discuss. This was perceived to be particularly true when the doctor was a man. One doctor commented:

I think that women in general tend to be ... less open to male doctors ... I don’t know if it’s the attitude of male doctors ... or whether they don’t feel comfortable about opening up not just with gynaecological issues but emotional issues as well. And we’re aware here that the female doctors have to spend more time with female patients a lot of the time because they tend to have more emotional problems or they’re just more willing to talk to a female doctor about it. So we only book in four [patients] an hour for female GPs whereas we get five an hour.

None of the doctors expressed concern about actually carrying out intimate physical examinations with women patients. However, men doctors did express anxiety about the effects of gender on women patients who were ...
undergoing such examinations. These doctors believed it was important that women had a choice about going to a woman doctor or a nurse for such examinations. Two said that if a woman expressed any anxiety at all they were immediately referred to a woman doctor. One commented:

When women do show signs of anxiety about being examined, I refer them to a lady doctor. It is not difficult to refer on. I think it's a function of experience. I've seen it all before.

Two men said they did not carry out intimate physical examinations without the presence of a woman nurse.

The tendency of men doctors to refer women patients to women doctors had implications for the women doctors. One had reduced her practice to half time because she found working with women patients on emotional issues very stressful. Another expressed anxiety about her counselling skills and regret that so little of her practice was about physical illness.

One doctor commented that for some women, particularly those from some linguistically and culturally diverse backgrounds, seeing a man doctor was in itself stressful and anxiety creating for both parties.

When women come in and they've put a barrier up merely because I'm a man and they would rather be seeing a female doctor but because I'm a male they think I won't be sympathetic or I don't know what. But they just, it's that barrier and I can sense that, you know, I can sense there's a barrier there. And sometimes to break that barrier I find difficult.

Doctors did think that they were skilled in identifying verbal and non-verbal cues that expressed anxiety by women patients. However, they did not have training in how women from different cultures might express anxiety, and few had given consideration to this issue.

Interviews with general practitioners revealed that generally doctors were aware that there might be concerns experienced by women patients that were difficult to deal with in a consultation.

When asked about the difficulties they experienced in working with women patients, the 'dis-ease' integral to the medical discourse became clear. Doctors felt confident in dealing with issues they perceived to be physical or purely medical in nature. They were much less at ease in areas that seemed to lie at the boundaries of their knowledge and power. Counselling or uncertainty about whether a patient was presenting with a medical or psychological difficulty, sexuality and sexual relationships, domestic violence and child abuse were all raised as issues which doctors found to be anxiety-creating for them in their practice. Gender issues and possible patient anxiety about these were also raised by both men and women doctors in different contexts.

How do doctors manage the possible conflicts of loyalty to colleagues and patient complaints about other medical practitioners?

In the interviews, doctors were asked what they would do if a woman reported to them an allegation of sexually inappropriate behaviour by another doctor. Two doctors said that patients had made statements to them about unpleasant experiences with another doctor. Neither of the women wanted to take it further. Doctors believed it was important to hear what the woman had to say.

Well I would let them talk about it, take the opportunity to tell me what had actually happened or give their impressions. Not be judgemental about it. Just try to listen.

However, all doctors saw themselves as acting as gatekeepers in testing the reliability and validity of such reports. They felt trapped between their duty to the patient and their loyalty to colleagues, and some of the group were quite explicit about this dilemma. For example, one doctor commented:

I mean, as a professional I hate to say to anyone that another doctor is wrong. I mean, forget about sexual intrusion and things like that. Even if I believe that a doctor has given the wrong antibiotics or something like that I'll probably say something like: "It might have been the thing to do at the time".

The advice given to women who had reported a sexually inappropriate incident to their doctor varied considerably.

Doctors had little information about the processes which would occur if a formal complaint were made, and were generally unclear about the rights of the patient in this situation.

Only one of the 12 doctors mentioned the Office of the Health Services’ Commissioner as an appropriate avenue for complaint, with six recommending the Medical Practitioners’ Board as a referral. Two doctors said that they would recommend that the woman return to the allegedly offending doctor to discuss the issue.

The consequences of unquestioned power and knowledge

Being positioned as the doctor-judge carries with it power, knowledge and status. But our interviews also revealed that there are problems and burdens associated with this position. Doctors reported on the need to contain their own anxieties, often under difficult circumstances and with little support, in order to maintain a level of trust with their patients. These difficulties were exacerbated when issues of gender difference were part of the patient doctor relationship, where the issues were not strictly 'medical' in nature, and when doctors were working with women patients from culturally and linguistically diverse backgrounds. For some women, the past supports of family and the church are no longer available, and the doctor-judge has become the person to whom they turn in times of difficulty.

Most of the doctors were aware of the difficulties but had few means to solve them. Medical practitioners work under increasing pressure to meet quotas of patients and there is little opportunity to debrief with colleagues or to seek outside assistance. Of particular concern was the lack of clear information by doctors about patient rights or the complaint mechanisms available to women who reported inappropriate behaviour by another health professional. This situation revealed the possible divided loyalties for doctors between attachment to their professional peers and the need to protect the rights of their patients.

It also revealed that when we place doctors in the position of doctor-judge they may become judges in areas other than medical practice. We need much better means of providing doctors with guidance in this area.

We believe that it is extremely important that doctors and their patients be able to communicate clearly together on issues that may be of importance to women patients. Such communication is made difficult by a discourse that places the doctor in the position of often unquestioned power and knowledge.
FOOTNOTES


14. ibid., p.39.


17. Gridley, op cit.


20. ibid.