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Rosemary Pringle
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1

Introduction

> Surprisingly little has been written on the careers of women doctors; the triumphant story of their entry into the profession is enthusiastically chronicled, but nobody analyses their achievements on arrival.
>
> *(Harrison, 1981: 53)*

Many feminists have been profoundly suspicious of the medical profession, seeing it as serving the interests of contemporary patriarchy. Male doctors, they argue, have acted virtually on behalf of men as a group to maintain the social subordination of women by controlling their bodies and reproductive capacities. Modern, professional medicine snatched healing out of the hands of women (its traditional practitioners) and turned women into the main objects of its practices, subjecting them to new forms of humiliation and surveillance. In particular, some feminists have been furious that male obstetricians and gynaecologists took control of childbirth, an area of great symbolic power for women, and claimed a near monopoly of knowledge about women's bodies. The women's health movement has been anti-professional in its philosophy, believing that knowledge and skills should be widely dispersed, and that doctors should hold no special authority as health practitioners.

Women doctors have therefore been regarded ambivalently by some feminists. There is the heroic past, when they played a key part in the history of feminism, scaling the heights of patriarchal power to gain entry to the profession, enduring ridicule and hostility from male doctors and medical students. And then there is the present, when women doctors, in the main, are seen as a conservative group with little sympathy for feminist causes. Where militant feminism had once been of

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assistance to women doctors, some women who trained in the 1970s thought that, if anything, it had hampered them, since male colleagues were likely to hold them personally responsible for what they saw as the excesses of women's liberation. For those doctors who do identify as feminists and place their skills in the hands of the women's health movement, sisterhood is still conditional on their renunciation of special privileges and their willingness to work on an equal basis with other health workers. For some hardliners they are 'honorary men', sometimes 'worse than the men', a position which is often echoed by nurses, whether or not they have had much experience of working with women doctors.

To some feminists it is easier to accept women doctors if it can at least be shown that they are still exploited and oppressed within the medical profession: there is something almost reassuring about the surveys that continue to provide evidence for this conclusion. Since the late 1970s there have been literally dozens of surveys of sexual divisions within the medical profession, carried out by governments, by the various colleges, by national medical associations and unions, by university departments and by independent researchers. Everywhere the same factors are identified as problematic: the difficulties in combining family and career; the high stress levels and suicide rates; the lack of part-time work and training; sexism in the syllabus; discrimination in appointments and promotions and in relation to training positions; the clustering of women in the lowest status positions and their absence from key specialties like surgery and obstetrics and gynaecology; difficulties in getting partnerships in general practice. Medicine, it is said, has failed to adapt to the presence of women by adopting more flexible patterns, providing part-time training and career opportunities or positively encouraging women to be surgeons and high flying consultants.

While there is some truth to this, the very fact that it has been so amply documented indicates that a major shift is taking place. To paraphrase Foucault (1980), what is interesting here is not just that women doctors are oppressed but that they are now so loudly and urgently saying that they are oppressed. Medicine, the occupation which above all has required a vocational commitment, a readiness to be available twenty-four hours a day, seven days a week, is being called upon to restructure. Through all these surveys, emphasis is placed on the need for change, on the importance of women practising in all areas of medicine, not just those that have been defined as gender appropriate. There is an awareness that unless medical work as a whole is restructured (or men miraculously take on a full 50 per cent of responsibility for child care) women will continue to be disadvantaged. The growing number of women graduates suggests a degree of democratisation and creates pressure for stronger representation across all specialties.

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The purpose of this book is deconstructive. I have treated the interview transcripts themselves as texts, and I have read them for what they do not say as well as for the repressions that make possible what they *do* say. Women doctors are simultaneously a part of (patriarchal) medicine and placed outside it, their presence in large numbers necessarily a destabilising one. Their speech both affirms and undercuts medical authority. If the masculinity of the medical profession rests on a binary opposition between 'women' and 'medicine', then 'women doctors' constitute the third term which undermines its functioning. Jane Flax (1990: 37–8) suggests that deconstructive readers should be disrespectful of authority, attentive to suppressed tensions or conflicts within the text and suspicious of all 'natural' categories. Rather than reinforcing women in a position of marginality or victimhood I have chosen to emphasise their success. In doing so I have been sceptical not only of medical authority but of the 'truths' of many feminist theorists and social scientists.

The book is intended not just as a description of women doctors but as an intervention into feminist theory and especially into the sociology of work and health. Social scientists have been attacking the pretensions of medicine and the professions for a long time while denying the force of their own criticisms. They continue to write as if nothing has changed. What if it can be shown that, after a century of marginalisation and downright hostility, women are having a major impact on medicine? It would then be difficult to go on conceptualising medicine as the linchpin of patriarchy or to assume western cultures are still patriarchal in a systemic sense. The presence of women doctors points to the need for a rethinking of many conventional assumptions about medical power and privilege, the operations of medical 'fields', the status of the professions, of 'patriarchy' and gender inequality. It provides an important opportunity and context for a substantial revision of feminist categories, concepts and strategies. Some readers may think I am naive, overly optimistic or cavalier in my treatment of the ongoing realities of male medical power. But it is possible to overstate the power and glamour of medicine in ways that unwittingly reinforce medical authority. Rather than dwelling on the realities of male medical power I can point towards its vulnerabilities and cracks.

A study of women doctors provides a window into some of the major changes of our times which have been characterised as 'postmodern'. While doctors are not about to be 'proletarianised' *en masse*, they need to be recontextualised in the shifting class relations of the postmodern world. With the restructuring of medical work and the shift to group practice doctors have had to rethink their relations with patients, with each other and with the health professionals who work alongside them. People want more egalitarian relationships with their doctors, and have less respect for medical authority. As every occupation seeks to

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'professionalise' itself the distinction between professions and occupations becomes blurred. Middle-class professionals are less protected than they used to be from the exigencies of the market and, while some doctors continue to work 120-hour weeks, others, especially in cities, are having trouble finding work except as locums or, in the case of specialists, as sessionals. Even the 'glamorous' end of medicine has become bureaucratised and routinised as surgeons spend their time doing standard hip and knee operations. Often they work through the night not because they are dealing with an emergency, but because, as resources become more limited, this is the only time they can book the theatre.

The movement of women into medicine is unsettling both to medical authority and to the overall organisation of work, to the relation between public and private worlds, and to the conditions of 'modernity'. The demand that women be accepted on equal terms with men, I will suggest, may no longer be able to be accommodated within a 'modern' package of reforms and points towards a world in which work, medicine and gender relations are dramatically repositioned.

Gender and status

Everybody 'knows' that in the former Soviet bloc the majority of doctors are women while in the United States they are men: 70 per cent in the old USSR as compared with 10 per cent in the USA in 1982 (Day, 1982: 103–4). Any number of binaries are invoked to explain this: men and women, socialism and capitalism, East and West, and public and private health systems. But the bottom line is that at the primary care level Soviet medicine had limited training and prestige and this is associated with the fact it was done by women. The wealth and prestige of American medicine is associated with the fact not only that it is private but also it has largely been the monopoly of men. Now that Western medicine appears to be falling off its pedestal, the question is inevitably raised, what is the relationship between the status of medicine and the proportion of women in it? Do women lower the status? Does their appearance indicate that medicine has already nose-dived? If there is a relationship between gender and status, what are its mechanisms?

The trends everywhere in the West are very similar. Women are concentrated in general or family practice and community or public health. They have made some impact on paediatrics, psychiatry, pathology and anaesthesia and a large impact on small specialties such as dermatology. They are moving into newer specialties such as geriatrics, rehabilitation medicine and genetics. Even in the former Soviet bloc they have been notoriously absent from surgery. In most countries they remain a tiny minority of surgeons and are seriously under-represented in the more

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prestigious (and lucrative) procedural specialties within internal medicine. Their distribution has been explained in both individual and institutional terms. The first emphasises gender-related preferences: for example that women are better at people work or emotion work and choose those areas. The second suggests that women have made long-term 'investment' decisions about their human capital by balancing their domestic and occupational roles (Day, 1982: 105; Riska & Wegar, 1993: 79–80).

Rather than locating the discussion at the level of the social system as a whole, I shall concentrate on the aspects of the medical culture that make it resistant to adapting to the needs of those who have others to care for or, indeed, who would like to be able to care properly for themselves! Caring for children will always be difficult to combine with occupations where dedication and competence are seen to reside in full-time commitment and long working hours. Medicine has evolved as a global culture with rigid conceptions of what constitutes good practice and huge reluctance to 'water these down'. But it is changing. While it is not inevitable that, because more than 50 per cent of students or graduates are women, they will come to be more evenly spread across medicine, it seems unlikely, given the strategic concerns of these women, that they will not make further major inroads over the next few years.

Medicine and modernity

As a child growing up in the 1950s I believed that I had been born at the precise moment when modernity came of age. While much of this can be put down to childhood megalomania there was some basis to my belief. It was the beginning of the space age, of jet travel, the triumph of science and technology, medical miracles, television, rock music, and all kinds of new electrical goods along with truth, justice and the American way. I was less aware of the underside: Hiroshima, Belsen, the nuclear threat or the damage being done to the environment. I believed that things were going to get continuously better, that progress was endless.

'Modernity' in all these senses is something that we now look back on as a world we have lost. What we lost, and when we lost it, are open to debate, for modernity has always had within itself the seeds of its own demise. From contemporary vantage points, modernity is generally understood to signify fluctuation and change as industrialisation and the growth of cities swept away the traditional social order and established social relations, leaving in its place the isolated individual and a sense of fragmentation and chaos. But there was another side to modernity which derived from the Enlightenment faith in objective science and reason, the possibility of affirming universal values of morality and justice,

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accumulating and expanding knowledge to be used for the emancipation of humankind. Scientific advances seemed to guarantee freedom from scarcity, want, and the effects of natural calamities. Enlightenment thought embraced the idea of rational progress and knowledge in place of the irrationality of myth, religion, superstition. Science would put people in charge of their own destinies, no longer subject to the whims of nature or the dictates of tradition.

Scientific medicine was a key aspect of modernity since it seemed to promise triumph over pain, suffering and disease. By the 1950s it was delivering very impressively. Developments in anaesthesia had made possible more daring surgery, while 'magic bullets' seemed capable of striking at just about every disease. Where medicine had previously been able to do little more than diagnose it was now able to cure. The arrival of chemotherapy and radium and drugs ranging from aspirin and paracetamol to salvarsan, insulin, penicillin and streptomycin, to name a few, all contributed to the rising prestige of medicine in the first half of the twentieth century. The discovery of sulphonamides in 1935, the first antibiotics suitable for mass use by non-specialists, marked the beginning of a golden age of uncritical faith in the social value of applied medical science (Hart, 1988: 18). In all countries, the period after World War Two saw a vast expansion of the hospital sector and the proliferation of specialties and sub-specialties. The development of relaxants turned anaesthesia into a complex science and made longer and more complex operations possible, culminating in transplant surgery. In internal medicine it looked as if infectious diseases could be eliminated and there would be miracle cures to deal with every problem. The remaining killers, cardiovascular disease and cancer, would soon be brought under control.

Many writers have observed how often women are located outside of modernity as its 'other' (Morris, 1988; Johnson, 1993). Women are represented as more traditional, closer to nature, limited by and to their bodies. Women's bodies are routinely presented as objects of sexual consumption for Western modernity. And women are seen as *consumers* of the fruits of modernity rather than as producers and as part of mass culture as opposed to the scientific elite. In relation to modern medicine, women have been positioned both as its objects and its chief beneficiaries. Their presence as healers was relegated to 'traditional' times, their skills denigrated because they worked 'with' nature and lacked mastery over it. If doctors were normatively male, patients became normatively female. In fact medicine was seen as of particular benefit to women in freeing them from their bodies. Modernity saw the superstitious fears of women's bodies evaporate and created a basis for replacing female bonding against male brutality with heterosexual solidarity.

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Thus, argues Edward Shorter, the major health changes of the first quarter of this century actually made possible the first great wave of feminism 'in alliance with men rather than in the context of traditional women's culture' (1984: 296). If women are the objects and consumers of masculine medicine, women doctors are placed symbolically in between. Since they are not properly either the subjects or the objects of medicine, they may challenge this dichotomy between subject and object on which modern medicine rested.

Since the 1970s the euphoria with the power of medicine has begun to evaporate. In a book and BBC television series entitled 'The Trouble with Medicine' Dr Melvin Konner describes how we were lulled into a false sense of security. 'We enter an illusory world in which anything that is broken can be fixed, in which anything that is wrong with us has its own private molecular magic wand that, when waved over us, will make it go away' (1993: 49). The so-called magic bullets not only had side effects but led quite quickly to the development of new strains of drug-resistant bacteria. The AIDS virus appeared at a time when medicine was already being forced to withdraw its claims to have permanently won the battle for infection control and to recognise that it was instead locked into something more like permanent guerrilla warfare. Doctors have to some extent been humbled and, Konner suggests, the community should withdraw the godlike expectations it has had of them and take more responsibility for its own health. While medical discoveries continue at a rapid rate, the mood has changed. Developments in reproductive technology, for example, have brought mixed responses, and the Human Genome Project, with its potential to create 'perfect' human beings, and another round of miracle cures for every thing from cystic fibrosis to homosexuality, inspires as much fear as optimism.

Part of this 'trouble' with medicine has to do with gender. Both medicine and modernity have been linked with masculine power and domination (Davies, 1996). The reversals to medical triumphs can be seen as a colossal blow to the masculine ego. Women have to some extent caused the 'trouble' in attacking patriarchal medicine and demanding new forms of health care. But they can also be represented as part of the solution, the new 'human' face of a humbler form of medical practice. What is going on here is a recasting of practice and priorities as medicine engages in diverse ways with the heritage of 'modernity'. The outcome of these processes is not foreclosed and is unlikely to be linear. On the contrary, it will be diverse, local, temporary and shifting. It is a world in which opportunities open up but may just as quickly close off again.

The story of western medicine's resistance to women and of women's struggles to gain entry has often been told. Having overcome the educational barriers, women had great difficulty getting hospital appointments

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or setting up practices. They were accepted in a limited range of work on condition that they behaved as 'lady doctors'. While the occasional brilliant surgeon or physician was tolerated, most women doctors before World War Two worked in community and public health or family planning. A surprising number from the UK and Australia sailed off to India as missionary doctors in a country where women could not see male doctors. A few were able to set up general practices either in remote areas or catering to a female clientele. Others went into practice with their husbands. By the early twentieth century women doctors were no longer a feminist *cause célèbre* and their numbers declined or at best remained static. Nursing, with its shorter training period and lower entry costs, began to be promoted as the more appropriate health profession for women. In England and Australia the proportion of women doctors grew slowly in the 1950s as women became more accepted in general practice and in some of the shortage specialties. Quotas remained in force at British and North American universities until the late 1960s (Crompton & Sanderson, 1990). In the United States the numbers lagged behind and it took the revival of feminism to force changes. In 1970 the Women's Equity Action League filed a class action complaint against every medical school in the US and shortly afterwards Congress passed Title IX legislation prohibiting sex discrimination in educational programs (Walsh, 1979: 450–4). The numbers of women medical students immediately increased but are still well behind Britain, Australasia and Northern Europe, not to mention the old Soviet bloc.

In the 1980s doubts were still being expressed about the level of community support for women doctors. Since then a sea change has taken place. Women have moved from being 'oddities' within the profession to perhaps its most valued members, the 'human' face of medicine. Doctors have been impelled to embrace a more feminine style, more holistic, and more concerned about communication. Even conservative governments have taken steps to ensure that women are represented in every branch of medicine. In 1991, for example, as part of Opportunity 2000, the British Department of Health established a goal to increase the percentage of women consultants to 20 per cent by 1994 and to accelerate the rate of increase in the surgical specialties to 15 per cent per annum. While these figures have yet to be reached, a few years earlier the project itself would have been inconceivable. Quotas, which had previously been used to *limit* the number of women admitted to medical schools, came to be used for the opposite purpose, to *increase* their representation in what had been male bastions.

Women doctors are in high demand, no longer perceived as anomalous but as 'family' women who understand everyday problems. Surveys have consistently confirmed the shift of public opinion since the 1970s

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in favour of women doctors (Schlicht & Dunt, 1987). They are thought to combine the good qualities of male physicians and female nurses – assertiveness and initiative combined with tenderness and nurturing (Waller, 1988). When I was first researching women doctors the topic that came up repeatedly on the computer was Pap smears. It was clear that many women experience Pap smears as a form of invasion verging on rape; they preferred to go to a woman doctor at the very least for this purpose. The most publicised contribution of women doctors to women's health undoubtedly *is* in relation to breast and cervical cancer. Certainly the government likes to measure women's health by the growing numbers of Pap smears and mammograms which, it argues, have improved rates of both cure and quality of life.

Members of the medical establishment now publicly welcome women doctors, seeing in them their best hope of reclaiming some of medicine's lost public esteem. Policy makers talk about the 'right' to see a woman doctor. 'Right' functions as a kind of code word for a safe place to seek help with a range of issues from menopause and gynaecological problems to domestic violence and sexual abuse, suburban neurosis, minor tranquilliser addiction, misery, desperation, poverty and despair – all of which are believed to be a result of living with gender inequality. Given that the medical component of many of these is quite small, it begs the question of why the appropriate first port of call should be a doctor. But whether we like it or not, women doctors *are* typically the first port of call for a great many women scarred by emotional, physical and sexual violence.

Even lip-service support for women doctors would have been significant but more than that has been forthcoming. Health ministers and deans of medicine also speak not only of equal opportunities for women but of the community's *right* to have access to women doctors and express a vision of medicine in which women take an equal place. Dame Rosemary Rue, an ex-president of the British Medical Association (BMA) argued in an editorial in the *British Journal of Hospital Medicine* (1992: 287–9) that a mixed profession was desirable at every level of education and training and in the practice of all branches and disciplines of medicine. Professor John Chalmers, President of the Royal Australian College of Physicians (RACP) and Dean of Flinders Medical School, told a graduation ceremony (1992: 726–7) that '. . . it is vitally important for the future of Medicine that it find ways to attract the brightest and best young women available into every avenue of professional medical practice . . .' He called on male colleagues, friends, partners and husbands to give their full support.

For Chalmers, women's entry is important because they are 'so well endowed with the characteristics of caring, of altruism and selflessness

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which our profession so particularly needs . . . Many of the difficulties facing the medical profession as a whole arise from perceptions that doctors have become too self interested, self centred and selfish.' Whether or not women do actually display the characteristics that Chalmers outlined (and there are studies which suggest the differences have been hugely overstated – see Miles, 1991: 145) their success in medicine demands that they situate themselves in this way. It offers many short-term advantages in competing with their male colleagues, especially when the public is demanding doctors with better communication skills. But it may also restrict them, as surely as the injunction to be 'ladylike' restricted earlier generations. Chalmers went on to speak of the 'biological realities' of child bearing and motherhood, which impose a different structure on a woman's career, as well as the 'social obstacles arising from the social structure as a whole and not merely professional problems'. He did not foreshadow any reorganisation of medicine beyond an extension of part-time work specifically for women with children. Modernity in this version implies the continued existence of distinct full-time and part-time patterns.

Medical time

Medical resistance to women doctors now centres on the issue of part-time work. It is argued that part-time work interferes with continuity of care and inevitably reduces its quality. Women's demands for a restructuring of medical time strike at the heart of the medical sublime. Doctors like to think that what differentiates medicine from other occupations and gives it a priestly dimension is its 24-hour on-call responsibilities. The profession suspects that those who do less cannot be real doctors or are not being serious about their careers. Not only do women challenge this but they do so in the name of a modernising force, seeking to sweep away the irrational, traditional and outdated work structures and teaching methods. It will no longer be good enough to learn simply by hanging around and 'doing the work'.

Medical time is a complex mixture of industrial and pre-industrial time, of clock time and body time. The rhythms of biological time are not necessarily consistent with the order of clock time. The ability to follow the 'course' of a disease through time, and to vary clinical procedures as it changes, is essential. Medical interventions become internalised by the organism as part of its own internal rhythms. Medical skill is acquired in the process of watching a disease progress, literally minute by minute, acquiring the judgment that enables the doctor to know instinctively when and how to intervene. 'Timely' interventions must intersect appropriately with body time, and will always be subject to a degree of

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