Doing gynaecology today

A qualitative study from the area of Basel, Switzerland

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Table of contents

Table of figures

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Summary

Background

The framework of this PhD thesis is the feminisation of medicine since the 1970s and the change of the medical culture over the same period. While in the 1970s mostly men were gynaecologists, today the majority are women. At the same time, a change in the physician-patient relationship has occurred which is often attributed to the increase in female doctors and depicted as a transition from physician-centred to patient-centred care. A shift of power in the direction of patients was at the heart of the feminist women's health movement too. This movement developed in the early 1970s and critiqued men as medical doctors, specifically in gynaecology, for deciding over women's bodies and their health. Following this, women's health centres were established with the objective to empower women through educational support and self-help approaches so that they are enabled to take care of their own health. The feminist movement prompted the growth of gender studies, which fed into the rising debate in the 1990s about whether female and male doctors would care for patients in different ways.

Since then, research efforts have focused largely on gender and communication in clinical encounters. These types of studies found that female gynaecologists talk in a more emotional manner and apply a more patient-centred communication style than male gynaecologists. However, they have not revealed how the observed gendered patterns may come about or what they might mean to gynaecologists and their patients. Moreover and as a consequence of the changes in conventional healthcare, a number of studies have questioned whether women's health centres still differ from mainstream care settings. They have neither provided a conclusive answer nor addressed the area of gynaecology, although it was a former cornerstone of the feminist women's health movement.

Objectives

The aim of this PhD thesis was to explore how working approaches are understood and practiced across different gynaecological care settings, including a women's health centre. Drawing on social constructionism and under consideration of gender, the objective was to provide an in-depth understanding of (a) gynaecologists' viewpoints on empowerment; (b) relational aspects of shared decision-making, and (c) professional identities based on gynaecologists' perspectives on their career paths.

Methods

This PhD thesis is based on the qualitative part of the SNF-funded mixed methods project 'Women and Gynaecology in Evaluation' (WAGE; SNF No. 32003B-121358). Research combined a set of qualitative methods: Semi-structured interviews with 18 female patients and 11 physicians (three men and eight women of which three were expert women from the women's health centre) as well as 33 observed consultations. The data was collected in the following six gynaecological outpatient care settings located in the Basel area, Switzerland: The outpatient department of the university's women's clinic; four privately run gynaecological practices with varying sub-specialisations (two led by female and two led by male gynaecologists) and one women's health centre born out of the women's health movement. Data collection was conducted between August 2011 and December 2012.

Findings

Variations of working approaches between female and male gynaecologists across all included settings were evident and appeared as rooted in the interrelations of gynaecologists' gender, their past and present socialisation and their physician-patient relationships. Gynaecologists' career paths were gendered and influenced their working approaches as well as integration into gynaecology, thereby exposing the constructions of professional identities in feminised gynaecology.

Gynaecologists' stances towards empowerment

A semiotic, interpretative perspective was applied to analyse gynaecologists' interpretations of a pelvic pain vignette built into qualitative interviews. This approach revealed gynaecologists' variations in medical reasoning and varying stances towards empowerment. Furthermore, it showed that their gendered socialisations in work settings affect their medical reasoning: Female gynaecologists across all settings strongly valued the integration of patients' voices. This enabled them to produce new ways of understanding symptoms and devise treatment options that extended beyond biomedical approaches, thus supporting empowering processes. Female doctors of the women's health centre stressed to a greater extent than other female gynaecologists the importance of focusing on women's societal life circumstances, thereby going beyond purely individual based care approaches. This created greater opportunities for handling women's well-being from varying viewpoints. They thus displayed the most comprehensive approach to women's care. Male gynaecologists displayed a greater interest in technical and biomedical aspects, declared to apply standardised diagnostic procedures to exclude physical risks, and understood functional pelvic pain as a sign of psychosocial distress. This being said,

both female and male gynaecologists showed dangers of stereotyping patients. Therefore, a self-reflexive approach to gynaecological practice is warranted. This would not only (Kristi Malterud, 2000) foster empowerment and patient-centred attitudes in clinicians, but would also give them the leeway to deliver women's health care in conformity with their own ideas, experiences and personalities.

Bearing in mind that care approaches develop from physician-patient relationships, relational aspects of shared decision-making were explored next.

Relational aspects of (shared) decision-making

The triangulation of interviews with gynaecologists and patients as well as participant observation of clinical consultations uncovered how decisions arise in physician-patient relations through a co-production of meanings and practices. Variations in decision-making emerged from contextual experiences and clinical interactions. Congruency in behaviour and meaning production appeared to be more important in making patients feel supported in decision-making than did gynaecologists' styles of communication. Shared decision-making was only observed in female physician/female patient relationships. It was grounded in sameness in female gender which was portrayed to facilitate reciprocal exchange. In these relationships the combination of medical expertise and womanhood produced feelings of closeness, empathy and support for the patients. In male gynaecologist/female patient constellations, reciprocal bonds were also constructed, but were based on an unequal distribution of medical knowledge with patients favouring direct medical advice. Clear advice made these patients feel supported. Female patients who did not receive medical advice considered to change to a female gynaecologist with a more biopsychosocial perspective, revealing the expectation of gynaecologists' gender-congruent behaviour in clinical relationships. Thus, it is deemed important that relational and gendered aspects of care approaches are acknowledged.

Because gender is central to the variations in empowerment and decision-making, close attention was paid to how gynaecologists reasoned about what has influenced their present working approach and how gender appears in these accounts.

Gynaecologists' professional identities

An embodiment perspective with theories of un/doing gender was used to analyse gynaecologists' views on their careers which largely started in the 1980s when they acquired their first work experiences in gynaecology. This disclosed that gynaecologists internalised the past hierarchical gender order of gynaecology in very different ways due to their differing gendered experiences. These processes set the course for the differentiation of female and

male gynaecologists' career socialisations and care approaches, uncovering gendered constructions of professional identities.

Female gynaecologists reverted to their own (bodily) experiences as women and female doctors so as to create solidarity with female patients and thereby distanced themselves from past hospital gynaecology which they portrayed as not having treated women well. They moved into private outpatient practices to have sufficient space for engaging in a more feminine way of providing gynaecological care, uniting their own embodied knowledge with conventional medical expertise. Male doctors emphasised their past experiences as senior physicians, researchers and surgeons. In that way they presented a cultural affinity to conventional biomedical care settings and care approaches. They distanced themselves from female doctors by assigning work aspects associated with women a lower profile. Thus, men seemed to be challenged by the feminisation of the profession. They made almost no reference to their own bodily experiences, hinting at men's challenging position in gynaecology wherein they need to perform pelvic examinations. They coped with this institutionalised situation by dissociating themselves from transgressive, sexualised behaviours through adopting the position of the neutral medical expert or the caring father figure.

By distancing themselves from each other, female and male gynaecologists reproduced gender differences and engaged in intra-professional boundary work. The female body appears as a central site upon which the gendered differentiation of gynaecology and professional identity is constructed. However, some forms of undoing gender were also observed, implying that socio-cultural changes in the profession may be under way.

Conclusion

Gendered past and present socialisations of female and male gynaecologists influence the ways in which they practice gynaecology. In our study, female gynaecologists were more inclined than male gynaecologists to integrate patients for sense-making of symptoms and devising treatment options, thereby showing a more pronounced stance towards empowerment and shared decision-making. Female doctors from the women's health centre presented the most inclusive and holistic approaches towards women's health care, implying that women's health centres still deliver care that cannot easily be obtained elsewhere. Care approaches, as exemplified by shared decision-making, arose from relational physician-patient interactions, through constructions of meanings and dependent upon gender-congruent behaviours. Accordingly, relational aspects of care approaches should be taken into account in medical training. Relation building skills based upon a self-reflective learning approach should be integrated into (postgraduate) training courses. This could help gynaecologists to offer best possible and

responsive support to women, fostering an empowerment perspective and taking into account the intimate and sensitive nature of gynaecological relationships.

Abbreviations

CoE	National Centres of Excellence in Women's Health
CWHC	Comprehensive Women's Health Centre
GT	Grounded Theory
SDM	Shared decision-making
SI	Symbolic Interactionism
VA	Veteran Affaires
WAGE	Women and Gynaecology in Evaluation
WHC	Women's Health Centre

1 Introduction and background

1.1 Preface

Gynaecology has significantly changed over the last decades. Today, it is among the most feminised fields of medicine. This is indeed the case in Switzerland (Hostettler & Kraft, 2014) where, forty years ago, gynaecologists were mostly men; today the majority are women. A normative change in the physician-patient relationship has taken place over the same period, which may be described as a transition from physician-centred to patient-centred care, implying a shift of power in the direction of patients. At the start of the 1970s, the feminist women's health movement had begun taking shape and critiqued men as medical doctors, specifically in gynaecology, for presiding over women's bodies and their health decisions. To counter this, they formulated strategies for improving care for women through empowerment and inclusive decision-making to give women influence in health care relationships. Such approaches have made their way into the current clinical canon. However, while the names have remained the same, they have a different meaning today. For example, empowerment is understood as patient education without questioning the involved power dynamics in clinical relationships like its feminist predecessor. What is more, the feminist movement triggered the development of gender studies, which in turn fed into the growing debate in the 1990s about whether women and men as medical doctors care for and relate to their fe/male patients in different ways.

Since then, research efforts have focused mainly on gender and communication in physician-patient-relationships. In the area of gynaecology, such studies largely used quantitative methods like rated recordings of communication and questionnaires for assessing patients' preferences and satisfaction. These studies failed to acknowledge the role of clinical relationships, how they come to be established and what they mean for participants. Therefore, this thesis applies a qualitative approach and focuses on gynaecologists, their care approaches, how clinical relationships are shaped, as well as how and why these might (not) be gendered. This PhD thesis presents two studies that address care approaches as they relate to empowerment (chapter 5) and shared decision-making (chapter 6) and one study that attends to the gendered aspects of professional identity (chapter 7) among gynaecologists in the Basel area, Switzerland.

The background to this PhD thesis is discussed in more detail in section 1.2, which provides a historical contextualisation of the topic. It describes the emergence of (feminist) women's health centres, the implications of the feminisation of medicine and how these changes relate to

observed shifts in care approaches and women's health. Section 1.3 gives an overview of the ways in which contemporary women's health centres provide care and outlines what is known with regard to the different working approaches of fe/male doctors in gynaecology, therewith demonstrating the research gaps this PhD thesis aims to close. Lastly, the framework, aims and methods are provided.

1.2 The feminisation of the medical profession

Over the last decades, the number of female medical doctors has continually increased in most "Western" societies (Adams, 2010; Boulis & Jacobs, 2008; Feuvre, 2009; Elianne Riska, 2010; Scheele, Novak, Vetter, Caccia, & Goverde, 2014; Weizblit, Noble, & Baerlocher, 2009), also in Switzerland (Hostettler & Kraft, 2014; Kraft, 2009, 2016). Today, gynaecology is among the most feminised medical fields. This change in sex composition continues to be of interest to feminists, women's health advocates and policy makers (Elianne Riska, 2010).

From a historical perspective, the increase of female medical doctors is intertwined with the developments of the feminist women's health movement in the 1970s and 1980s, which concentrated especially on the field of gynaecology (Boulis & Jacobs, 2008; Buddeberg-Fischer, 2003; Ebermann, Krondorfer, Mauerer, Reinisch, & Wimmer-Puchinger, 2010; Elianne Riska, 2010; J. E. Thomas & Zimmerman, 2007). The movement raised several questions, including: Why was gynaecology almost exclusively performed by men who presided over women's bodies and their health decisions? How could care be applicable to women, when men's bodies were the point of reference (Lagro-Janssen, 2010; Elianne Riska, 2010)? How was it possible that the normal life phases of women came to be defined and controlled by medicine? How could the narrow medical view of health and illness be expanded? How could the relation between health/illness and social conditions be addressed? In what way could women's health issues be supported (Elianne Riska, 2010)? The movement sought to advance gender equality and quality of health care for women by empowering and increasing women's opportunities and abilities for self-determined decision-making. Such strategies included providing (self-) education and in-depth information, promoting self-help approaches and taking collective action (Buddeberg-Fischer, 2003; Elianne Riska, 2010). Activist women's ideas were put into practice through women's health centres (WHCs), established to provide an alternative to conventional (male) medicine. WHCs offered women-centred care approaches, ensured that only women cared for women and saw women as partners and active participants in their own care (Boston Women's Health Collective, 1970; Broom, 1998; J. E. Thomas & Zimmerman, 2007). Such centres were founded in a number of "Western" countries, including Switzerland (Broom, 1998; J. E. Thomas & Zimmerman, 2007; van den Brink-Muinen, Bensing, & Kerssens, 1998; Zobrist, 2005).

Another feminist branch pursued a more reformist agenda and promoted the integration of women into the medical profession (Elianne Riska, 2010). In that sense, the women's movement also advanced the feminisation of the medical profession. However, Boulis' and Jacobs' analysis of the US context (Boulis & Jacobs, 2008) shows that the influx of women has been fuelled by the convergence of several factors, like a normative turn in medical education and practice; a change in women's position in society, accompanied by increased opportunities for women in higher education; and the emergence of more lucrative fields such as business and finance, especially in the 1990s, that lured men away from medicine.

Studies over the last decade on the increase of women in medicine and related changes in the sex composition of the profession point to the persistence of horizontal and vertical gender segregation (Boulis & Jacobs, 2008; Buddeberg-Fischer, 2003; Hostettler & Kraft, 2014; Kraft, 2009; Elianne Riska, 2001, 2010), as evidenced by the concentration of female physicians in fields considered to be of lower status such as child and adolescent psychiatry, paediatrics and gynaecology/obstetrics — areas that coincide with gender essentialist notions of women's tasks (Boulis & Jacobs, 2008; Hinze, 1999; Löyttyniemi, 2009; Elianne Riska, 2010; R. K. Thomas, 2000). In contrast to women, male doctors continue to concentrate in medical fields that are commonly regarded as being of higher status, such as surgery and surgical sub-specialities — areas that are consistent with gender essentialist notions of men's tasks and characteristics, like instrumentalism and decisiveness (Davies, 2003; Hinze, 1999; Löyttyniemi, 2009; Elianne Riska, 2001). Moreover, the progression of women towards leadership positions in the medical academy has been slow (Carnes, Morrissey, & Geller, 2008). Women doctors also tend to have lower incomes than men due to gender differences in employment status. Thus, women, overall, are under-represented in high-paying specialities and senior positions where men are still in the majority (Adams, 2010; Boulis & Jacobs, 2008; Hinze, 1999; Elianne Riska, 2010). These findings are reflected in Switzerland, in the field of gynaecology. Whereas the majority of gynaecologists today are women (58 per cent), female gynaecologists are concentrated in the outpatient private sector, represented by 53 per cent of practice owners being women gynaecologists. In clinic settings, women outnumber men at lower levels, with 78 per cent of all assistant doctors being women, whereas most higher-ranking positions are held by men, with 75 per cent of current chief gynaecological physicians being male (Kraft, 2016). Gynaecology, along

with the other feminised professions such as psychiatry and paediatrics, is among those medical areas drawing the lowest incomes in Switzerland.[1]

The lack of women in leadership positions in the medical academy has recently been linked to the limited advancement of women's health and to issues of gender differences in health (Carnes et al., 2008; Henrich & Viscoli, 2006; Schiebinger & Schraudner, 2011). A US study surveyed all US medical schools in 2004 and found that courses or themes on gender differences in health and care or women's health issues were limited, even though the US (along with the Netherlands and Sweden) is particularly advanced when it comes to integrating such issues in the medical curriculum (Elianne Riska, 2010). Henrich and Viscoli (Henrich & Viscoli, 2006) found that a female dean of the medical school was associated with a greater variety of gender issues taught. The finding points to the importance of having women in leadership positions in medicine. The Dutch approach to gender in medical training takes knowledge of what sex and gender mean for health and illness and applies it to medical practice (Dielissen, 2012; Lagro-Janssen, 2010), yet the approach has faced challenges. Identified obstacles include the perception that biomedical knowledge is gender neutral, whereas gender inequalities in health were understood as feminist and political rather than medical concerns (Lagro-Janssen, 2010). However, studies at the crossroads of gender and medicine show the importance of including gender-sensitive agendas into current health care reform processes to promote quality of care for both men and women (Kuhlmann, 2009). They also highlight the complex nature of sex and gender in relation to medical knowledge, health/ illness and health care relationships (Bitzer & Riecher-Rösler, 2005; Kuhlmann & Annandale, 2010).

Concurrent to the feminisation of the medical profession, a normative change in the physician-patient relationship has taken place, particularly between 1985 and 2000. This change has been described as a transition from physician-centred to patient-centred care, implying a shift of power in the direction of patient and often linked to discussions about improving quality of care (Heritage & Maynard, 2006; Kaba & Sooriakumaran, 2007; Whelan, 2009). There is no overall consensus regarding the definition of patient-centeredness (de Haes, 2006; Epstein et al., 2005; Mead & Bower, 2000a, 2000b), a concept which is not clearly distinguishable from shared decision-making or empowerment approaches because of its conceptual and empirical overlap (Deccache & van Ballekom, 2010; Glyn Elwyn et al., 2001; Holmström & Röing, 2010; Mead & Bower, 2000a; Zoffmann, Harder, & Kirkevold, 2008). A large body of literature has promoted a patient-centred approach to care (Kaba & Sooriakumaran, 2007), emphasising the importance of

[1] Gynaecology: average hourly earnings are at 108 CHF, compared to 136 CHF average hourly earnings in cardiology where 90 per cent are men; average hourly earnings in surgery are at 127 CHF, with 94 per cent of surgeons being men (Kraft & Laffranchi, 2012).

sharing power and responsibility in physician-patient relationships and of including a biopsychosocial perspective rather than an exclusively biomedical approach (Mead & Bower, 2000b; Stewart, Brown, Weston, McWhinney, & McWilliam, 1995).

The patient-centred approach is generally understood as a shift away from the traditional doctor-centred approach (Heritage & Maynard, 2006). The doctor-centred approach had its golden age in the 1950s, when Talcott Parsons formulated his functionalist perspective of the clinical relationship, giving medical doctors a paternalistic role towards sick patients. At first glance, the approach appears to be based on gender neutral terms (Charles, Gafni, & Whelan, 1997; Elianne Riska, 2010), but the concept is now understood to be implicitly organised around masculine presumptions (Elianne Riska, 2010). The earlier understanding of the clinical relationship structure derived from concepts of the (middle-class) family, thereby giving doctors the role of fathers who make patriarchal decisions on behalf of their children (the patients) who were perceived to have hardly any autonomy. Accordingly, the role of mother was ascribed to nurses (Davies, 2003; Kaba & Sooriakumaran, 2007). Today, a patient-centred approach is either displayed through gender-neutral terms, in the sense of an 'equal encounter' between two adults (Kaba & Sooriakumaran, 2007), or through gender-essentialist notions of femininity (Boulis & Jacobs, 2008; Elianne Riska, 2010), presuming that women might have changed medical practice due to women's presumed "natural" caring and nurturing characteristics so that "the masculine view of medicine lost its relevance for the emerging health care environment" (R. K. Thomas, 2000: 17).

1.3 Gender, care approaches and gynaecology

The increasing number of women gynaecologists, along with the shift in care approaches over the same period, has given rise to new questions. First, under the assumption that conventional medical care has changed, are WHCs still needed or do they still offer something that cannot be obtained elsewhere? Second, as patients may now choose men or women as gynaecologists, do women have a preference and if so, for whom? Third, are there differences between how women and men practice gynaecology? And, fourth, are patients more satisfied with men or women as gynaecologists? This section discusses the current literature on WHC assessment and the current knowledge on assessing gender differences in gynaecological practice. At the same time, the rationale for this PhD thesis is presented.

A number of studies have dealt with the question of whether WHCs still differ from conventional care settings that offer women's health services (R. T. Anderson et al., 2002; B. A. Bean-Mayberry et al., 2003; B. Bean-Mayberry et al., 2007; Broom, 1998; Harpole, Mort, Freund, Orav, & Brennan, 2000; Phelan, Burke, Deyo, Koepsell, & LaCroix, 2000; van den Brink-Muinen

et al., 1998; Van Den Brink-Muinen, 1997; van den Brink-Muinen, 1998). When assessing WHCs' performance against other medical care settings (primary, general or internal care), most studies used patients' characteristics and/or satisfaction as well as rated video recordings of consultations and report on the Dutch, Australian and American contexts.

The country-specific contexts in which WHCs have been assessed are very different. In the Netherlands and in Australia, WHCs had their roots in the feminist women's health movement (Broom, 1998; Van Den Brink-Muinen, 1997; van den Brink-Muinen, 1998; Warin, Baum, Kalucy, Murray, & Veale, 2000) and were mainly evaluated in the late 1990s. Soon after that, many feminist WHCs closed due to financial constraints coinciding with increased privatisation of healthcare starting in the 1990s (Boscoe, Basen, Alleyne, Bourrier-Lacroix, & White, 2004; den Broeder, 2001; Hardon, 2003; Jamieson, 2012; Waaldijk, 2011). Those WHCs that survived were the exception rather than the rule (Boscoe et al., 2004; den Broeder, 2001; Waaldijk, 2011). A similar situation was reported for the Swiss context ("Frauenberatungszentrum Bern," 2016; Zobrist, 2005). In Austria the situation is slightly different. Feminist women's health care, initially embedded as a project in the services of a clinic for gynaecology and obstetrics (Semmelweiss-Klinik, Vienna), has developed into a women's health programme in Vienna which was established in 1998. Thus, the original project has turned into a city-wide, multi-sectoral public health approach (Wimmer-Puchinger, 2012). It is based on repeated needs assessments and participatory processes and has led to a very broad range of projects, programmes and activities, targeting particular groups of women like migrants, adolescents, young parents, and women with disabilities (Wimmer-Puchinger, 2008, 2012). The programme is continuously running and is regularly evaluated and reviewed by an expert board, with support and funding of the City of Vienna (Wiener Programm für Frauengesundheit, 2014a, 2014b).

The rising incorporation of women's healthcare (issues) into mainstream medical services from the mid-1990s onwards also accounts for the limited number of studies on feminist WHCs in recent years (R. T. Anderson et al., 2002; Armstrong, 2010; Hardon, 2003; Jamieson, 2012; Milliken et al., 2001). For this reason, 'the next generation of studies' come from the first decade of the millennium and primarily focus on the federally funded WHCs attached to hospitals, a development found mainly in the US (R. T. Anderson et al., 2002; B. A. Bean-Mayberry et al., 2003; B. Bean-Mayberry et al., 2007; Milliken et al., 2001; Yano, Goldzweig, Canelo, & Washington, 2006). These WHCs were founded to counterbalance the fragmentation of women's health care (B. Bean-Mayberry et al., 2007) and by 2003, almost one-half of all US hospitals had a WHC/women's clinic (Harpole et al., 2000; J. E. Thomas & Zimmerman, 2007). Here, we must differentiate between the federally funded National Centres of Excellence in

Women's Health Care (CoE) founded in key academic medical centres and the comprehensive WHCs (CWHCs) linked to university partners but developed within the Veterans Affairs (VA) systems to account for the needs of an increasing number of women veterans (B. Bean-Mayberry et al., 2007). A similar development occurred in Canada where six Centres of Excellence for Women's Health were established in 1993, of which half have already closed (Armstrong, 2010; "Canadian Women's Health Network," 2016). To my knowledge, the Canadian centres have not been assessed. Thus, while more recent literature mostly assesses academic initiatives in the US, these centres are not comparable with the WHCs that started as feminist grassroots endeavours, launched to provide a community alternative to mainstream care (den Broeder, 2001; Stumm & Vera, 2001; Waaldijk, 2011).

The literature to date suggests that WHCs serve particular groups of the population; however, the characterization of these groups differs from country to country. In Australia, WHC patients were in poorer health and had lower incomes and education levels (Broom, 1998). In the Netherlands, WHC patients tended to be younger, more educated, working and childless (Van Den Brink-Muinen, 1997). In the US, patients of a hospital-associated WHC were younger and had fewer chronic medical conditions compared to women patients in the respective comparison group (Phelan et al., 2000).

Whether WHCs still offer care that may not be obtained elsewhere remains debated in the literature. Broom (Broom, 1998) examined the views of women in the Australian context in the 1990s and concluded that WHCs still offer best-practice in areas such as sympathetic care, empowerment and participation in decision-making, which was still an innovative model for mainstream medical care. Warin et al. (Warin et al., 2000) reported that patients' experiences with space and time in three feminist and community health centres in Southern Australia had a positive effect on patients' health status. In contrast, van den Brink-Muinen and colleagues (van den Brink-Muinen et al., 1998; van den Brink-Muinen, 1998) reported that the principles of women's health care in the Dutch context, such as consideration of patients' social/personal situation and shared decision-making, seemed to be applied across all settings. Yet, they also noted that female general practitioners from the WHC and the other general practice settings appeared to be more alike than their male colleagues in that female doctors looked at and talked more with their patients and verbally expressed more attentiveness and warmth than did male doctors (van den Brink-Muinen et al., 1998).

Publications from the US indicate that female patients are more satisfied with the care obtained in hospital-associated VA women's clinics (B. A. Bean-Mayberry et al., 2003), compared to female patients from the comparison group. VA women's health clinics again, need to be

differentiated from the nationally funded CWHCs operating the VA system, because they developed from primary care (Yano et al., 2006). For VA women's clinic settings, Bean-Mayberry et al. (B. A. Bean-Mayberry, Chang, McNeil, & Hudson Scholle, 2006) found that a female provider and the provision of gynaecological care were associated with excellent patient ratings for communication. It seems that the VA women's health clinics have incorporated a number of concepts from their 'big sisters', the CWHCs, although there are exceptions (Yano et al., 2006). VA women's health clinics are less prepared to deliver reproductive and mental health care services and slightly less likely to ensure that women are able to see same-sex providers.

Comparing CWHCs with CoEs (B. Bean-Mayberry et al., 2007), it was revealed that all served primarily urban areas, but that the CoEs offered more extensive reproductive services, while the CWHCs had more on-site mental healthcare available (explained by the needs of female veterans returning from combat). Female patients were more satisfied with the care received at CoEs, compared to female patients from the comparison group (R. T. Anderson et al., 2002). CoE patients obtained significantly more screening tests and counselling services. Harpole et al. (Harpole et al., 2000) also emphasized that patients of a hospital-associated WHC received more gender-specific health counselling than the other patients surveyed. Because the higher quality of care at CoEs could be attributable to the higher number of female doctors working at the CoEs, Henderson et al. (Henderson, Scholle, Weisman, & Anderson, 2004) analysed the impact of gender on quality of care but were unable to establish any association. Anderson et al. (R. T. Anderson et al., 2001) examined female patients' concepts and definitions of healthcare quality at the CoEs and found that women accessing the centres placed a high value on excellent medical care, defined as healthcare that is in tune with women's bodies and lives and employs a holistic approach.

Another strand of literature, however, is critical of the ways in which women's health has become integrated into mainstream medical care. Thomas and Zimmerman (J. E. Thomas & Zimmerman, 2007) explored the differences between feminist and hospital-associated WHCs in the US with regards to empowerment, based on analyses of in-depth interviews, participant observation and written documents and brochures. They showed that hospital settings integrated some feminist concepts, but did so in the name of revenue production. Hospitals offered women choices about medical services based on pharmaceutical information but did not put the power relation between doctor and patient into question. This is in contrast to the feminist understanding of women's health care as a process of informed, active decision-making through supportive education and information, which is important to foster patients' autonomy and control. This acquisition of formerly feminist concepts in mainstream medicine was linked to

consumerism, managed care programmes and the introduction of quality of care associated with patient centeredness (J. E. Thomas & Zimmerman, 2007). Meyer (Meyer, 2000) equally stressed that the hospital-associated WHCs in the US would ultimately increase women's dependency upon medical professionals. Authors from Canada (Boscoe et al., 2004) and the Netherlands (Waaldijk, 2011) likewise critiqued the effect of privatised healthcare on limiting the space to speak about gender in medicine and on minimising the commitment to giving women a voice so as to address well-being from various positions (Boscoe et al., 2004; Waaldijk, 2011)

The literature reviewed here raises several questions. Do WHCs deliver care that better corresponds to women's needs and preferences? How are care approaches across different settings understood by physicians and patients alike? Are observed differences merely a question of doctors' gender? The studies cited did not address gynaecology, specifically, although it was once the cornerstone of the feminist health movement. As gynaecology is now among the most feminised medical areas, the reconsideration of gender and care approaches is even more relevant. For this reason, the present PhD thesis explores how medical doctors and patients understand and practice different care approaches across gynaecological care settings, including a WHC.

Aspects of gender in gynaecology have been addressed in communication research. Such studies have primarily focused on dimensions of patient-centeredness, assessing whether it makes any difference if the gynaecologist is a man or a woman (Christen, Alder, & Bitzer, 2008; Janssen & Lagro-Janssen, 2012; A. M. Van Dulmen & Bensing, 2000). Other care approaches, such as empowerment or SDM, have hardly been explored in gynaecology with only very few studies (regarding genetic counselling) tackling the proposed ideal of non-directiveness in decision-making processes (G Elwyn, Gray, & Clarke, 2000; Rantanen et al., 2008). To my knowledge, gender aspects relevant to SDM have, until now, almost not been addressed (Wyatt et al., 2014). The same applies to physicians' preferences or experiences of decision-making, which have been mostly neglected in favour of exploring patients' preferences and experiences (Murray, Pollack, White, & Lo, 2007b).

It has been established that most female patients prefer a female rather than a male gynaecologist (Baskett, 2002; Childs, Friedman, Schwartz, Johnson, & Royek, 2005; Ekeroma & Harillal, 2003; Janssen & Lagro-Janssen, 2012; Makam, Mallappa Saroja, & Edwards, 2010; Racz, Srikanthan, Hahn, & Reid, 2008). Preferences for a female gynaecologist have been found to increase when a pelvic exam is performed (Ekeroma & Harillal, 2003; Janssen & Lagro-Janssen, 2012; Johnson, Schnatz, Kelsey, & Ohannessian, 2005) but seem to decrease when women have more experiences with intimate examinations (Racz et al., 2008). These findings

could be grounded in women's experiences of embarrassment, vulnerability, fear and discomfort during pelvic examinations (Grundström, Wallin, & Berterö, 2011; Janssen & Lagro-Janssen, 2012; Larsen, Oldeide, & Malterud, 1997; Oscarsson & Benzein, 2002; Rizk, El-Zubeir, Al-Dhaheri, Al-Mansouri, & Al-Jenaibi, 2005; Seehusen et al., 2006; Yanikkerem, Ozdemir, Bingol, Tatar, & Karadeniz, 2009). However, the preference for a female gynaecologist is not always strong (Christen et al., 2008; Fisher, Bryan, Dervaitis, Silcox, & Kohn, 2002; Janssen & Lagro-Janssen, 2012) and aspects such as gynaecologists' experience, professionalism and knowledge, board-certification, communication skills and courtesy, as well as clinical competence have been stated to affect women's preferences (Janssen & Lagro-Janssen, 2012; Johnson et al., 2005; I. Piper, Shvartz, & Lurie, 2008; Schnatz, Murphy, O'Sullivan, & Sorosky, 2007). In this context, it should be noted that the feminisation of gynaecology remains a charged issue and findings on women's gender preference appear to be used as a springboard for developing a critical stance towards the influx of women into the profession (Johnson et al., 2005; Schnatz et al., 2007). Schnatz and colleagues (Schnatz et al., 2007) have argued that women's preferences for a female gynaecologist are influenced by gender stereotypes that may be counteracted. Johnson et al. (Johnson et al., 2005) have advised to better consider the qualities patients appreciate in gynaecologists rather than to 'think gender'. Buddeberg-Fischer (Buddeberg-Fischer, 2003) has warned against the development of a female monoculture in Swiss gynaecology, while Balayla (Balayla, 2010) asserts that "society should continue to embrace the practice of male gynaecologists" (p.74).

There are only a limited number of studies available concerning gender differences in gynaecology/obstetrics with regards to communication style and patient satisfaction. Communication studies have indicated gender differences in the ways doctors deliver care to women patients. Early studies mainly focused on primary care (Hall & Roter, 2002; Roter, Hall, & Aoki, 2002; Roter & Hall, 2004) and reported that female physicians engage in significantly more partnership behaviours, psychosocial counselling, psychosocial questioning and emotionally-focused talk than male physicians. Because the findings corresponded well to those recorded in non-clinical populations, Hall and Roter (Hall & Roter, 2002) suggested that the socialisation processes affecting fe/male doctors may not be strong enough to remove the effects of gender-role socialisation. The same meta analytic reviews (Hall & Roter, 2002; Roter et al., 2002; Roter & Hall, 2004) included a few studies from gynaecology/obstetrics. It seems that male/female communication patterns in gynaecology/obstetrics were reversed, as male doctors expressed higher levels of emotionally focused talk than their female colleagues did, while patients were less satisfied with men's performance. The findings indicated that gender-related practice

patterns differ in each speciality. Male gynaecologists were thought to feel under pressure to meet the challenges posed by the feminisation of gynaecology by enhancing their communication skills (Roter & Hall, 2004), while women patients might have felt prejudice and scepticism towards male doctors in this speciality (Hall & Roter, 2002). However, more recent studies on gender differences in gynaecologists' communication behaviours mirror the gendered communication patterns observed in earlier studies of primary care settings, whereby female doctors talk in a more affective manner and apply a more patient-centred communication style than male gynaecologists (Christen et al., 2008; Janssen & Lagro-Janssen, 2012).

Most communication research in gynaecology used ratings of videotaped consultation recordings, as well as scales, to assess patients' preferences and satisfactions based on standardised questionnaires for measuring patient-centeredness. While such studies provided valuable insights, they have also been criticised. Ratings of videotaped consultation recordings fail to recognise the importance of context and content of medical consultations (Charon, Greene, & Adelman, 1994; Heritage & Maynard, 2006), implying that the way people talk would be independent of the subject and of the nature and character of the physician-patient relationship (Britten, 2011; Matthias, Salyers, & Frankel, 2013). Rated video-recordings are a great method for measuring physicians communication behaviour, but do not factor in the reciprocal and dynamic nature of clinical relationships and thus, regularly miss out patients' parts (Heritage & Maynard, 2006; Roter & Hall, 2004). Still, the effect of provider characteristics are studied to a much lesser extent than patients' characteristics due to the assumption that only patients' emotions and attitudes affect clinical relationships but not those of trained professionals (Hall, 2003). Accordingly, communication research in medicine/gynaecology has remained on a fairly descriptive level (Hall, 2003). Scholars have further asserted that observed communicative behaviour may not correspond to the ways in which patients and physicians experience and perceive the interactions (Salmon, Mendick, & Young, 2011; Young, Ward, Forsey, Gravenhorst, & Salmon, 2011). Other studies indicate that patient preferences vary in relation to illness (Heritage & Maynard, 2006) and they may not match patients' experiences, while patient preferences have also been used by researchers to categorise patients to apparently fixed groups such as active, collaborative, or passive patient roles (Entwistle & Watt, 2006). Patient satisfaction has not proven to be a good marker for clinicians' efforts in engaging patients (Entwistle & Watt, 2006), as both patient satisfaction and patient preference may be distorted by what is socially desired as good patient behaviour. Accordingly, scholars have pointed out implications for future research. Qualitative approaches and the integration of different data sources, including physicians' and patients' perspectives and experiences, are considered the

best means for capturing the complexities of physician-patient relationships and care approaches and for understanding how clinical relationships are shaped (Britten, 2011; Cribb & Entwistle, 2011; Hall, 2003; Heritage & Maynard, 2006; Roter & Hall, 2004; Salmon et al., 2011; Salmon & Young, 2005; Young et al., 2011). We use these insights and a qualitative approach to explore working styles across gynaecological settings, including a WHC, to better understand and explain the existing differences and similarities among female and male gynaecologists' approaches to care in Switzerland. The inclusion of men and women doctors was deemed important to give both sexes the opportunity to express their views, experiences and emotions concerning their work in gynaecology under feminisation.

2 Framework: The WAGE project

This thesis is based on the qualitative part of the mixed methods project 'Women and Gynaecology in Evaluation' (WAGE, SNF No. 32003B-121358). The overall purpose of the WAGE project was to contribute to the ongoing debate on the quality of care in gynaecology.

A pilot study conducted for the WAGE project (Zobrist, 2005) included a comparison of patients at the only WHC still in existence in Switzerland at that time with patients at another gynaecological practice located in the Basel area. The comparison revealed a number of differences between women who had consulted the WHC and those who had accessed the other gynaecological practice: Women patients at the WHC were, on average, younger, more satisfied with contraception and had a more positive attitude towards their own bodies despite having more experience of violence; they also experienced the pelvic examination more positively than the patients in the other care setting. However, this study focused exclusively on the patient side and did not address the working approaches adopted in the two settings involved. Accordingly, as an extension of this medical dissertation, the WAGE project took on a more comprehensive approach through the inclusion of six different gynaecological outpatient care settings located in the Basel area (Switzerland). By applying a mixed methods approach, the overall project aim was to assess the gynaecological working approaches applied (qualitative part) and to analyse the extent to which these might have an influence on women's health outcomes (quantitative part).

The basis for this PhD thesis is the qualitative part of the WAGE project, which applied a grounded theory (GT) approach to data analysis, as formulated by sociologist Kathy Charmaz (Charmaz & Belgrave, 2012; Charmaz, 2006), in order to assess the variations and similarities in working approaches across included gynaecological outpatient care settings. The study relied on the interpretation of data obtained from the semi-structured interviews held with (a) gynaecologists and (b) patients, as well as (c) participant observations of consultations.

In the following section, the aims and an outline of this thesis are described, and the study setting and the methods involved are outlined.

3 Aims and outline of this thesis

The **primary aim** of this PhD thesis was to explore the similarities and variations in working approaches across the gynaecological outpatient care settings that were included in this study. This aim is considered significant as it contributes to the debate on care approaches in gynaecology, which was discussed in the preceding literature review (chapter 1).

In accordance with the constructionist GT approach applied to data analysis (Charmaz, 2006), the **general objective** was to investigate the way gynaecologists work with and relate to patients and why they do it in a certain way and not differently. Accordingly, during the analysis, themes and categories were crystallised in the collected data and were then integrated into article manuscripts. The emergent and more **specific objectives** and explicit **research questions** which were addressed are as follows:

Research question 1: How do gynaecologists make sense of medical signs, diagnose and understand their patients?

Specific aims:

I. Study empowering approaches
II. Explore gynaecologists' perceptions, beliefs and attitudes
III. Assess influencing dimensions

Research question 2: How do gynaecologists relate to their patients?

Specific aims:

I. Explore (shared) decision-making approaches
II. Study physician–patient relationships in gynaecology
III. Assess the different perspectives involved (physicians, patients and observations of consultations)

Research question 3: How do gynaecologists reason about what influenced their working approaches?

Specific aims:

I. Explore professional identity constructions
II. Study gynaecologists' perspectives on their careers
III. Assess differences and similarities in their narratives

3.1 Outline of this thesis

Proceeding from the introduction and the background (chapter 1), the framework (chapter 2), the aims of the thesis (chapter 3) and the methods applied are described (chapter 4).

Chapter 5 presents the findings of the semi-structured interviews with regard to gynaecologists' reasoning about a pelvic pain vignette to understand what may underlie empowering approaches (article 1 "Variations in gynaecologists' reasoning over a pelvic pain vignette: What does it tell us on empowering approaches?").

In chapter 6, the findings of an integrative qualitative analysis of semi-structured interviews conducted with patients and gynaecologists, as well participant observation of consultations, are discussed to explore the relational aspects of shared decision-making (article 2 "Understanding relational aspects of shared decision-making in gynaecology: A qualitative analysis of patients' and physicians' perspectives as well as clinical consultations").

Chapter 7 describes the findings from the semi-structured interviews held with gynaecologists regarding their views upon their career paths in order to trace what influenced their working approaches thereby revealing how professional identities are constructed (article 3 "Professional identity in a feminised profession: More than un/doing gender in gynaecology?").

In chapter 8, the main findings resulting from findings included in chapters 5 to 7 are summarised. This is followed, in chapter 9, by a discussion, including the strengths and limitations of the research as well as the implications of the study findings for research and policy and practice.

4 Methods

The research was conducted in the Basel area in Switzerland, where six different gynaecological outpatient care settings were selected for the WAGE project prior to data collection using maximum variety sampling. This sampling strategy enabled us to subsequently combine the qualitative with the quantitative part of the WAGE project and to maximise the representation of diversity in working approaches. This allowed the similarities and differences in approaches to be identified (Teddlie & Yu, 2007). We were therefore unable to apply theoretical sampling as is commonly considered essential for GT (Charmaz & Belgrave, 2012; Charmaz, 2006), but this trade-off between representativeness and saturation is intrinsic to mixed methods approaches (Creswell, 2003a; Teddlie & Yu, 2007). The settings identified for the research included (a) the outpatient department of the university's women's clinic; (b) four privately run gynaecological practices with varying sub-specialisations and (c) one WHC born out of the women's health movement of the 1980s. These settings differ in terms of the services offered, organisational aspects and the gender of the gynaecologists (see table 1, p.34).

4.1 Conceptual framework

A conceptual framework may be understood as a network of entwined concepts that provides a comprehensive understanding of a phenomenon (Bowen, 2006; Jabareen, 2011). A conceptual framework can be formed from sensitising concepts (Bowen, 2006), which provide initial ideas on how to commence studies, thus allowing certain questions to be asked about the issue under research (Charmaz & Belgrave, 2012; Charmaz, 2006). The sensitising concepts included in this study were the following: medical care concepts that influence contemporary gynaecological practice, such as patient-centeredness (de Haes, 2006; Kjeldmand, Holmström, & Rosenqvist, 2006; Lamiani et al., 2008; Mead, Bower, & Hann, 2002; Mead & Bower, 2000b; Rademakers, Delnoij, Nijman, & De Boer, 2012; a M. Van Dulmen, 2003), gender aspects in medical care (Klea D. Bertakis, 2009; Blanch-Hartigan, Hall, Roter, & Frankel, 2010; Carnes, 2010; Christen et al., 2008; Cronauer & Schmid Mast, 2010; Davies, 2003; Janssen & Lagro-Janssen, 2012; Elianne Riska, 2001; Roter et al., 2002; van den Brink-Muinen, 1998; A. M. Van Dulmen & Bensing, 2000; Zaharias, Piterman, & Liddell, 2004), women's health care (B. A. Bean-Mayberry, Yano, Caffrey, Altman, & Washington, 2007; Broom, 1998; Hunt, 1998; Kuhlmann & Babitsch, 2002; LaFleur & Taylor, 1996; Kristi Malterud, 1993; Van Den Brink-Muinen, 1997; van den Brink-Muinen, 1998; Zobrist, 2005) and various decision-making models (Charles et al., 1997; G Elwyn, Edwards, Kinnersley, & Grol, 2000; Glen Elwyn, Edwards, & Kinnersley, 1999;

Entwistle, 2009; Joseph-Williams, Edwards, & Elwyn, 2014; Mast, 2004; Rodriguez-Osorio & Dominguez-Cherit, 2008; van den Brink-Muinen, 1998; Wensing, Elwyn, Edwards, Vingerhoets, & Grol, 2002).

The preceding introduction has illustrated the conceptual framework and the reviewed literature on the complex relations between gynaecology, gynaecological care and gender, and what is known with regard to care concepts, specifically patient-centeredness, as there is a paucity of research on shared decision-making and empowerment in this speciality. Moreover, the reviewed literature places an emphasis on medical communication and clinical relationships, which links back to the theoretical idea of the symbolic interactionism that underlies the constructionist GT, as followed in this study and as formulated by Kathy Charmaz (Charmaz, 2006; Sandstorm, Martin, & Fine, 2003). Symbolic interactionism here relates to the way behaviours and meanings arise from social processes such as the physician–patient relationship.

4.2 Design and purpose of data collection tools

This thesis applied the following set of qualitative methods to reveal perceptions and experiences of care approaches and physician–patient relationships from various individual perspectives (Britten, 2011; Flick, Von Kardoff, & Steinke, 2004; Salmon & Young, 2005; Young et al., 2011):

1. Qualitative semi-structured interviews with physicians
2. Qualitative semi-structured interviews with patients
3. Participant observation of gynaecological consultations.

While semi-structured interviews are considered as a means of accessing subjective viewpoints (Flick, Von Kardoff, et al., 2004), participant observation is understood as a way of learning about what individuals do in their everyday lives (Kawulich, 2014). Therefore, these two approaches capture different aspects of the same research issue (Flick, 2004) and are considered to be vital means for understanding why people might act in certain ways (Britten, 2011; Flick, von Kardoff, & Steinke, 2004). The observation of a research issue from no fewer than two different viewpoints is considered to be triangulation and aims to uncover new ways of understanding and conceptualising a research issue (Flick, 2004). In this research study, this method therefore served to provide a deeper understanding of and about clinical relationships and care approaches (Salmon et al., 2011; Salmon & Young, 2005; Young et al., 2011). This kind of triangulation was particularly adopted in chapter 6, where different perspectives were

contrasted to obtain insights into the complexities of decision-making processes in gynaecological relationships.

The topic guides for the semi-structured interviews and the participant observation were designed in accordance with the conceptual framework. The semi-structured interview guides used open-ended questions throughout. All tools were designed in (Standard) German. They were piloted outside the gynaecological outpatient settings included in the study, which assisted in optimising the topic guides. Overall, the use of guides ensured that the main research topics were covered.

The semi-structured interview guide used for obtaining gynaecologists' viewpoints concentrated on the following areas: Physicians' specialization, women's concerns, working approaches, significant influences on the latter and four case vignettes. Vignettes are commonly used to obtain an insider perspective through the selective simulation of a fictional situation of a topic under research (Hughes & Huby, 2002; O'Dell, Crafter, de Abreu, & Cline, 2012; Spalding & Phillips, 2007). Vignettes are thus considered to produce implicit abstractions of real life situations (Hughes & Huby, 2002; Spalding & Phillips, 2007). The case vignettes, which addressed menopause, vaginal mycosis, metrorrhagia and pelvic pain, were constructed with the gynaecologists involved to ensure their relevance to practice. The vignettes were kept brief to allow gynaecologists room for interpretation when asked to outline what they would do in a certain situation. The semi-structured interview guide used to obtain the patients' views focused on the choice of gynaecologist and the patients' expectations and experiences of clinical consultations. The final part of all the interviews was designed in an open manner to allow emergent themes to be pursued. All interviews were semi-structured and based on open-ended questions throughout, allowing interviewees to voice their feelings and concerns freely. All interviews ended with an open, final part to pursue emergent themes. Interviews were adjusted to the interview dynamics.

Participant observation was used to complement the qualitative interviews. The focus of observation was on the decision-making processes that occur during gynaecological consultations. The topic guide developed focused on the details of decision-making such as conversational openings, exploration of concerns, actions taken, diagnosis, options and the decision-making processes themselves.

4.3 Data collection

We conducted 11 semi-structured interviews with physicians between August 2011 and March 2012. The interviews lasted up to 90 minutes and were conducted in the practices after hours.

Eighteen interviews with patients were held during 2012 and lasted about 45 minutes. The patients were entitled to select the interview locations and all interviews were adjusted in line with the interview dynamics. While conducting interviews, questions and participant responses were reframed to ensure member checks to enhance the study's validity (Krefting, 1991). Interviews were audio-recorded and transcribed into (Standard) German.

Participant observation of 33 consultations was conducted during August/September 2011. Of all the patients who were identified for observation, one refused to participate owing to her elevated social status. During the observations, the observer sat next to the consultant's desk, but did not intervene except on one occasion when a WHC physician asked her to share her experiences with a patient. This request was consistent with the WHC's care approach, which assumes that healthy women do not necessarily need to be seen by medical specialists (Zobrist, 2005). All observations were recorded using the topic guide.

4.4 Participants' characteristics

Maximum variety sampling was used to select the six gynaecological outpatient care settings. The semi-structured interviews and the participant observation of consultations were conducted in these settings.

The semi-structured interviews were held with one physician per care setting with two exceptions: Because of the university hospital's and the WHC's complex working environment, we purposefully sampled two physicians from these settings. To account for the particularities of the WHC, three expert women were also sampled. These women were qualified in midwifery, naturopathy and psychotherapy. They had been trained by the centre's physicians to provide basic gynaecological services so that they could consult with patients alongside the gynaecologists. This approach is particular to the WHC and is intended to reduce physician–patient distance, as they are considered specialists in 'normal' women's health affairs (Broom, 1998; J. E. Thomas & Zimmerman, 2007; Van Den Brink-Muinen, 1997; van den Brink-Muinen, 1998; Zobrist, 2005). Because it emerged that the female gynaecologists' and expert women's perspectives were very similar, we decided to include the expert women as well. Moreover, an understanding of the WHC's working approach would have incomplete without them.

Overall, eight medical doctors and three expert women were interviewed, that is 11 in total; eight of these were women and three were men (see table 1, p.34). All but two clinicians were board-certified gynaecologists. The two exceptions were, firstly, one female clinician who was working at the WHC. She has been trained in gynaecology, but had not completed the gynaecological curriculum required for being board-certified. The other was a female assistant doctor who was

working at the university hospital and was undergoing gynaecological training during the data collection. All clinicians, apart from the assistant doctor, had acquired their first work experiences during the 1980s. This was due to the overall WAGE project design, which required settings to be operational for at least ten years because of the study's interest in long-term patients.

For the patient interviews, we selected three patients per setting based on criteria relating to educational background, life phases (e.g. pre/post-menopausal) and relationship status. In total, 18 patients were interviewed. Only two patients at the university's women's clinic expressed health concerns. This was considered to be indicative of higher morbidity levels (for more detailed information see chapter 6).

Participant observation took place during an ordinary morning in each gynaecological setting. Because WHC consultations lasted 40 minutes, almost twice as long as in the other settings, two mornings were required. Data was recorded for every second consultation, following the observed consultation. In the afternoons field notes were reviewed. Thirty-three consultations were observed across all the settings. Two of six observed consultations at the WHC were conducted by the expert women (for more detailed information see chapter 6).

4.5 Data entry and analysis

Data was imported into Atlas.ti (Version 6.2). Analysis followed Kathy Charmaz's constructionist GT (Charmaz & Belgrave, 2012; Charmaz, 2006), because its contrasting principles are best suited to researching similarities and differences (Charmaz & Belgrave, 2012; Charmaz, 2006; Teddlie & Yu, 2007). Thus, a constant comparative method was applied in terms of which data was reviewed line by line, employing open coding and writing memos as ideas arose. Four study group members (BS, KG, NW and EZ) with different educational backgrounds (medicine, epidemiology, social science and medical anthropology), but all with experience in qualitative research, read the transcripts individually. This approach to data analysis is considered to be investigator triangulation and is intended to further develop, revise or check the subjective perspective of the interpreters and thus to ensure the validity of the data (Flick, 2004; Krefting, 1991; Shenton, 2004). During weekly, face-to-face meetings of the study group, each transcript was jointly interpreted and contrasted with other transcripts to gain an in-depth understanding of the data. In the process, a set of focused codes emerged (Bowen, 2006; Charmaz, 2006). We used an iterative analysis to identify possible discrepancies and convergences between data types. The threads were then integrated and the group members engaged in the analysis, eventually reaching consensus on the final categories. At least two team members were present at all the meetings to validate findings. Data saturation was achieved with the initial sample as a result of the recurrence of the variations within the emergent categories, such as

closeness/distance in physician–patient relationships, women-centred strategies, physician–patient conversations, decision-making and therapies. We discovered that the identified categories reflected the way gynaecologists made sense of their career pathways. Subsequently, this aspect was further explored in the data and, from this analytic process, the category of 'biographical pathway' evolved. The recurrence of differences not only illustrated saturation of the category but also showed that career pathways held very different meanings for women and men as gynaecologists, which subsequently became the subject of the third study (chapter 7). If saturation had not have been achieved with the original sample, we would have collected more data.

4.6 Ethics

The data was collected after ethical approval had been given by the Ethics Committee of Basel in 2009 (No. EK265/09). All study participants gave informed consent prior to data collection. They were informed of their right to withdraw and were assured of confidentiality. The participants in the observed consultations and interviews remained anonymous.

4.7 Rigor

Rigor was ensured by numerous measures. Triangulating within tools and across different data methods and participant perspectives was used to take advantage of the strengths of each method and to explore the issue of interest from different positions and points of view (Bowen, 2006; Flick, 2004; Krefting, 1991; Shenton, 2004). The qualitative interviews with the gynaecologists and the patients proved to be valuable instruments for obtaining their subjective views (Helfferich, 2011), which were subsequently complemented by participant observations during the consultations. In this way it was possible to ascertain whether there were differences between what the interviewees said and what they did, which also increased the validity of the study (Kawulich, 2014). In the semi-structured interviews with the gynaecologists, within-method triangulation was applied by posing open questions using vignettes (Flick, 2004). I also kept a self-reflective journal, which during data analysis contributed to a better understanding of the interviews and the observed consultations (Morrow, 2005). It also helped me to deal with the issue of subjectivity, as an interview is contextual and negotiated, resulting in a reconstruction of reality which serves a specific purpose but which may also be affected by status, gender, race and age (Charmaz, 2006). The self-reflective notes and thoughts were integrated into group interpretations to reflect jointly on interview dynamics (Helfferich, 2011). While conducting interviews, I reframed questions and paraphrased participants' responses to ensure member checks, consequently enhancing the study's validity (Krefting, 1991). The four study researchers taking part in the analysis of data in the interpretation group come from different disciplines and

are experienced qualitative researchers. Thus, they were able to conceptualise large amounts of qualitative data and apply a multidisciplinary approach to analysis (Helfferich, 2011; Krefting, 1991). Findings were presented to the gynaecologists in April 2013, who subsequently confirmed that the findings reflected their care approaches.

Table 1: Characteristics of gynaecological care settings

Setting	WHC Women's Health Centre	H Outpatient department, University's Women's Clinic	P1 Joint Practice	P2 Single Practice	P3 Joint Practice	P4 Single Practice
Year of opening	1980	1960s	1992	1989	1991	1996
Number of care providers (number of board-certified gynaecologists)	9 (1) includes 4 expert women	Approximately 60, in different stages of professional education (approximately 30)	2 (2)	1 (1)	2 (2)	1 (1)
Sex of care providers	Female	Female/male distribution approximately 85%/15%	Female	Male	Female	Male
Approximate number of patients per year	5.900	41.000	4.200	4.000	5.600	3.800
Services offered beyond general gynaecology	Integrated care, psychosocial approaches	Colposcopy, psychosomatics, antenatal care, endocrinology, infertility, urogynaecology, senology, gynaecological oncology	Surgery, infertility, obstetrics (no delivery assistance); psychosomatics, sexual medicine, children's gynaecology	Obstetrics, surgery, infertility	Endocrinology, infertility, psychosomatics, care of oncological patients, difficult pregnancies, crises-intervention, diet counselling	Obstetrics, prenatal/feto-maternal medicine, surgery

5 Variations in gynaecologists' stance towards patient-empowerment

Article 1: *Variations in gynaecologists' reasoning over a pelvic pain vignette: What does it tell us on empowering approaches?*

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5.1 Abstract

This study aims to explore gynaecologists' medical reasoning about pelvic pain management to understand what may underlie empowering approaches. 11 semi-structured interviews with physicians were conducted across 6 outpatient gynaecological settings within the Basel area (Switzerland). Analysis followed a constructive interpretative grounded theory approach. Three emergent perspectives regarding patient empowerment were identified. They demonstrate how the complex socialisations of men and women as gynaecologists in their work environment affect their medical reasoning. While some perspectives hamper, others enable clinicians to take an empowering approach. Training courses in self-reflective approaches are recommended to support clinicians in developing and supporting an empowering approach towards patients with chronic pelvic pain and to go beyond a biomedical perspective.

Key words

gender; medical reasoning; gynaecology; pelvic pain; Switzerland

5.2 Background

Although chronic pelvic pain poses a high burden of disease on women(Latthe, Latthe, Say, Gülmezoglu, & Khan, 2006; McGowan, Escott, Luker, Creed, & Chew-Graham, 2010), there exists no uniform definition due to the complexity of its clinical picture and to the wide range of possible physical and/or psychosocial causes (Deutsche Gesellschaft für Gynäkologie und Geburtshilfe, 2009). The diagnosis is often made by exclusion, that is when pain persists for 3 months or more and no underlying pathology is identified by ultrasound or laparoscopy (Allison & Lev-Toaff, 2010; Deutsche Gesellschaft für Gynäkologie und Geburtshilfe, 2009). In the absence of an identifiable organic pathology, pelvic pain is labelled functional or somatoform (Deutsche Gesellschaft für Gynäkologie und Geburtshilfe, 2009; Karnath & Breitkopf, 2007; Matheis, Martens, Kruse, & Enck, 2007).

Many patients therefore do not receive a medical explanation for their pain. This may not alleviate their fears and they may re-enter in a cycle of investigations (McGowan et al., 2010; Price et al., 2006). The few studies which have explored women's perspectives on medical consultations for chronic pelvic pain (MacBride-Stewart/Grace 2007; McGowan/Luker/Creed 2007; Price/Farmer/Harris 2006), have shown that they often feel ignored, rejected, dismissed, devalued, and without help to better manage their condition: "I am not sure if anything can help…, a cure would be good or some recognition that this condition does exist…we…would like to have better things to do than be dismissed and left at limbo…" (McGowan/Luker/Creed 2007: 270); "I felt like it was going on and on…and there was no answer…that was the hardest part." (Price et al., 2006: 450).

This has led to calls that physicians should take on a more empowering attitude, recognising patients' concerns and supporting them in developing coping mechanism (Kristi Malterud, 2000; McGowan et al., 2007; Price et al., 2006; Vincent, 2011). However, there are ambiguities as to what an empowering attitude might indeed consist in. Price et al. (Price et al., 2006) have advised 'effective reassurance', but within a biomedical understanding of the condition. In contrast, authors like McGowan and colleagues (McGowan et al., 2010, 2007) state that going beyond the biomedical would be the only way to include patients' subjective experiences and for helping them in formulating self-management options. Alternatively, the group of Kristi Malterud (Kristi Malterud, 2000; Werner, Steihaug, & Malterud, 2003) presents a more pronounced empowering strategy by emphasising, particularly when dealing with medically unexplained conditions, power inequalities involved in medical consultations. According to them, physicians need to be aware of their role in diagnostic processes to share power and knowledge with patients so that joint symptom interpretations might open new explanatory perspectives. This

'strong empowerment' approach has its roots in the 1970s, when the feminist women's health movement propagated a shift of power and information to women in order to enable them to own their health and body (The Boston Women's Health Collective, 1973). Yet, 'patient empowerment' has over time hanged its meanings. Former emancipatory aspects have been replaced by educational elements to support patients in making 'informed decisions' (Aujoulat, D'Hoore, & Deccache, 2007; Kirsti Malterud, 2010; Kristi Malterud, 2000).

Physicians confronted with chronic pelvic pain patients however often find themselves uncomfortable, struggling to realise an empowering strategy. They prefer to diagnose irritable bowel syndrome instead of chronic pelvic pain (McGowan et al., 2010) and often feel unprepared to treat pain without an organic cause or to manage this condition effectively. This in turn may challenge their professional competences (Kristi Malterud, 2000; McGowan et al., 2010) and lead them to reinforce their expert position by putting blame on patients (Malterud 2000: 603). Hence, knowing more about clinicians' reasoning on pelvic pain management may help to elucidate professional perspectives which may empower women and allow giving directions to improve care for pelvic pain patients.

While a number of studies have addressed the perspectives of chronic pain patients (MacBride-Stewart/Grace 2007; McGowan/Luker/Creed 2007; Price/ Farmer/Harris 2006), physicians' attitudes have remained understudied (McGowan/Escott/Luker 2010), and the need for more research on care providers has been identified (Hall, 2003). A qualitative approach serves best to investigate physicians' medical reasoning which is understood as a complex interpretative process of evidence construction (Burnum, 1993; Leder, 1990; Kristi Malterud, 1999, 2000; Nessa, 1996; Waymack, 2009), allowing insights into what is – or is not – interpreted as a relevant sign for diagnosis and management (Puustinen, 1999). It may also reveal variations in beliefs about what kind of position towards patients physicians might favour and how these may relate to empowering doctor-patient relationships (Kristi Malterud, 1999, 2000; Undeland & Malterud, 2008).

The few studies which have applied an interpretative perspective towards diagnostic and management processes concentrate on unexplained medical symptoms, but not specifically chronic pelvic pain (Malterud/Candib/Code 2004; Malterud 1999, 2000; Undeland/Malterud 2008). So far, studies on pelvic pain management were conducted in general practices (Kristi Malterud, 2000; McGowan et al., 2010, 2007; Wileman, May, & Chew-Graham, 2002; Zondervan et al., 1999). Although gynaecological outpatient practices have the highest prevalence of medically unexplained conditions of any speciality (Nimnuan, Hotopf, & Wessely, 2001), little is known on how chronic pelvic pain is managed in gynaecology (Abercrombie & Learman, 2012).

The aim of this study is to provide a greater understanding of gynaecologists' medical reasoning about what constitutes good pelvic pain management, paying particular attention to inclusive and empowering perspectives. Findings are based on a grounded theory analysis of semi-structured interviews with gynaecologists.

5.3 Methods

This paper reports on the qualitative investigation of a mixed methods project called "Women and Gynaecology in Evaluation", funded by the Swiss National Science Foundation (SNF No. 32003B-121358). The qualitative part served to characterise gynaecologists' working approaches in selected outpatient settings in which quantitative patient data was collected. Both study parts are to be integrated to explore reciprocities. Six different gynaecological outpatient settings in the Basel area (Switzerland) were selected by maximum variety sampling prior data collection. This strategy served to maximise the representation of diversity in gynaecological working approaches, enabling us to trace their similarities and differences (Teddlie/Yu 2007: 81). Settings included: (a) the outpatient department of the university's women's clinic; (b) four privately run gynaecological practices with varying sub-specialisations; and (c) one women's health centre (WHC).

Ethical Considerations

The Ethics Committee of Basel (Nr. EK265/09) gave ethical approval prior to the study in 2009. Preceding data collection, participants were required to give informed consent. They were informed on their right to withdraw and assured confidentiality/anonymity. All interviews were anonymised.

Conceptual framework

The study was led by an interest in medical care concepts influential for current gynaecology such as patient-centeredness (de Haes 2006; Mead/Bower 2000; Rademakers/Delnoij/Nijman 2012), gender research (Bertakis 2009; van den Brink-Muinen 1998; Carnes 2010; Christen/Alder/Bitzer, 2008; Davies 2003; Eriksson, 2003; Riska 2001), feminist care approaches related to women's health care (Bean-Mayberry/Yano/Caffrey 2007; van den Brink-Muinen 1998; van Den Brink-Muinen 1997; Zobrist 2005) and various decision-making models (van den Brink-Muinen 1998; Charles/Gafni/Whelan 1997; Elwyn/Edwards/Kinnersley, 1999; Entwistle 2009; Mast 2004; Wensing/Elwyn/Edwards 2002). They served as 'sensitizing concepts' (Bowen 2006:2-3; Charmaz 2006: 16) which, according to constructionist grounded theory, are understood as providing ideas regarding what to pursue during research. Thus, they helped us designing data collection tools. Empowerment emerged as a cross-cutting yet poorly

defined theme which is considered as vital for current health care, putting emphasis on physician-patient relationships (Aujoulat/D'Hoore/Deccache 2007; Feste/Anderson 1995; Holmström/Röing 2010; Malterud 1993; Piper 2010). The importance of relational aspects is likewise recognised by symbolic interactionism which informed the constructionist grounded theory followed herein (Charmaz, 2006).

Sampling and participants

Purposive sampling was used to select physicians across the six selected outpatient gynaecological care settings (see table 2, p.41), which differ in services offered, organisational aspects, and gender of practicing gynaecologists.

We conducted 11 semi-structured interviews with clinicians. Because of the university hospital's and the WHC's complex working environments, we purposefully sampled two physicians in these settings. To account for WHC's particularities, three expert women were sampled as well. They had undergone curricula in midwifery, naturopathy and psychotherapy and were additionally trained by the WHC's physicians to provide basic gynaecological services alongside gynaecologists. This approach is particular to WHCs to reduce physician-patient distance, as expert women are considered specialists in 'normal' women's health issues (Broom, 1998; J. E. Thomas & Zimmerman, 2007; J. E. Thomas, 1999; Van Den Brink-Muinen, 1997; van den Brink-Muinen, 1998; Zobrist, 2005). Because female gynaecologists' and expert women's medical reasoning emerged as being alike, we decided to include them. Also, an understanding of the WHC's working approach would have been impossible without them.

Overall, 8 medical doctors and 3 expert women were interviewed (8 women and 3 men). All but 2 physicians were board-certified gynaecologists. The two exceptions were, first, one female physician working at the WHC who has been trained in gynaecology, but not completed the gynaecological curriculum required for being board-certified, and, second, a female assistant doctor who is working at the university hospital, undergoing the gynaecologic training curriculum during data collection. All clinicians, with the exception of the assistant doctor, gained their first work experiences during the 1980s. This is due to the overall project design which required settings to be operational for at least ten years because of the interest in long-term patients.

Interview design and data collection

Interviews followed a semi-structured interview guide with open-ended questions. Gynaecologists were encouraged to express themselves freely, while being guided to talk about the following themes: gynaecologists' specialisation, women's concerns, working approaches, significant influences on the latter, and 4 clinical vignettes. The vignettes served to compare

Table 2: Characteristics of gynaecological care settings and number of interviewed clinicians

	Women's Health Centre	Outpatient department, University's Women's Clinic	Joint Practice	Single Practice	Joint Practice	Single Practice
Year of opening	1980	1960s	1992	1989	1991	1996
Number of care providers (number of board-certified gynaecologists)	9 (1) includes 4 expert women	Approximately 60, in different stages of professional education (Approximately 30)	2 (2)	1 (1)	2 (2)	1 (1)
Sex of care providers	Female	Female/male distribution approximately 85%/15%	Female	Male	Female	Male
Approximate number of patients per year	5.900	41.000	4.200	4.000	5.600	3.800
Services offered beyond general gynaecology	Integrated care, psychosocial approaches	Colposcopy, psychosomatics, antenatal care, endocrinology, infertility, urogynaecology, senology, gynaecological oncology	Surgery, infertility, obstetrics (no delivery assistance); psychosomatics, sexual medicine, children's gynaecology	Obstetrics, surgery, infertility	Endocrinology, infertility, psychosomatics, care of oncological patients, difficult pregnancies, crises-intervention, diet counselling	Obstetrics, prenatal/feto-maternal medicine, surgery
Number of interviewed physicians (expert women)	2(3)	2	1	1	1	1

gynaecologists' explicitly expressed working approach with their implicit attitudes presented regarding a given situation. It is with this aim that qualitative research regularly applies vignettes to gain a more balanced understanding of a topic (Hughes, 1998). We kept vignettes brief to allow gynaecologists room for interpretation when being asked to outline what they would do. The vignettes, addressing menopause, vaginal mycosis, metrorrhagia and pelvic pain, were constructed with gynaecologists involved to assure their practice relevance. This paper presents findings regarding the pelvic pain vignette:

"A 35 year old slender business woman with laptop and mobile, seemingly stressed, presents herself with lower abdominal pain, locating it at the ovaries by pointing to them."

The final interview part addressed potential interests of physicians and emergent themes identified during the prior interviews.

Interviews were completed between August 2011 and March 2012 by BS, a social scientist with background in medicine. They were adjusted to interview dynamics, lasted up to 90 minutes and were accomplished in practices outside opening hours. They were audio-recorded and transcribed into standard German.

Data analysis

All data was imported into Atlas.ti (6.2). Analysis followed constructionist grounded theory (Charmaz/Belgrave 2012; Charmaz 2006) which applies an inductive approach and uses contrasting principles to investigate similarities and differences emerging from the data to come up with a new theory. The interviews were analysed by reviewing line-by-line and applying initial, open coding, while writing memos on ideas arising. This led to the emergence of focused codes (Charmaz, 2006). 4 study group members (BS, KG, NW, EZ) with different professional backgrounds (medicine, epidemiology, social science, sociology, medical anthropology) and experience in qualitative research read interviews individually. During group meetings each interview was jointly interpreted and contrasted with other interviews within/across settings to realise a comprehensive analysis. The group members met weekly, at least two were present throughout all meetings and served as member-checks for ensuring the findings' validity. Final categories were established by consensus. Data saturation was achieved with the initial sample as evinced by the re-occurrence of the identified variations within the emergent categories, such as proximity/distance in physician-patient relationships, women-centred strategies regarding examination, physician-patient conversations, decision-making processes and therapies. If we had not achieved saturation with the initial sample, we would have conducted more interviews.

Ensuring rigor

To ensure rigor, numerous measures were taken. A self-reflective journal was kept, which ensured a better understanding of interviews during analysis (Morrow, 2005). While interviewing, BS reframed questions and paraphrased participants' responses which served as on-spot member-checks to enhance the study's validity (Krefting, 1991). Study researchers had different disciplinary backgrounds and are experienced qualitative researchers. This enabled them to conceptualise the large volumes of qualitative data and apply a multidisciplinary approach (Krefting 1991: 219). Findings were presented to gynaecologists in April 2013 who confirmed these reflected their approaches.

5.4 Results

All physicians interpreted pain as the leading symptom, followed by an almost identical diagnostic search with ultrasound to identify any explanatory pathology. Virtually every physician assumed no organic cause and reasoned about functional pelvic pain. Despite these similarities, their reasoning differed in the kind and extent to which an empowering perspective was presented, enabling us to identify 3 differing perspectives. These have been categorised using physicians' expressions (see table 3): 1. "Everything is fine – Do not worry" – Ensuring exclusion of disease; 2.: "There is room to talk…" – Advocating meaningful care; and 3.: "There is no single answer" – Tailoring individual support.

Table 3: Perspectives and characteristics of sampled gynaecologists/expert women across care settings

	Women's Health Centre	Outpatient department, University's Women's Clinic	Joint Practice	Single Practice	Joint Practice	Single Practice
Number and sex of interviewed physicians (expert women),	2 (3) Female	2 One female, one male	1 Female	1 Male	1 Female	1 Male
board-certified	1	1	1	1	1	1
Three emergent perspectives identified	Advocating meaningful care	Exclusion of disease	Tailoring individual support	Exclusion of disease	Tailoring individual support	Exclusion of disease

"Everything is fine – Do not worry"– Ensuring exclusion of disease

This position is represented by narratives about the relevance of standardised diagnostics aiming at excluding health risk to make patients feel safe. It was mainly followed by men who were board-certified gynaecologists and led their own practices, but also by one female medical doctor (see table 3, p.43). Although they differed in their (sub)specialisations (feto-maternal to psychosomatic medicine), their accounts portrayed them as science-oriented gynaecologists. They read pain as the key sign for initiating standardised diagnostics. These were depicted as means for excluding health risks, as reflected 1. by the interpretation of a male gynaecologist trained in psychosomatic medicine (I1) and 2. by the perspective of the female assistant doctor (I2):

"According to the leading symptom of lower abdominal pain, the aim is to check the region of the ovaries. There exists an algorithm: Is pain cyclic or not?…is [it] related to any infection or organic disease...By ultrasound, we would exclude such. Our function is to exclude any dangerous diseases. If excluded, one would communicate: 'We are sure, you may relax.' Such pains are called functional with 2 possible therapeutic options: symptomatic treatment or… psychosomatic consultations". (I1)

"If diagnostics do not reveal any pathology, I try to fix another appointment in the next week; especially to check if the pain persists and how she responds to the pain killers prescribed."(I2)

All physicians presented sustained diagnostic procedures. By doing so they generated a picture of controlling knowledge production. This approach seemingly allowed them to present certainty on physical normality. Within physicians' interpretations, women only became addressees when being reassured, although clinicians were unable to provide an explanation. Psychosocial signs such as stress were not mentioned as relevant for diagnosis and management. Gynaecologists expressed neither including women's understandings of the condition nor creating room for conversations. Instead, in their narratives, their controlling and powerful position as experts was reinforced, as was presented by another male gynaecologist who emphasised the strength of diagnostics to identify the "real reason" behind pain, whereas women would often wrongly associate the pain with the ovaries:

"…this is a good example, because it is frequent…and mostly it has nothing to do with the ovaries…patients often have this idea that the location of the pain should clearly show what it is…and we have the diagnostic options to investigate the surroundings of the ovaries…one is able to exclude the majority of physical risks…" (I3)

Another male gynaecologist maintained his control through an explanatory shift, providing an alternative meaning to pain while offering treatment:

“If everything is fine, I explain the psychosomatic nature of irritable bowel syndrome. I prescribe a plant-based remedy which works perfectly…There is no cause for concern. ” (I4)

Gynaecologists within this perspective presented concrete measures to tackle women’s pain, mostly as a two-step approach: 1. to prescribe pain killers and 2.to refer women to psychosomatic treatment.

“There is room to talk...” – Advocating meaningful care

This position puts more emphasis on an empowering perspective, as the exclusion of organic causes served as a starting point for advocating meaningful care. It was followed by the physicians and expert women of the WHC (see table 3, p.43). Of the 2 physicians one was a board-certified gynaecologist and one trained in general gynaecology without board-certification but with specialisation in psychotherapy. Both are qualified in psychosomatics. The 3 expert women had undergone training in midwifery, naturopathy and psychotherapy. Their perspectives towards pelvic pain management were alike: They posed pain and stress as equally relevant signs, as recognised 1. by the female gynaecologist (I5) and 2. by the expert women trained in naturopathy (I6):

“It is interesting why they know that the ovaries are causing the pain and name it. I take the medical history. I let her speak about stress...It is important that there is room to talk…Pregnancy and venereal diseases must be excluded…physical examination follows…a sonography. Usually nothing is found. The point is whether rest is beneficial and how she achieves it. Typically, it is a holistic therapy. I attempt to work with the body through massage…” (I5)

“I try having a conversation to ask since when she experiences the pain…I examine and we decide together…if any physical cause is excluded, I would, if she wishes, propose a conversation on stress to see what is possible…it depends! Is a massage of help or can I support her in taking free time?” (I6)

Gynaecologists and expert women displayed themselves as offering meaningful care by combining the biomedical view with women’s concerns. Instead of exclusively offering reassurance, they displayed an enabling attitude: they described themselves as offering room for conversation to build a relationship without pressuring women to accept this. They explicitly acknowledged a societal influence on women’s health, thereby turning the individual experience

into a common one, and allowing women to attribute meaning to the pain. This is depicted in the interpretation by the physician trained in gynaecology:

“I would respond to her fear, and today, one uses ultrasound. Usually no underlying organic cause is found. She is relieved, but blames herself for a self-destructive life style due to too much stress and masculinity. I choose the topic of stress and see how she responds. How can one cope with stress? One might want to practice shiatsu or do something unrelated to rational logic. Masculinity is good, but a pity to sacrifice femininity which is linked with […] cycles and patience. Maybe she talks about pain during sexual intercourse, sexuality may play a role...” (I7)

Gynaecologists and expert women presented themselves as being aware of the impact of society on women’s lives and health, offering women the opportunity to situate their experience in a distinct social context. They read stress as alienating women from their bodies and encouraged a holistic treatment approach. Thereby, they aimed to give women a means to reflect about womanhood which served to develop management strategies with emphasis on the body. This is illustrated by the expert woman qualified in psychotherapy:

“Such a woman has to get back into her body. She is better off with a compress, requiring lying down...” (I8)

“There is no single answer“ – Tailoring individual support

As before, the inclusion of patients’ experiences into reasoning processes is the key characteristic of this position. Yet, it differs by emphasising women’s individual understandings of pain and the creation of a mutual understanding and management strategy. The physicians who tailored such an approach were the 2 women working in gynaecological group practices (see table 3, p.43), both being board-certified gynaecologists and specialised in psychosomatics. They read pain and stress as equally important signs and depicted themselves as reciprocally interacting with women. They illustrated how they build a dialogue wherein they fostered mutual exchange, as was stated by one female gynaecologist:

“I ask: ‘... Since when do you have the pain?...What do you think about it…?’ She answers: ‘I think there is something wrong with my ovaries. A friend of mine had a cyst...’ I reply: ‘You are afraid…I propose doing an ultrasound…ok? I do not believe that I will find anything, it is just to be sure…’. If I suspect any infection …sexual history becomes relevant…followed by an examination, ultrasound…therapy according to findings. If stress becomes an issue, I react to it. It depends on her needs – maybe a new appointment, a sleeping pill...” (I9)

Communication and understanding appeared as tools for an enabling relationship built on partnership and trust. They portrayed both sides as navigating towards a joint management

strategy. Apparently, diverse outcomes were possible, whereby medical expertise was exposed as convening with women's concerns, as was expressed by the female gynaecologist already quoted before:

"Sure, therapy is according to outcomes. If stress indeed has emerged as a priority, then I offer – depending on the situation – I ask whether she needs anything…and then there are diverse responses possible." (I9)

Support was tailored to the patient's personal needs and aimed to empower women to take control over the situation. They openly displayed a complex view of women's pain beyond biomedical concepts, rejecting conformity to the stereotype of 'the stressed woman'. This was expressed by the other female gynaecologist:

"…there is no such patient…where you know she is stressed – another manager with pain...I need to look at the whole…perhaps she is happy with her career and enjoys the ringing phone…there are people who like it and who are absolutely not stressed" (I11)

5.5 Discussion

This study expands research findings on chronic pelvic pain by focusing on gynaecologists' perspectives towards good management practices, while paying attention to empowerment. To our knowledge, it is the first study using an interpretative approach towards medical reasoning in gynaecology.

Main results

Our findings suggest that variations in medical reasoning are rooted in interactions between gynaecologists' work environments, their (sub-)specialisations and gender: Female gynaecologists socialised in group practices presented a greater interest in psychosomatics, clearly tended to support the inclusion of women's perspectives, and went beyond a biomedical interpretation of pelvic pain, thus facilitating empowering processes. Male gynaecologists, affiliated to or working in hospital settings with science-based evidence orientation, displayed a greater interest in technical and biomedical aspects, declared to apply standardised diagnostic procedures to exclude physical risks, and understood functional pelvic pain as a sign of psychosocial distress.

Reflections on empowering perspectives

In our study, female gynaecologists expressed that they generate, together with their patients, a comprehensive interpretation of pelvic pain, resonating with what Kristi Malterud has designated as empowering practices (Kirsti Malterud et al., 2004; Kristi Malterud, 1993, 2000). Malterud has

emphasised the responsibility of physicians to share power with patients, as a precondition for giving patients space to voice their perspectives and experiences. This may allow a new understanding of complex symptoms which remain unexplained by a sole biomedical approach. This strategy has also been perceived as valuable to validate the suffering of chronic pelvic pain patients and to help them to find management strategies (McGowan et al., 2007).

Although some emergent perspectives of gynaecologists seemed more apt to realise an empowering approach, each stance towards symptom interpretation may have to deal with some sort of pitfall (Malterud 2000: 607). For example, female gynaecologists from the group practices favoured an individualised stance towards symptom interpretation and management, whereas those from the WHC proposed a social contextualisation. Whereas an individualised stance may allow learning more about a specific woman, it might reinforce that the pain is perceived as a personal failure. In contrast, a social contextualisation may empower women to understand their pain at the crossroads of individual and collective experiences, giving them the opportunity to alleviate feelings of isolation (McGowan et al., 2007; Price et al., 2006). On the other hand, by interpreting stress as the almost single cause of pelvic pain, WHC's physicians might be prone to allocate diverse patients into a uniform group instead of reading symptoms as a result of multiple, complex and interactive causes. Such a 'universalistic trap' (Kristi Malterud, 2000) was also observed in the reasoning largely presented by male gynaecologists, who interpreted pelvic pain as virtually being evoked by an underlying psychosocial illness. However, according to a meta-analysis this attribution seems not to be adequate (McGowan, Clark-Carter, & Pitts, 1998): No matter whether women suffered from organic or non-organic pelvic pain, they showed no significant differences regarding psychosocial characteristics. Thus, male gynaecologists' stance may result in getting caught in a 'psychosocial trap' (Kristi Malterud, 2000).

We agree that gynaecologists' self-reflectivity about their role in knowledge production during medical encounters is a necessity for a 'strong empowering approach' (Aujoulat et al., 2007; Baarts, Tulinius, & Reventlow, 2000; Kristi Malterud, 2000). It may facilitate to become a qualified reader of patients' suffering, to recognise psychosocial conditions and to challenge biomedical exclusivity (Aujoulat et al., 2007; Kirsti Malterud, 2010; Kristi Malterud, 2000). Moreover, solely an inclusive, empowering approach may retrieve information on sexuality, which is relevant in the case of pelvic pain, because it may indicate a history of sexual abuse (MacBride-Stewart & Grace, 2007; Kristi Malterud, 2000; Werner et al., 2003). Surprisingly, the relation between intimate partner violence or sexual abuse and pelvic pain was almost absent in the reasoning of the interviewed gynaecologists, although this association is well established

(Hilden, Sidenius, Langhoff-Roos, Wijma, & Schei, 2003; Lampe et al., 2003; Poleshuck et al., 2005; Randolph & Reddy, 2006; Siedentopf, 2009).

Gender and gynaecologists' socialisations

Previous studies have acknowledged the effect of gender on gynaecologists' communication with patients (Christen et al., 2008; Hall & Roter, 2002; Janssen & Lagro-Janssen, 2012; Kerssens, Bensing, & Andela, 1997; A. M. Van Dulmen & Bensing, 2000), and a recent systematic review has concluded that female gynaecologists show a more patient-centred communication style and are more willing to include patients' perspectives than their male counterparts (Janssen & Lagro-Janssen, 2012). A Dutch study has reported – similarly to our study – that female physicians across all their included care settings were more alike and inclined to include patients personal/social situations than their male colleagues (van den Brink-Muinen, 1998). All the above studies have largely relied on video recordings of medical consultations and thus analysed observed material. However, clinical relationships and the construction of diagnostic evidence include a subjective dimension arising from physicians' attitudes and emotions. Therefore, a switch from a descriptive to a more explanatory mode of understanding may be warranted (Hall, 2003). While our findings resonate with the findings of the above studies on gender and communication in gynaecology, it goes beyond in showing that medical reasoning of gynaecologists relates to their socialisations, producing a complex interaction of gender and professional socialisation.

Joan Acker (Acker 1990) had thematised that the organisational structure of work commonly maintains gender segregation and permeates into (organisational) thinking and work relations. A number of studies have explored interactions between gender and work within the medical profession (Cassell, 1998; Davies, 2003; Eriksson, 2003; Hinze, 1999; Risberg, 2003; Eliane Riska & Wegar, 1993; Elianne Riska, 2001), particularly since the influx of women into medicine – into gynaecology in particular – has, at least numerically, 'feminised' the medical profession (Klea D. Bertakis, 2009; Buddeberg-Fischer, Klaghofer, Abel, & Buddeberg, 2006; Chang, Odrobina, & McIntyre-Seltman, 2010; Schnuth, Vasilenko, Mavis, & Marshall, 2003; R. K. Thomas, 2000). However, women are not evenly spread across the sub-specialisations of gynaecology (Buddeberg-Fischer, 2003). Female gynaecologists currently concentrate more on patient-focused areas, while male gynaecologists rather specialise in surgical and science-oriented areas. Our study mirrors such a gender-stratified social environment within gynaecology, but also suggests that this may re-affect gynaecologists' reasoning and attitudes towards patients. Whereas De Jong (De Jong, 2008) has actually shown that work environments form normative communities which may result in harmonisations of general practitioners'

behaviours, she has not found any evidence that gender might explain such behavioural similarities.

Our findings reveal complex interactions between gynaecologists' work environments, sub-specialisations and gender, which may influence and synchronise their medical reasoning. The interpretations of the vignette showed that the work environment of both the university hospital and the WHC seemed to cause a certain alignment of interpretations, no matter of clinicians' gender (fe/male physicians in the hospital) or medical (sub-)specialisations. However, certain work environments and sub-specialisations within gynaecology apparently were more appealing to either men or women, thereby harmonising their reasoning processes. Men were more inclined to work within single practices and in hospitals or to be affiliated to hospitals, presented a greater interest in technical/science-oriented specialisations, and their reasoning revealed a preference for standardised diagnostics reinforcing their expert position. Women rather choose to work in group practices, were more interested in psychosomatics, were more willing to share power with patients and to interpret symptoms jointly. However, any oversimplifications need to be avoided, as neither female gender nor a psychosomatic sub-specialisation alone guarantees an empowering perspective.

Limitations and strengths

While the objective of qualitative research is not representativeness, we acknowledge the relatively small sample size. Due to this and the Swiss context, we caution to extend conclusions to other settings. The mixed methods approach of the project did not allow for theoretical sampling of gynaecological settings in the qualitative part, because we needed to identify these prior to collect the quantitative health data of respective patients. This trade-off is intrinsic to mixed methods approaches (Creswell, 2003b; Teddlie & Yu, 2007). However, maximum variety sampling served the project purpose well, as it allowed identifying a diverse mix of gynaecological settings.

Limitations are offset by several strengths. Rigor was assured through acknowledged measures. We are able to stress a high internal validity of data, as analysis exposed great consistency. The generation of included gynaecologists is most appropriate for research on differences in current gynaecological care, because they have been exposed to the range of care approaches practiced between 1985 and 2000 (Whelan, 2009).

5.6 Conclusion

Our study's findings show how the complex socialisations of gynaecologists (through sub-specialisations, work environments, gender) influence their medical reasoning. While primarily

female gynaecologists, socialised in group practices, revealed more pronounced empowerment strategies than male gynaecologists, their approaches differed between taking an individual stance and linking the individual experience to the social circumstances of women with chronic pelvic pain. Whereas empowering approaches have not been clearly defined but considered crucial for women with chronic pelvic pain to alleviate suffering and to find ways to live with the condition, physicians' self-reflexivity is viewed as a precondition for their implementation. While the integration of psychosomatic training in the curriculum for training in gynaecology/obstetrics in 2002 in Switzerland marks a step in this direction (Tschudin et al., 2013), it might not be sufficient to consolidate self-reflective approaches. Thus, advanced postgraduate training courses in self-reflective, empowering approaches are recommended.

6 Variations in relational aspects of (shared) decision-making

Article 2: *Understanding relational aspects of shared decision-making in gynaecology: A qualitative analysis of patients' and physicians' perspectives as well as clinical consultations*

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6.1 Abstract

Rationale, aims and objectives:

Following increased interest in the complexity of relational aspects of shared decision-making, this study traces the meanings and practices of the ways decisions are shared in clinical encounters within gynaecology.

Methods:

Guided by grounded theory, we analysed semi-structured interviews with 18 patients and 11 physicians as well as 33 observed consultations from six gynaecological outpatient care settings, selected by maximum variety sampling in the Basel area of Switzerland.

Results:

The results show how clinicians and patients co-produce different meanings and practices regarding decision-making across various care settings. Although female and male clinicians equally engaged in reciprocal bonds with patients in the decision-making process, the nature of these bonds differed and patients attributed gendered and different emotional meanings to decision-making. Shared decision-making was only advocated in female physician/female patient constellations, grounded in 'being in reciprocal exchange' due to sameness in gender and displayed as a means for creating closeness, empathy and support. In male physician/female patient constellations, the reciprocal bond was constructed upon unequal distribution of medical knowledge with patients favouring direct medical advice. However, whether patients felt supported in decision-making processes rather seemed to depend upon the continuity of clinical relationships than on the decision-making practices or care setting.

Conclusion:

By integrating different perspectives, insights into the complexity of relational aspects of SDM in gynaecology were obtained. Emotional meanings and practices of SDM differ according to gender constellations, care settings and continuity of clinical relationships.

Key words

Clinical relationship, empathy, gender congruence, gynaecology, medical knowledge, medical professionalism, patient perspectives, person-centered healthcare, physician perspectives, qualitative methods, reciprocal bonding, shared decision-making, support, Switzerland

6.2 Introduction

Shared decision-making (SDM) is promoted as part of a patient-centered approach to physician-patient relationships (Bensing, Rimondini, & Visser, 2013; de Haes, 2006; Joseph-Williams, Elwyn, & Edwards, 2013; Wensing et al., 2002). Recent concepts of SDM emphasize the merging of physicians' knowledge and patients' preferences, distinguishing it from paternalistic and informed decision-making models (Entwistle & Watt, 2006; Entwistle, 2009). Despite numerous endeavours to conceptualise SDM (Cribb & Entwistle, 2011; G Elwyn, Edwards, et al., 2000; Glen Elwyn et al., 1999; Entwistle, 2009; Wensing et al., 2002), it remains not fully clear how it is contextualised and practiced: Whereas some researchers link it to the patient-centred element inherent in 'identifying common ground' which requires physicians to understand patients' illness experience (Bensing et al., 2013; Joseph-Williams et al., 2013; Stevenson, Barry, Britten, Barber, & Bradley, 2000), others understand SDM as a more rational model related to evidence-based medicine which necessitates physicians to discuss the available evidence and give options to patients whose preferences are accordingly incorporated (Legare et al., 2011; Wensing et al., 2002).

Previous research on SDM has been criticized for relying on unitary data sources such as consultation recordings or preference scales and being overly focused on the moment of decision-making alone and measuring patient involvement (Entwistle, 2009; Matthias et al., 2013). These studies have drawn attention to SDM's relational and affective aspects (Entwistle, 2009; Matthias et al., 2013) of which little is known: it is not clear what SDM means for physicians and patients or how the process of SDM indeed is practiced in clinical work (Bensing et al., 2013; Britten, 2011; Edwards, Davies, & Edwards, 2009; Hall, 2003). The complexity of such aspects in clinical relationships are best studied through an integrative approach which combines physician's and patients' interview perspectives with observation of consultations (Katz & Alegría, 2009; Mead et al., 2002; Mead & Bower, 2000b; Salmon et al., 2011; Salmon & Young, 2009; Zandbelt, Smets, Oort, Godfried, & De Haes, 2004; Zoppi & Epstein, 2002). However, only a few studies applying such a complex analytic approach towards clinical relationships and medical communication have been conducted (Beckett, Elliott, Richardson, & Mangione-Smith, 2009; Mead et al., 2002; Mendick, Young, Holcombe, & Salmon, 2010; Salmon et al., 2011) and even less such studies have been realized regarding SDM specifically (Lown, Clark, & Hanson, 2009; Nguyen et al., 2014; Saba et al., 2006; Stirling et al., 2012).

The relevance of SDM is widely acknowledged for primary care (Berger, Braehler, & Ernst, 2012; G Elwyn, Edwards, et al., 2000; Glen Elwyn et al., 1999; Entwistle & Watt, 2006; Müller-Engelmann, Keller, Donner-Banzhoff, & Krones, 2011; Stevenson et al., 2000), a field where physicians may not have a clear preferences about the treatment choice or where psychosocial complaints are regularly addressed (Davidsen, 2009; Glen Elwyn et al., 1999).

In these balanced situations, SDM should be applied (G Elwyn, Edwards, et al., 2000; Wensing et al., 2002). These situations are equally common in gynaecology, where patients are often healthy women consulting on contraception, preventive issues or minor health conditions. However, apart from genetic counselling (G Elwyn, Gray, et al., 2000; Rantanen et al., 2008), only few studies have investigated SDM in gynaecology (Dehlendorf, Diedrich, Drey, Postone, & Steinauer, 2010; Hoffmann, Lindh-Astrand, Ahlner, Hammar, & Kjellgren, 2005; This & Panel, 2010).

This study therefore aims to provide insight into the meanings and practices of the ways decisions are shared in clinical relationships within the field of gynaecology, paying attention to how relational aspects emerge. The findings presented are based on an integration of a) semi-structured interviews with physicians and b) their patients as well as c) participant observation of clinical consultations,

6.3 Methods

This paper reports on the qualitative part of the mixed methods project "Women and Gynaecology in Evaluation" (WAGE), funded by the Swiss National Science Foundation (SNF No. 32003B-121358). The qualitative part explored differences in gynaecologists' working approaches across various outpatient care settings from which patients' quantitative health data was collected. Six different gynaecological outpatient care settings in the Basel area (Switzerland) were selected prior to data collection by maximum variety sampling to maximize heterogeneity in gynaecological approaches, thereby allowing to trace their similarities and differences (Teddlie & Yu, 2007). Settings included: (a) the outpatient department of the university women's clinic; (b) four privately run gynaecological practices with varying sub-specializations; and (c) one women's health centre (WHC) born out of the women's health movement of the 1980s.

Conceptual framework and study design

Medical care concepts that influence contemporary gynaecology, such as patient-centeredness (de Haes, 2006; Mead & Bower, 2000b; Rademakers et al., 2012), gender (Klea D. Bertakis, 2009; Carnes, 2010; Christen et al., 2008; Davies, 2003; Elianne Riska, 2001; van den Brink-Muinen, 1998), women's health care (B. A. Bean-Mayberry et al., 2007; Van Den Brink-Muinen, 1997; van den Brink-Muinen, 1998; Zobrist, 2005) and various decision-making models (Charles et al., 1997; Glen Elwyn et al., 1999; Entwistle, 2009; Mast, 2004; van den Brink-Muinen, 1998; Wensing et al., 2002), served as 'sensitizing concepts' (Bowen, 2006; Charmaz, 2006) and helped to design data collection tools. This approach is consistent with Kathy Charmaz' constructionist grounded theory, which is rooted in symbolic interactionism (Charmaz, 2006). This theory thereby elucidates how behaviours and

meanings arise from social processes (Charmaz, 2006; Sandstorm et al., 2003) and is in line with the study's focus on relational aspects of SDM in clinical consultations.

Data collection

The present study analyses SDM from a variety of integrated data sources. The data was collected after the ethical approval by the Ethics Committee of Basel (Nr. EK265/09) in 2009 and encompassed: (a) semi-structured interviews with clinicians and (b) patients as well as (c) participant observation of clinical consultations. It was gathered by BS, a social scientist experienced in qualitative research and with a background in human medicine.

Interviews with clinicians were completed between August 2011 and March 2012. They lasted up to 90 minutes. Interviews were conducted in practices outside opening hours. They concentrated on physicians' specialization, women's concerns, working approaches and significant influences on the latter. Interviews with patients were collected during 2012 and lasted about 45 minutes. Patients were entitled to select interview locations. Interviews focused on choice of gynaecologist, patient's expectations and experiences of clinical consultations. All interviews were semi-structured and open-ended, with an open, final part to pursue emergent themes. Interviews were adjusted to interview dynamics. They were audio-recorded and transcribed into (Standard) German.

Participant observation was conducted during August/September 2011. Only one patient refused to participate owing to her high social status. The observer sat next to the consultation desk, but did not intervene with only one exception, when a WHC physician asked her to share experiences with a patient. This request was consistent with the WHC's care approach, which assumes that healthy women do not necessarily need to be consulted by medical specialists (Zobrist, 2005). All observations were recorded using a topic guide, which compiled decision-making details such as conversational openings, exploration of concerns, actions taken, diagnosis, options and decision-making processes.

Sampling and participants

Maximum variety sampling was used to select the six selected outpatient gynaecological care settings (see table 4, p.57), which differ in services offered, organisational aspects, and gender of gynaecologist

Table 4: Characteristics of gynaecological care settings and overview of interviewed clinicians and participant observation

Setting	WHC Women's health centre	H Outpatient department, University women's clinic	P1 Joint practice	P2 Single practice	P3 Joint practice	P4 Single practice
Year of opening	1980	1960s	1992	1989	1991	1996
Number of care providers (number of board-certified gynaecologists)	9 (1) includes 4 expert women	Approximately 60, in different stages of professional education (Approximately 30)	2 (2)	1 (1)	2 (2)	1 (1)
Sex of care providers	Female	Female/male distribution approximately 85%/15%	Female	Male	Female	Male
Approximate number of patients per year	5.900	41.000	4.200	4.000	5.600	3.800
Services offered beyond general gynaecology	Integrated care, psychosocial approaches	Colposcopy, psychosomatics, antenatal care, endocrinology, infertility, urogynaecology, senology, gynaecological oncology	Surgery, infertility, obstetrics (no delivery assistance); psychosomatics, sexual medicine, children's gynaecology	Obstetrics, surgery, infertility	Endocrinology, infertility, psychosomatics, care of oncological patients, difficult pregnancies, crises-intervention, diet counselling	Obstetrics, prenatal/feto-maternal medicine, surgery
Number and sex of interviewed physicians (expert women)	2(3) All female	2 One female, one male	1 Female	1 Male	1 Female	1 Male
Identifiers of interviewed physicians (expert women)	PhyWHC1-2 (ExWHC3-5)	PhyH1-2	PhyP1	PhyP2	PhyP3	PhyP4
Number of observed consultations	6	5	5	6	6	5
Identifiers of observed consultations	Obs1-Obs6WHC	Obs1-Obs5H	Obs1-Obs5P1	Obs1-Obs6P2	Obs1-Obs6P3	Obs1-Obs5P4

We conducted 11 semi-structured interviews with clinicians (see forthcoming paper by Schwind et al. 2015). Because of the university hospital's and the WHC's complex working environments, we purposefully sampled 2physicians per setting. To account for the particularities of the WHC, 3 expert women were sampled. They were qualified in midwifery, naturopathy and psychotherapy. To provide basic gynaecological services they were trained by the centre's physicians so that they are able to also consult patients alongside gynaecologists. This is an approach particular to the WHC to reduce physician-patient distance, as they are considered specialists in 'normal' women's health affairs (Broom, 1998; J. E. Thomas & Zimmerman, 2007; Van Den Brink-Muinen, 1997; van den Brink-Muinen, 1998; Zobrist, 2005). Because female gynaecologists' and expert women's perspectives emerged as being alike, we decided to include them. Also, an understanding of the WHC's working approach would not have been represented without them.

Overall, 8 medical doctors and 3 expert women were interviewed (see table 4, p.57); 8 were women and 3 were men. All but two clinicians were board-certified gynaecologists. The two exceptions were: First, one female clinician who is working at the WHC. She has been trained in gynaecology, but has not completed the gynaecological curriculum required for being board-certified; second, the female assistant doctor who is working at the university hospital and was undergoing the gynaecologic training curriculum during data collection. All clinicians, but the assistant doctor, gained their first work experiences during the 1980s. This is due to the overall project design, which required settings to be operational for at least ten years because of the study's interest in long-term patients.

For patient interviews, we selected three patients per setting based on criteria regarding educational background, life phases (e.g. pre/post-menopausal) and relationship status. Overall, 18 patients were interviewed. Patient characteristics are shown in table 5, p.59.

Table 5: Overview of interviewed patients across gynaecological settings

Setting	WHC Women's health centre	H Outpatient department, university women's clinic	P1 Joint practice	P2 Single practice	P3 Joint practice	P4 Single practice
No. of interviewed patients	3	3	3	3	3	3
Age of interviewed patients (range)	26-56	24-78	25-65	26-no data	26-70	37-61
No. of interviewed patients in menopause	1	1	1	1	1	1
No. of interviewed patients in partnership/marriage	2	2	3	1	2	2
No. of interviewed patients with university degree	1	0	2	0	1	1
Patients' identifiers	Pat1-Pat3WHC	Pat1-Pat3H	Pat1-Pat3P1	Pat1-Pat3P2	Pat1-Pat3P3	Pat1

Only two patients at the university's women's clinic expressed health concerns. It was considered indicative of higher care levels.

Participant observation took place during an ordinary morning in each gynaecological setting. Because WHC consultations lasted 40 minutes, almost twice as long as in other settings, 2 mornings were required. Data was recorded for every second consultation, following the observed consultation. In the afternoons field notes were reviewed. Thirty-three consultations were observed across settings. Two out of 6 observed consultations at the WHC were completed by expert women. For further details see table 5, p.59.

All study participants gave informed consent preceding data collection. They were informed of their right to withdraw and were assured of confidentiality. Observed consultations and interviews were anonymized.

Data analysis

Data was imported into Atlas.ti (Version 6.2). Analysis followed Kathy Charmaz's constructionist grounded theory (Charmaz & Belgrave, 2012; Charmaz, 2006). Its contrasting principles are most suited to research similarities and differences (Charmaz & Belgrave, 2012; Charmaz, 2006; Teddlie & Yu, 2007). Thus, a constant comparative method was applied when reviewing data line-by-line; employing open coding and writing memos on arising ideas. In the process, a set of focused codes emerged (Bowen, 2006; Charmaz, 2006). Four study group members (BS, KG, NW, and EZ) with different educational backgrounds (medicine, epidemiology, social science, medical anthropology) and experience in qualitative research read transcripts individually. During weekly, face-to-face meetings each transcript was jointly interpreted and contrasted with other transcripts to gain an in-depth understanding of the data. The analysis followed an integrative approach inspired by the works of Salmon et al. (Salmon et al., 2011) whereby clinical relationships can be studied from differing perspectives to identify novel ways of conceptualizing and understanding it. This approach allowed us to follow different, interlinked strands of analyses to deal with challenges caused by integrating multi-level data: First, cross-setting analyses enclosed the 3 different perspectives of a) interviews with clinicians and b) patients as well as c) observed clinical consultations. Each of the 3 perspectives formed a unit of analyses, which permitted to assess how each side constructed the clinical relationship regarding decision-making and how these units related to each other. Second, within setting, integrative analyses: The units of analyses were the selected gynaecological settings and how respective physicians and patients viewed decision-making processes in clinical consultations. We used an iterative analysis to identify possible discrepancies and convergences between data types. The threads were then integrated and the group members engaged in the analysis consensually established final categories. At least 2 team members were present at all meetings to

validate findings. Data saturation was achieved with the initial sample due to the re-occurrence of the variations within the emergent categories such as closeness/distance in physician-patient relationships, women-centred strategies to examination, physician-patient conversations, decision-making and therapies. If saturation had not have been achieved with the original sample, we would have collected more data.

Ensuring rigor

Rigor was ensured by numerous measures. A self-reflective journal was kept, which contributed to a better understanding of interviews and observed consultations during data analysis (Morrow, 2005). While conducting interviews, BS reframed questions and paraphrased participants' responses to ensure member checks, consequently enhancing the study's validity (Krefting, 1991). Study researchers come from different disciplines and are experienced qualitative researchers. Thus, they were able to conceptualise large amounts of qualitative data and apply a multidisciplinary approach to analysis (Krefting, 1991). Triangulating different data methods and participant perspectives (Bowen, 2006; Krefting, 1991; Shenton, 2004) further validated the findings. These were presented to the gynaecologists in April 2013. They confirmed that the data reflected their care approaches.

6.4 Results

The first round of data interpretation presented a spectrum of decision-making practices. Whereas male and hospital based doctors rather gave direct biomedical advice without including patients' perspective, female clinicians' presented a more egalitarian relationship through investigating the perceptions of patients and sharing decisions.

Further analysis, however, revealed a more multifaceted picture. Physicians' and patients' accounts overall converged with observed consultations regarding the range of decision-making approaches, but the way patients made sense of the experienced relationship and decision-making differed. Their accounts showed a greater emphasis on emotional and relational aspects of decision-making processes compared to physicians' perspectives. To demonstrate these patterns across included gynaecological care settings, findings are organized according to the patients' own words (see table 6, p.62): (a) "It's a huge enterprise – but I felt treated with consideration"; (b) "In the hands of a professional and competent woman"; (c) "He has technical knowledge and patients do not".

Table 6: Overview of the three emergent perspectives across gynaecological settings

Setting	WHC Women's health centre	H Outpatient department, university women's clinic	P1 Joint practice	P2 Single practice	P3 Joint practice	P4 Single practice
The 3 emergent perspectives	2 In the hands of a professional and competent woman	1 It's a huge enterprise - but I felt treated with consideration	2 In the hands of a professional and competent woman	3 He has technical knowledge, patients do not	2 In the hands of a professional and competent woman	3 He has technical knowledge, patients do not

For each of the three perspectives, we first outline the way decision-making was presented in the views of the physicians and observed consultations. Based on this, the patients' perspective is illustrated.

"It's a huge enterprise – but I felt treated with consideration"

Patients and gynaecologists of the outpatient department of the university's women clinic followed this outlook. The accounts of physicians displayed implicit and explicit aspects of patient-centeredness. One assistant doctor spoke about her approach towards patients as 'counselling in the sense of a conversation' and 'not giving advice' (PhyH1). She tacitly underpinned her perspective with ideas of patient-centeredness aiming at building a more partnership- and dialogue-based relationship:

"I…try to learn how women are doing without immediately focusing on the gynaecological dimension…I seek to pass on authenticity and autonomy…the way you appear conveys trust and confidence" (PhyH1).

Her view thereby exposed a less biomedically focused approach as a means for building a trusting relationship with patients. Although the hospital physicians interviewed expressed a preference in a more egalitarian relationship, they agreed that the hospital's organizational demands would restrain them from following such an approach:

"The sequence of 20 minutes long consultations makes it difficult to accommodate everything one desires. It is already difficult to include what is medically necessary." (PhyH1), and

"Regular implementation of patient-centeredness fails due to the daily routine…the capacities…are used up addressing the…[disease-oriented] dimensions alone…" (PhyH2).

Accordingly, observed consultations diverged from the underpinned ideal presented in physicians' interviews of a more egalitarian relationship facilitating sharing decisions. Instead, they displayed disease-oriented approaches with physicians' controlling information and decision-making, while personal and emotional concerns of patients were absent from the dialogues (see table 7, p.64).

Table 7: Details on observed consultations across the three identified perspectives

	1	2	3
The three perspectives	It's a huge enterprise – but I felt treated with consideration	In the hands of a professional and competent woman	He has technical knowledge, patients do not
Included settings	H	WHC, P1, P3	P2, P4
Details on observed consultations	Consultations were with no exception opened by closed ended questions such as: "You are coming because of your medical results…" (Obs4H) or "I saw that you came due to problems urinating…". No room was given for going beyond a biomedical perspective. Patients answered physicians' questions accordingly and received biomedical explanations upon inquiry. Their personal experiences and perspectives were not investigated. Medical advice was given based upon medical results alone. This perspective is exemplified by the consultation (Obs5H) with a patient in her early 40s with increased prolactin levels. In the course of the consultation the patient indicated concerns regarding early menopause which the physician explained from a biomedical perspective without investigating the patient's worries any further, segueing seamlessly into diagnostic and therapeutically advice: Physician: "You come because of your increased prolactin levels…." Patient: "My gynaecologist did find these…" Physician: "Did you experience dizziness?...or a headache?" Patient: "No. Could the increased prolactin levels cause early menopause?" The clinician explained that pituitary hormones influence ovarian hormone production, causing menopausal-like symptoms, but that based on her age she could not be in proper menopause: Physician: "You should take an antagonist. You only need to take it once a week. I recommend an MRT to clarify whether an adenoma might be the reason…"	Consultations were systematically opened by inviting patients to control agendas "How are you doing?", (Obs2WHC); or "What can I do for you today?", (Obs2P3). Patients in turn controlled the structure and content of conversation, whereas clinicians rather mirrored their concerns, now and then introducing options which patients were given room to reflect upon and to refuse. This kind of interaction wherein clinicians and women follow each other is well displayed by the case of a timid, young woman who asked for a follow-up pill prescription, although she had previously had unprotected intercourse (Obs4P1): Physician: "Do you have the same partner?" Patient: "At the moment I have no partner." Physician: "If you want, it is possible to take an HIV Test." Patient: [shaking her head negatively] Physician: "Ok. How is your nausea…?"	The approaches towards consultations and decision-making between the two male clinicians differed. Physician Phy2 controlled decision-making, although he regularly opened consultations by private conversations addressing topics such as holidays and children. Although he built personal relationship with patients, he exhibited a biomedical perspective and gave direct medical advice which did not integrate patients' illness experiences. His controlling approach towards decision-making is exemplified by a conversation with a menopausal woman seeking preventive care (Obs2P2): Physician: "When was the last mammography? I recommend one, so that you do not worry." Patient: "Ok…" Physician: "I give you a referral letter for mammography – you have nothing – I just want it in cold print…take the chance" Patient: "I am going to get an appointment…" In this consultation he advised mammography by implicitly assuming the patient's anxiety and in turn explicitly taking over an ensuring position. PhyP4 in contrast systematically opened conversations by asking in one breath "How are you doing? Have you been sick last year?". Therewith he delimited patients' conversational room and in the course continued to exhibit a disease-oriented, but more consumerist approach towards decision-making. This is illustrated by a woman with enlarged myomas to whom the same gynaecologist said: "The choice is yours. The sole reason for operating [myomas] is to relieve your suffering; there are no other reasons.", (Obs5P4).

Patients' accounts regarding decision-making consistently converged with observations. They displayed to have received direct medical advice:

"There was only one therapeutic choice." (Pat1H) and

"She explains…what you need to take…which I must take now" (Pat2H).

Their interview transcripts did not indicate any inclusion of their personal perspectives, but explicitly showed reception of medical information, which they seemingly perceived as insufficient. As patient PatH1 explained her worries:

"Without my training in nursing, the information would have been swift and short,…too superficial." (PatH1).

One patient perspective diverged, as she felt having had choice:

"The birth control counselling was good and I could decide." (Pat3H).

This patient was a healthy women in her 20s who accessed the clinic for her annual preventive check-up, whereas the others expressed health concerns:

"I discovered a lump in my breast and went straight to the clinic, because I know the breast centre is good… and my gynaecologist would have referred me anyway." (Pat1H).

The other patient accessed the emergency clinic due to a painful salpingitis many years ago and turned into a long-term patient, because she developed breast cancer in the meantime:

"I stayed at the university women's clinic [because of the breast cancer]…The irradiation therapy was conducted in the clinic and everything was combined in one house" (Pat2H).

These patients based their choice of the clinic on their perceived severity of health concerns and their perception of the clinic's expertise as going beyond the know-how of a single gynaecologist. Although seemingly feeling comforted by the clinic's comprehensive biomedical expertise, patients displayed to prefer continual clinical relationships in private practices:

"Of course [you see] so many different physicians, they change again and again. In a private practice you see the same practitioner…which I prefer."(Pat1H) and

"It is a little impersonal, each time you see another gynaecologist." (Pat3H).

Patients described the experienced temporal and impersonal clinical relationships as:

"They try hard and are friendly" (Pat2H),

"Pleasant, friendly and simply professional (Pat3H) and

"The patient is left to her own fate. This is difficult." (Pat1H).

Therewith, patients stressed the rather friendly yet distanced character of temporary clinical relationships, while linking it to 'being professional' but causing feelings of aloofness and loneliness. Patients thus overall did not indicate an emotionally supportive relationship.

"In the hands of a professional and competent woman"

This perspective was followed in continuing clinical relationships and when gynaecologists and patients both were women. In physicians' interviews the aspect of 'being in reciprocal exchange' with patients emerged as the prominent feature of the clinical relationship regarding decision-making. This was expressed in clinicians' accounts:

"With what I know and due to my experience, I can frame the concerns of women…she has a viewpoint and I have mine – which we discuss mutually" (PhyP1) and

"She comes to me with a wish and I can offer the way I am, how I examine, what I can provide – thus, something shared, mutual arises" (ExWHC5).

Two features defined their perception 'being in interactive relation': First, their accounts emphasized their individuality and professionalism as a candid framework for decision-making processes. Second, their sense of decision-making was displayed as a partnership-based and dialogic process between 2 individuals being in relation and discussion whereby a decision is implicitly evolving. The reading of consultation data converged with physicians' perspectives and showed reciprocal dialogue, the inclusion of patients' perspectives and joint decision-making (see table 7, p.64).

Patients' accounts reflected the dialogic and partnership-based decision-making processes whereby they equally presented an emphasis on 'being in reciprocal exchange':

"There is room for…a dialogue…" (Pat2WHC),

"I can think something through and bring in my thoughts…without being dismissed" (Pat3P3); and

"We discussed it…she responded to my problem" (Pat1P1).

Indeed, 'being in reciprocal exchange' with clinicians' regarding decision-making was being of emotional importance to patients:

"I never felt that she decided…she is supporting me and then it is clear…" (Pat1P1),

"[She is] not manipulative…her opinion is…not directly evident" (Pat1P3) and

"There are answers to my questions and offers…She does not tell you what to do…" (Pat3WHC).

Therefore, having the possibility to bring in thoughts and discuss issues during medical encounters enabled patients with regard to 2 aspects: They expressed to feel supported by their clinical relationships, while also being in control of their own decision-making processes. These patients also displayed feelings of rejection regarding more direct medical advice:

"I would dislike, if she would coax me into doing something" (Pat1P3).

We noticed patients' antipathy toward more hierarchical clinical relationships which they linked to direct exertion of influence on their own health decisions. In common with physicians, patients ascribed meanings to their clinical relationship which went beyond physicians' medical professionalism:

"I feel like being in the hands of a competent and professional woman" (Pat3P3); "I wanted to share my concerns with a woman" (Pat2P1);

"I wanted to share my concerns with a woman" (Pat2P1) and

"Could a male gynaecologist empathize with a woman?" (Pat1P3).

Patients of female gynaecologists explicitly interlaced 'being in reciprocal exchange' with female physicians' professionalism as well as the joint experience of 'being a woman'. Their accounts showed that both professionalism and sameness in female gender were perceived as reasons for their feelings of support and empathy, while also being a mean for emphasizing parity within the clinical relationship.

"He has technical knowledge, patients do not"

This position was followed in continuing clinical relationships wherein gynaecologists were men and patients were women. By contrast with female gynaecologists, male medical doctors described their position as medical experts as key to their sense of decision-making:

"In daily routine, e.g.…vaginal dryness – I have a schema which…women understand…If explained, they take the vaginal tablet" (PhyP2);

"We have some latitude…who says there should be a check-up annually…patients should know their dis-/advantages and do it as they want" (PhyP4) and

"The aim is to respond to consumers, it is a service and we have customers" (PhyP4).

Therefore, clinicians portrayed themselves as actively managing the clinical relationship, but their decision-making approach explicitly differed, as did the relational aspects assigned: Physician PhyP2 argued to use decision aids which would make patients follow his expert advice and portrayed the clinical relationship as an unequal encounter between medical expert

and compliant patient. In contrast, physician PhyP4 displayed his expert position a determining his leeway for decision-making wherein he represented himself as being reactive towards patients' needs. Therefore, simply acting upon a medical expert position does not necessarily mean an apprehension of decision-making as direct medical advice. Consultation data mirrored the physicians' differing approaches towards decision-making in clinical relationships (see table 7, p.64).

All patients of the male clinicians explicitly pronounced the importance of physicians' medical competence:

"He has technical knowledge, patients do not" (Pat1P2) and

"Reputation corresponds with professionalism" (Pat1P4).

Patients thus consistently communicated the importance of medical professionalism and physicians' expert status which in turn was represented as a tool for explicitly attributing the physician a higher position within the clinical relationship. And, patients openly displayed a preference for professionals exposing medical knowledge and giving advice:

"I really like it when the gynaecologist reveals his position" (Pat2P4).

The way patients displayed decision-making in clinical relationships differed in accordance with the different practices physicians revealed in their accounts and consultations. The patients of the more directing physician PhyP2 valued his decisiveness:

"My gynaecologist is straightforward…it simply is well" (Pat3P2) and

"He has a swift…solution" (Pat1P2).

With this they displayed that the physician fulfilled their preferred role in providing directive decision-making by which they felt supported. In contrast, the patients of physician PhyP4 who presented a consumerist decision-making style emphasized the physician's quiet and restrained character:

"He seemed a bit unapproachable…I feel like having to tear the answers out of him..." (Pat1P4) and

"It could be easier if he would be less reserved…" (Pat2P4).

Thereby, his patients explicitly linked feelings of disconnectedness to his approach and openly confirmed to experience a sense of difficulty when having control over decision-makings. This made his patients reflect about whether a clinical relationship with a female gynaecologist might solve their hesitations:

"He is someone timid…sometimes I think it could be easier with a woman" (Pat1P4) and

"I am missing the aspect of what it means for me as a woman…for my body" (Pat2P4).

Patients therefore escaped the experienced paradox of wanting medical advice but not receiving it by openly considering whether a clinical relationship with a female gynaecologist would be more beneficial for them. They thus equally indicated that a female physician/female patient relationship in gynaecology might produce emotional feelings of closeness and the inclusion of what decisions mean for women, their bodies and womanhood.

6.5 Discussion

We examined the relational aspects of SDM in clinical relationships through a comprehensive integration of clinicians' and patients' perspectives, complemented by clinical consultations. The first round of data interpretation presented a picture which seemed to resemble previous evidence that female gynaecologists are doing better than their male counterparts in building clinical relationships through integrating patients' perspectives and sharing decisions (Christen et al., 2008; Janssen & Lagro-Janssen, 2012). However, further analysis revealed that female and male gynaecologists equally engage in reciprocal bonds with their patients regarding decision-making, yet the nature of these conjointly produced clinical relations and patients' attributed emotional meanings regarding decision-making essentially differed. These differences can best be understood by recognising that female patients differed in what made them feel supported when engaging with female and male gynaecologists, thereby carefully exposing the gendered meanings of decision-making processes in clinical relationships inside private outpatient practices. The importance of continuing clinical relationships for feeling supported in decision-making processes was further emphasized by the findings in the clinic's context: Although patients apprehended the medical advice as reasonable due to the (perceived) severity of their health status they did feel alone due to the temporary nature of clinical relationships experienced.

There is previous evidence that clinicians' perspectives on physician-patient relationships converge with observed consultations (Levinson & Roter, 1995; Street, Gordon, & Haidet, 2007; Young et al., 2011), whereas patient's perspectives regarding the clinical relationship have shown to deviate from the latter (Young et al., 2011). This differs from our study wherein clinicians' and patients' interviews converged with observed consultations regarding decision-making in great accordance with the identified perspectives. However, the emotional meanings patients attributed to decision-making processes essentially differed. Female physician/female patient relationships advocated SDM, but made sense of this experience by portraying 'being in

reciprocal exchange' based upon medical professionalism and sameness in female gender. This, in turn created feelings of support, empathy and parity regarding decision-making within patients' accounts. On the other hand, in clinical relationships of different gender constellations (male physician and female patient) the reciprocal bond was constructed upon the unequal distribution of medical knowledge with patients favouring direct medical advice. Only when receiving a direct solution these patients felt supported by their experienced clinical relationships, else they expressed feelings of disconnectedness. Consecutively, this made them consider engaging with a female gynaecologist whom they portrayed as possibly establishing a closer and more empathetic clinical relation. Our findings thereby approximate those of a review by Mast (Mast, 2004) showing that female physicians behave in a gender congruent way when expressing a participatory counselling style, while male physicians act accordingly when using a paternalistic decision-making approach. Contrary to discussions that male physicians might have some leeway in changing their gendered behaviours (Mast, 2004; Schmid Mast, Hall, & Roter, 2007), our findings however indicate that it might be important for male gynaecologists to act in a gender congruent way by controlling decisions.

The importance of continuing clinical relations for making patients feel supported was further uncovered within the clinic's context. Although patients actively sought care from the clinic and presented the medical advice received as reasonable, the temporal clinical relationships made them feel aloof and alone. Although this reverberates with studies insofar that these emphasize that patients with severe illnesses favour direct medical advice (Butow, Maclean, Dunn, Tattersall, & Boyer, 1997; Mendick et al., 2010; Vogel, Helmes, & Hasenburg, 2008), our study indicates that such patients might feel less supported and cared for because of the clinic's temporal physician-patient relationships which might be unable to create reciprocal understandings due to their temporal limitation. This reflects the findings of the study by Murray et al. (Murray, Pollack, White, & Lo, 2007a) which emphasised the importance of on-going physician-patient relationships for establishing preferred decision-making processes.

Towards a more comprehensive understanding of SDM in clinical practice

Scientists have implicated the relevance of integrating different data sources to better understand the complexity of clinical relationships (Mead & Bower, 2000b; Salmon et al., 2011; Young et al., 2011), while researchers focusing on SDM have recently advocated to broaden the concept by drawing attention to its relational and affective aspects (Entwistle, 2009; Matthias et al., 2013). Our study fruitfully combines both perspectives and the findings reflect the critical importance of triangulating data sources to generate a broader understanding of what SDM means to physicians and patients. As a result, the present study is to our knowledge among the

first to explore SDM beyond one-sided approaches such as patients' preferences and characteristics as well as competences when researching SDM.

As our study highlights the importance of gendered and emotional meanings regarding SDM in gynaecology, it certainly warrants the need for further research on gender and decision-making practices in this particular medical field, especially since the overall relevance of gender regarding clinical interaction in gynaecology has been acknowledged (Christen et al., 2008; Galasiński & Ziółkowska, 2007; Janssen & Lagro-Janssen, 2012; Uskul & Ahmad, 2003). Possible interventions could address the identified entry points to SDM in gynaecology which were of significance for clinicians and patients alike, while opening up a discourse on what kind of relational meanings might impede the sharing of decisions. However, such an approach does not resolve the existing tensions between the ethical aspects of SDM promotion and the complexities of everyday clinical practice (Cribb & Entwistle, 2011; Joseph-Williams et al., 2013): Should male and female physicians and their patients both be pressed to change according to the SDM ideal? How would such a change alter the emotional and gendered meanings which seemingly evolve from clinical encounters? Would meanings arising from SDM practices differ between the diverse medical fields and depending on clinical situations?

Limitations and strengths

We acknowledge several limitations. Although representativeness is not the objective of qualitative research, we recognize the relatively small sample size. Therefore and because of the Swiss context, comparisons with other countries should be made cautiously. The mixed methods approach of the WAGE project did not allow for theoretical sampling of gynaecological settings, which were selected by maximum variety sampling instead. Yet, this approach allowed identifying a diverse mix of gynaecological approaches and was the only way to realize a future association between the qualitative and the quantitative part. This trade-off, however, is intrinsic to mixed methods approaches (Creswell, 2003b; Teddlie & Yu, 2007).

These limitations are offset by several strengths. Rigor was established through various measures. Internal validity is high, as data analysis showed great consistency between interviews and observations. The findings of this qualitative study partly refer back to a previous analysis of WAGE data: The quantitative analysis indicated that male sex of included gynaecologists was associated with discordance between patients and physicians concerning reasons for actions taken (Gross, Schindler, Grize, Schwind, & Zemp, 2013). The findings were reasoned to possibly depend on male clinicians' working approaches. As patients are women in gynaecology, some researchers consider this to be a limitation to the study, as they think that the gendered results may be attributable to patient gender and gender concordance with female

gynaecologists no matter whether male gynaecologists might equally communicate in a patient-centred way (Christen et al., 2008). We view this as a strength which allows exploring the particularities of this field. The generation of gynaecologists included is appropriate for researching differences in contemporary gynaecological care, because they have been exposed to the explosion of care approaches between 1985 and 2000, which oscillated between evidence- and experience-based care approaches (Whelan, 2009).

6.6 Conclusion

Our study fills an important gap by integrating different data sources to give insight into relational aspects of SDM in gynaecology. The qualitative analysis showed that clinicians and patients coproduce different meanings and practices regarding the decision-making process across different care contexts. Our findings revealed the gendered and emotional meanings of decision-making in clinical relationships in gynaecological consultations: Female and male gynaecologists equally engaged in reciprocal bonds with their patients regarding decision-making, yet the nature of these conjointly produced clinical relations and patients' attributed emotional meanings essentially differed. SDM was only advocated in female physician/female patient relationships, but grounded in 'being in reciprocal exchange' due to sameness in gender which was displayed as means for creating closeness and empathy. Yet, whether patients felt emotionally supported in decision-making rather seemed to depend on patients' experience of a continuing clinical relationship than on the decision-making practice or care setting.

7 Variations in professional identity constructions

Article 3: *Professional identity in a feminised profession: More than (un)doing gender in gynaecology?*

This paper has been submitted:

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7.1 Abstract

The feminisation of medicine has led to explorations of women's experiences as physicians, pointing towards a conflict-laden relationship between feminine and professional identity. These works have not addressed gynaecology, though it is one of the most feminised fields.

Eight semi-structured interviews were conducted with men and women working as gynaecologists in outpatient practice settings in the Basel area (Switzerland) to investigate how they construct their professional identities, applying theories of un/doing gender complemented by an embodiment perspective.

The findings reveal that women have formed a professional identity aligned with womanhood, referring to their own bodily experiences and distancing themselves from conventional gynaecology. Men appeared to be challenged by feminisation. They employed strategies associated with men entering female-typed professions to maintain their masculinity, however, they made almost no reference to embodiment. The addition of an embodiment perspective shed light on the complexities of gendered gynaecological identities.

Key words

Gynaecology, Feminisation, Professional identity, Gender, Embodiment

7.2 Introduction

Gynaecology has undergone rapid feminisation over the last decades in Switzerland (Buddeberg-Fischer et al., 2006; Buddeberg-Fischer, 2003; Hostettler & Kraft, 2014; Kraft, 2009), as it has in many other countries (Boulis & Jacobs, 2008; Ross, 2003; R. K. Thomas, 2000; Weizblit et al., 2009). The influx of women has led researchers to explore women's positions in medicine. Such works have predominantly focused on the existing sex segregation in medicine (Buddeberg-Fischer et al., 2006; Hinze, 1999; Hostettler & Kraft, 2014; Kilminster, Downes, Gough, Murdoch-Eaton, & Roberts, 2007; Kraft, 2009; Elianne Riska, 2001). This segregation is characterised by a higher percentage of women than men active in the ambulant, outpatient and patient-centred sector (Hostettler & Kraft, 2014; Kilminster et al., 2007; Kraft, 2009), while more men than women hold leadership positions and are involved in science and research (Boulis & Jacobs, 2008; Hostettler & Kraft, 2014; Kraft, 2009; Lyon, 2002). Sex differences are equally apparent in speciality choices, with women dominating 'low status' fields such as paediatrics, psychiatry, and gynaecology, while more men opt for 'high status' areas such as surgery and surgical subspecialties (Boulis & Jacobs, 2008; Buddeberg-Fischer et al., 2006; Heru, 2005; Hinze, 1999; Hostettler & Kraft, 2014; Kilminster et al., 2007; Kraft, 2009). Gender essentialist stereotypes as the presumed reasons behind this sex segregation continue to suppose that women harbour certain qualities such as nurturance and caring that make them suited to medical areas like paediatrics and obstetrics. Men are considered to be at home in the profession's surgical fields, where masculine behaviours, like instrumentalism and decisiveness, are highly valued (Boulis & Jacobs, 2008; Elianne Riska, 2001, 2010; R. K. Thomas, 2000). This way, gender has been found to influence the way physicians integrate into medical specialities (Lorber, 1984; Elianne Riska, 2001) and is considered a powerful influence on identity constructions in the medical profession (Adams, 2010; Cassell, 1998; Davies, 2003; Eriksson, 2009; Löyttyniemi, 2009).

Another strand of research has concentrated on how women negotiate gender identity as medical doctors (Cassell, 1998; Davies, 2003; Eriksson, 2003, 2009; Löyttyniemi, 2009). These studies have examined the experiences of women who entered medicine in the period of the so-called feminisation of medicine, focusing primarily on women's gendered negotiations in surgery (Cassell, 1998; Davies, 2003; Eriksson, 2003; Elianne Riska, 2001). They show that women are caught in a conflict between preserving their feminine gender identity and adhering to a seemingly genderless professional identity filled with masculine connoted requirements such as "dissociating oneself from the patient, the private, emotions, the body and sexuality, as well as being mentally strong…and stable" (Eriksson, 2009: 93). By shifting the focus away from surgery

to medical fields with a high proportion of women, such as gynaecology, we might better observe whether a more feminine re-formulation of professional identity is evolving. Some of the studies cited above (Cassell, 1998; Davies, 2003; Eriksson, 2009) have accounted for gender as it concerns the 'body', either understanding gender as being inscribed 'on the body' (Davies, 2003) or seeing the gendered body as symbolic of the incorporated social order by means of Bourdieu's concept of habitus (Cassell, 1998). These authors have not accounted for bodily experiences concerning the gendered body. To our knowledge, only Kristina Eriksson's publication in the anthology "Body claims" (Eriksson, 2009) applied an embodiment approach by exploring how pregnant physicians experience their own body to investigate gendered aspects of their medical professional identity (Eriksson, 2009). She states that "[as] physicians treat and deal with bodies, they experience and (inter)act, they (re)present themselves as physicians with and through their own bodies" (p.93).

In comparison, few studies have explored how male physicians have negotiated their gender identity (Eriksson, 2003; Galasiński & Ziółkowska, 2007). To our knowledge, Kristina Eriksson's dissertation "Physicianship, female physicians and normal women" which explored the symbolic doing of female and male surgeons and gynaecologists in their professional lives, is not available in English. Galasiński and Ziółkowska focused on women's identities in male doctors' narratives, and only touched on men's gendered constructions of professional identity. Thus, research to date has not adequately addressed how men might come to terms with masculinity (and femininity) in a changing medical culture. Only by including both sexes can we sufficiently explore the gendered negotiations of professional identities and work cultures (Mcdonald, 2013).

This article considers how women and men construct their professional identities as gynaecologists at the crossroads of gender and embodiment. Using eight semi-structured interviews conducted with gynaecologists working in outpatient practice settings in the Basel area (Switzerland), we explore how gynaecologists relate to and challenge traditional norms around femininity and masculinity. We first introduce the changing gendered character of gynaecology and explain how this relates to literature on gender identity in medicine and sex-typed professions. We subsequently address the issue of (un)doing gender through embodiment and then turn to the methodology used. In the analysis and discussion, the findings are related to the existing literature. The conclusion illustrates the potential of incorporating an embodiment perspective when exploring wo/men's positioning in gynaecology.

7.3 Gendered gynaecology

There are different ways of understanding organisations and professions as gendered (Britton, 2000). We can consider the degree to which they are dominated by one sex or the symbolic,

dominant discourse rooted in hegemonic masculinities and femininities; and/or how they are understood and organised through gender differences. Moreover, gender identities of professions are not fixed but reproduced and in flux (Acker, 1990). Formal designators of professional identity might be in place, such as doctors' white coat, but are scarce, as "the source of hegemony….is socially constructed…changing in time and space" (Katila & Meriläinen, 2002). The question therefore is how well one's own (gender) identity is perceived to fit the historical, socio-cultural norms and gendered stereotypes of a profession (Hatmaker, 2013; Katila & Meriläinen, 2002) and whether one accepts, challenges, or rejects the professional status quo (Katila & Meriläinen, 2002). Thus, gender provides a means for defining who (mis)fits certain professional positions (Leonard, 2003).

This study focuses on gynaecology, a field under change in its gendered character. Its origins lie in midwifery, which in earlier centuries was considered dirty work and a female matter (Bolton, 2005; Buddeberg-Fischer, 2003; King, 2007). During the 19th century, midwifery was taken over by men and from there evolved the profession of the male gynaecologist (Drife, 2002; King, 2007). This has contributed to the existing division of labour: midwifery has largely been performed by women and has been considered to be subordinate to medicine, the domain of men (Bolton, 2005; Davies, 2003; King, 2007).The professions were attributed essentialist gendered notions, with women as midwifes (and nurses) being ascribed stereotypical feminine traits - caring, nurturing, comforting - and men as doctors in gynaecology, associated with conventional masculine characteristics - paternalism, decisiveness, objectivity, and competitiveness (Bolton, 2005; Davies, 2003; Löyttyniemi, 2009). The feminist health movement, becoming powerful from the 1970s onwards, has critiqued what they understood as the male domination of medicine: the profession's masculine underpinnings and the paternalistic physician-patient relationship (Buddeberg-Fischer, 2003; Ebermann et al., 2010; J. E. Thomas & Zimmerman, 2007). Activist women focused on gynaecology, as they no longer wanted to be treated by men who decided over their heads, bodies, and sexual and reproductive health. To empower women to take their own health decisions, they established women's health centres (WHCs), where services were conceptualised as women-centred such that exclusively women cared for women, who were seen as partners and active participants (J. E. Thomas & Zimmerman, 2007). From the 1980s onwards, a shift in care approaches, commonly referred to as a move from doctor-centred to patient-centred care occurred (Heritage & Maynard, 2006; Whelan, 2009) which has become associated with the influx of women (Boulis & Jacobs, 2008; Davies, 2003; Elianne Riska, 2001, 2010; R. K. Thomas, 2000). Whether this indeed is the case

is debatable, as wider social changes and shifting disease patterns occurred alongside (Boulis & Jacobs, 2008; R. K. Thomas, 2000).

Some authors (Davies, 2003; Eriksson, 2009; Hinze, 1999; Löyttyniemi, 2009) have argued that medicine's professional culture is intricately connected to the socio-historically constructed masculinist ideal of what Raewyn Connell calls 'hegemonic masculinity' (R. W. Connell & Messerschmidt, 2005). Its qualities, as e.g. hierarchical authority and objectivity, are understood to be embedded in practice patterns that allow men's dominance over women to persist (R. W. Connell & Messerschmidt, 2005). Hegemonic masculinity is considered superior to femininity and to alternative forms of masculinity, such as homosexuality (R. W. Connell & Messerschmidt, 2005; Schippers, 2007). Hegemonic masculine behaviours are not normal in a statistical sense, but they are normative in that men are required to position themselves towards these (R. W. Connell & Messerschmidt, 2005; Schippers, 2007). Therefore, men who enter female-typed professions deviate from hegemonic masculine norms and behaviours (Connell 1987, 2005, cited in Mcdonald, 2013), challenging the conventional notions of what it means to be a man (McDowell, 2015), thereby confusing the work order. In contrast, women who enter into male-typed professions deviate from feminine notions and behaviours and challenge men's professional superiority. The question then is how women and men situate themselves in relation to the dominant gendered discourse (Katila & Meriläinen, 2002).

Empirical research on the implication of non-traditional career choices for women has emphasised that women's gender identity in male-typed professions is devalued (Hatmaker, 2013) and that women accept being discriminated based on their gender (Powell, Bagilhole, & Dainty, 2009), distancing themselves from their feminine gender identity (Adam et al., 2006). Thereby, they preserve the profession's underlying hegemonic masculine notions (Irvine & Vermilya, 2010). These findings were documented among women entering the masculine domain of surgery (Cassell, 1998; Davies, 2003; Eriksson, 2003). Likewise, it is assumed that men's masculinity is challenged when entering female-typed professions. But rather than submitting to feminine ideals, men have been found to enact their masculinities (Heikes, 1991; B. Lupton, 2000; Simpson, 2011; Wingfield & Myles, 2014). They either succeed in reaching top administrative and leadership positions in conformity with characteristics of masculinity (Heikes, 1991; Wingfield & Myles, 2014), or they were penalised due to an association with homosexuality and linked to culturally feminine notions (Harding, 2007; B. Lupton, 2000; Rajacich, Kane, Williston, & Cameron, 2013). However, what happens to men and their masculinities when they have not chosen to cross professional gender boundaries, but

experience changes to their profession from the inside by an increase of the number of women, as in gynaecology?

7.4 Un/doing gender through embodiment?

Numerous studies from different disciplines agree that gender is a constitutive element of professional identity (Adam et al., 2006; Britton & Logan, 2008; Britton, 2000; Gottfried, 2003; Halford & Leonard, 2000; Hatmaker, 2013; Irvine & Vermilya, 2010; Leonard, 2002; Mcdonald, 2013; Nentwich & Kelan, 2014; Pilgeram, 2007; Pullen & Knights, 2007; Tyler & Cohen, 2010; van den Brink & Stobbe, 2009). Yet, empirical research at the interface of work and gender has struggled with the concise integration of gender theories (Nentwich & Kelan, 2014). Although referring to the concept of 'doing gender' by West and Zimmermann, empirical studies have been found not to soundly define it (Nentwich & Kelan, 2014). Compliant with West and Zimmermann's conception (C. West & Zimmerman, 2009; Candace West & Zimmerman, 1987), 'doing gender' is concerned with how individuals (inter)act and are judged based on what is considered suitable feminine or masculine behaviour (Kelan, 2010; Nentwich & Kelan, 2014; Pullen & Knights, 2007; C. West & Zimmerman, 2009; Candace West & Zimmerman, 1987). The concept has been much-lauded for its contribution to transforming an apparently natural status of being a woman/man into a processual state of enacting woman/manhood (C. West & Zimmerman, 2009). Simultaneously, it has been critiqued for evoking gender conformity and appearing as a project of comprehensive accomplishment (Deutsch, 2007; Pullen & Knights, 2007), which might be prone to reifying differences between the sexes (Mcdonald, 2013). Risman (Risman, 2009) emphasises the possible trap of labelling new gender behaviours as alternatives to conventional gender norms rather than recognising its genuine new nature and proposes moving towards 'undoing gender'. Likewise, Deutsch (Deutsch, 2007) has suggested applying 'doing gender' only to interactions that reproduce gender difference and using 'undoing gender' when differences are being reduced. Nentwich and Kelan (Nentwich & Kelan, 2014) criticise this differentiation, as it only involves the "gradual relevance of doing gender" (p.123) and maintains gender inequalities.

More recent empirical studies on work and gender elaborate on Judith Butler's approach (Mcdonald, 2013; Nentwich & Kelan, 2014; Pullen & Knights, 2007; Tyler & Cohen, 2010). It differs from conceptions of 'doing gender' by concentrating on how gender performance is accomplished and emphasises how alternative forms might change the established gender order and transform the conventional gender binary (Nentwich & Kelan, 2014; Poggio, 2006). Judith Butler showed "how doing gender involves considerable ambiguity, incompleteness and fluidity, since it is often tied up with processes of undoing at levels of identity, self, text, and practice"

(Pullen and Knights, 2007: 505). Concordantly, the ambiguity and flexibility as well as context specificity of gendered identity constructions have increasingly become of importance (Nentwich & Kelan, 2014).

For this paper, we follow McDonald (Mcdonald, 2013) who argues that the two approaches un/doing gender fruitfully complement each other. Along these lines, doing gender involves realising gender differences compliant with conventional gender norms and reproducing the dominant gender order. In contrast, undoing gender comprises the enactment of similarities between men and women (Deutsch, 2007; Mcdonald, 2013), and the subversion of existing gender norms to promote social change (Butler, 2004; Mcdonald, 2013). Although gender identities, behaviours and norms may be fluid and multiple, conventional gender stereotypes are often used to discuss gendered features, because no other terminology exists to denote such aspects (McDowell, 2015). We too apply the binary terms masculine/feminine, also because interview narrations largely corresponded to the conventional binary configurations. We concordantly operationalised emergent gender norms by reference to the wider literature.

An embodiment perspective is important for exploring medical professional identity (Eriksson, 2009), thus we have examined works from the field of organisational studies that have accounted for the living body. Such researchers have only recently recognised the importance of incorporating an embodiment perspective into their studies (Braun, 2011; Dale & Latham, 2015; Dale, 2005; Gottfried, 2003; Hindmarsh & Pilnick, 2007; Küpers, 2015). The current turn, according to Dale and Latham (Dale & Latham, 2015), is due to a growing uneasiness towards representation and discourses that were prominent during the 1980/90s. Organisational studies have incorporated phenomenological approaches (Dale & Latham, 2015; Dale, 2005; Hindmarsh & Pilnick, 2007; Küpers, 2015; Pullen & Rhodes, 2015) to expose new ways of understanding the self and other, cultural representations and social aspects in work contexts (Dale, 2005). With reference to Merleau-Ponty, embodiment understands ‘the body’ as both corporeal and social (Dale, 2005) which supports the search for alternatives to the Cartesian dualism of body/mind and object/subject (Dale, 2005; Hindmarsh & Pilnick, 2007). To our knowledge and with very few exceptions (Braun, 2011; Gottfried, 2003), empirical studies at the interface of work and embodiment have hardly focused on gender in any sustained way (Dale & Latham, 2015; Dale, 2005; Hindmarsh & Pilnick, 2007; Küpers, 2015). Hindmarsh and Pilnick (2007) have characterised this as follows: “While (sometimes) about the body, studies of gender…in organizations tend to elude an embodied understanding” (p.1397).

In uniting gender and embodiment, we follow Ute Gahlings (Gahlings, 2006), a proponent of new phenomenology concepts. Although she has critiqued Judith Butler’s perspective of

understanding the gendered body as a social and discursive production alone, she agrees that gender identity is created at the crossroads between cultural and historically specific relations. However, she departs by seeing gender identity as co-constructed by specific bodily materiality and biographically generated bodily experiences. For Gahlings, gender identity is developed along the axes of body and bodily experiences, which are interlinked with biography, discourse and socio-cultural and historic specificities. Accordingly, we apply un/doing gender as formulated above, but add a phenomenological perspective. That is, gender identity is constructed through interaction and discourse, but is also understood as evolving along bodily materiality and (biographically generated) bodily experiences.

7.5 Methodology

Data analysis followed Kathy Charmaz' constructivist-interpretative approach towards Grounded Theory (Charmaz & Belgrave, 2012; Charmaz, 2006) to explore how gynaecologists negotiate their professional identities based on biographical reflections. Of interest was how fe/male gynaecologists relate to or challenge traditional gender characteristics to investigate their views of the profession's socio-cultural underpinnings. Due to the constructivist-interpretative perspective adopted, we were not interested in offering an objective truth but concerned about reflecting the multiple created realities, since what it means to be a gynaecologist differs according to the individual, the situation and the work environment (Charmaz, 2006; Creswell, 2003b; McDowell, 2015).

The research setting

This research derives from the qualitative part of the mixed methods project, "Women and Gynaecology in Evaluation", funded by the Swiss National Science Foundation (SNF No. 32003B-121358). The qualitative part served to characterise gynaecologists' working approaches in selected outpatient settings in which quantitative patient data was collected. Both study parts will be integrated to explore reciprocities. Six gynaecological outpatient settings in the Basel area (Switzerland) were selected by maximum variety sampling prior to data collection. This strategy enabled us to maximise the representation of diversity in working approaches to trace their similarities and differences (Teddlie/Yu 2007: 81). Therefore, we were unable to follow theoretical sampling, which is essential for Grounded Theory, but this trade-off between representativeness and saturation is intrinsic to mixed methods approaches (Creswell 2003: 21-22; Teddlie/Yu 2007: 86-87). Identified settings included: (a) the outpatient department of the university women's clinic; (b) four privately run gynaecological practices with varying sub-specialisations; and (c) one women's health centre (WHC) with roots in the feminist women's health movement.

The theoretical framework

The qualitative part of the WAGE project was guided by an interest in medical care concepts influential to contemporary gynaecology such as patient-centeredness (de Haes 2006; Mead/Bower 2000; Rademakers/Delnoij/Nijman 2012), gender research (Bertakis 2009; van den Brink-Muinen 1998; Carnes 2010; Christen/Alder/Bitzer, 2008; Davies 2003; Eriksson, 2003; Riska 2001), feminist aspects of women's health care (Bean-Mayberry/Yano/Caffrey 2007; van den Brink-Muinen 1998; van Den Brink-Muinen 1997; Zobrist 2005) and various decision-making approaches(Charles et al., 1997; Glen Elwyn et al., 1999; Entwistle, 2009; Mast, 2004; van den Brink-Muinen, 1998; Wensing et al., 2002). These served as 'sensitising concepts' (Bowen 2006:2-3; Charmaz 2006: 16) that provided a framework of ideas about what to follow during research and helped in designing the semi-structured interview guide.

The sampling process and participants' characteristics

Purposive sampling was used to select eight participating gynaecologists across six pre-selected outpatient settings in the Basel area (Switzerland). Because of the university hospital's and the WHC's complex working environments, we purposefully sampled two physicians per setting. From the four privately run settings, we included one gynaecologist each. Three of the interviewed gynaecologists were men and five were women. All but two women were board-certified gynaecologists. Of these, one was a female physician working at the WHC. She has been trained in gynaecology, but has not completed the gynaecological curriculum required for board-certification. The other was a female assistant doctor working at the university hospital who was undergoing the gynaecological training curriculum. While this assistant doctor was in her early forties, all other participating gynaecologists had gained their first work experiences during the late 1970s and early 1980s. This selection was rooted in the project design, which required outpatient gynaecological settings that had been operational for at least ten years to ensure long-term patients for the quantitative part of the study. This was an unexpected benefit in that the generation of identified gynaecologists was part of the initial feminisation of gynaecology. They are thus valuable for researching how women and men relate to the feminisation process.

The interview design and data collection

Interviews followed a semi-structured interview guide with open-ended questions. Gynaecologists could express themselves freely while being encouraged to talk about the following themes: gynaecologists' specialisations, women's concerns, working approaches, significant biographical influences on the latter, and four sample vignettes or scenarios. The final

interview part pursued potential interests and emergent themes identified during previous interviews. Interviews were completed between August 2011 and March 2012 by BS, a social scientist with background in medicine. They were adjusted to interview dynamics, lasted up to 90 minutes and were conducted on site in the practice settings outside opening hours. They were audio-recorded and transcribed into (Standard) German.

The analysis

All data was imported into Atlas.ti (6.2). Analysis followed constructionist Grounded Theory (Charmaz/Belgrave 2012; Charmaz 2006), which applies an inductive approach and uses contrasting principles to research the similarities and differences that emerge from the data to discover a 'new theory'. This method was adopted to analyse interviews, reviewing line-by-line and applying initial, open coding, while writing memos on arising ideas. This process led to the emergence of focused codes (Charmaz 2006: 57-59). Four study group members (BS, KG, NW, EZ) with different professional backgrounds (medicine, epidemiology, social science, medical anthropology) and experience in qualitative research read the interview transcripts individually. During group meetings, each interview was jointly interpreted and contrasted with other interviews within/across settings to produce a comprehensive analysis. The group members met weekly and at least two were present throughout, serving as member-checks to ensure the trustworthiness of the findings. Final categories were established by consensus. Data saturation was achieved with the initial sample as indicated by the re-occurrence of identified variations within the emergent categories such as proximity/distance in physician-patient relationships, women-centred strategies for examination, physician-patient conversations, decision-making processes and therapies. If we had not achieved saturation with the initial sample, we would have conducted more interviews. We discovered that the identified categories reflected how gynaecologists made sense of their career pathways. Subsequently, this aspect was further explored in the data and from this analytic process, the category of biographical pathway evolved. Through this process, it became apparent that career pathways had very different meanings to women and men, which is the subject of the present article.

We followed strategies commonly used to ensure the trustworthiness of qualitative research (Krefting, 1991; Shenton, 2004): A self-reflective journal was kept, which warranted a better understanding of interviews during analysis (Morrow 2005: 255). During interviews, BS reframed questions and paraphrased participants' responses which served as an on-the-spot member-check (Krefting 1991: 217). Study researchers come from different disciplines and are experienced qualitative researchers, which enabled them to conceptualise large volumes of

qualitative data and apply a multidisciplinary approach (Krefting 1991: 219). Findings were presented to gynaecologists in April 2013, who confirmed that these reflected their approaches.

7.6 Findings

The central strategies that emerged demonstrate that the interviewed gynaecologists form different gendered professional identities. Women interviewees used their bodily experiences to construct what gynaecology means to them, showed solidarity with female patients and separated themselves from what they considered to be a masculine form of hospital gynaecology in the past. Male interviewees applied their bodily experiences to a much lesser extent, but separated themselves from their female colleagues by portraying some as less professional. The interviewees largely related to conventional configurations of masculinity and femininity and distanced themselves from each other. We start by describing women's perspectives, followed by men's perspectives. Select citations are used to best represent the interviewees' applied strategies.

Women's perspectives

Women's narrations were largely biographical reflections about what has shaped their current practice, wherein they no longer have a marginal status. Reflecting on their choice to follow a career in gynaecology at a time when men far outnumbered women, they referred to their minority experiences as female clinicians. Comments from Karla, a gynaecologist who has her own practice, and Magda, who works at the WHC, demonstrate how women felt offended during their gynaecological training in hospitals:

*"Work in the hospital, horror…cold specula, inconsiderate examinations, hundred people standing around a woman who had to spread her legs, all dreadful - m*isogynist *comments about female colleagues and patients; I left a patient's room and hardly outside- gossiping, mobbing, everything. And I always felt – this cannot be, this cannot be it." - Karla*

"There was a huge difference between my everyday life and what was said in gynaecology…when I was working in the hospital, I thought…you cannot treat women that way." - Magda

They emphasise how the hospital environment acts against women as patients, colleagues and themselves. Magda argues that there was a discrepancy between the way that gynaecology functions and her life as a woman. Both express feelings of dismay and concern. We see that they feel different based on their gender identity. They take these feelings as a basis to distance themselves from what they perceive as an anti-woman hospital environment. Similar feelings of not belonging to the professional community have been expressed by women in surgical fields

who felt discriminated against by their male colleagues (Cassell, 1998; Davies, 2003). As shall become evident, the interviewed women use their experiences to distance themselves from hospital gynaecology. They talk about their hospital experiences in a negative, disapproving manner, establishing notions of outsiderness, and associating these experiences with men who were the majority of physicians at the time. Karla discusses how she established her decision to follow a gynaecological career:

"My first thought when choosing gynaecology was, that there were male gynaecologists only. But, women need to be treated by women." - Karla

Karla conveys her irritation with the past situation when only men were gynaecologists. To her, this appeared to be unreasonable and served as a basis for her choice to pursue gynaecology. The interviewees, so far, indicate that their desired way of practicing gynaecology has its roots in womanhood. The distancing of one's self from past hospital gynaecology appears to be an important precondition for establishing a professional identity and practice in line with womanhood. Ingrid and Magda who work at the WHC express these ideas as follows:

"I dislike hierarchies and these exist in hospitals. This was very extreme and I have suffered a lot of these. The experience that I could not have a say or was unable to bring in my own ideas influenced my decision to come to this practice. It was important for me…that my perceptions are taken seriously." - Ingrid

"I had no time for patients, as I was required to write reports; I needed to do this and that and produce statistics. And, it was VERY important for me that if I would have my own practice, then I would have time and could 'do it myself' – the way I like to do it. I found this terrific." - Magda

Past hospital experiences were associated with hierarchies, lack of time and statistical objectivity, a work culture under which they suffered and felt silenced. The normative features they draw on —hierarchy, objectivity and activity— are culturally associated with masculinity (Davies, 2003; Schippers, 2007). The two women imply that the hospital setting is filled with masculine notions. They describe moving into private practices to practice gynaecology in a way that is compatible with their own ideas. Feeling unable to change prevailing hospital practices arises also in the conversation with Claudia, the assistant doctor at the university's women's clinic:

"The framework of working conditions…is relatively tight. Shaping…realising own ideas…it is rather that we communicate among ourselves and possibly influence superiors, but to…change something yourself is of course not possible…" - Claudia

Claudia experiences the hospital culture as hierarchical, differentiating between an influential superior, and a less powerful inferior. Although she associates the hospital with hierarchical and authoritative norms aligned with masculine connotations (Davies, 2003; Löyttyniemi, 2009), she does not distance herself from these as have the other interviewed women. Her account appears less gendered. We interpreted the differences to be the result of generational shifts. Whereas most of the interviewed women were pioneers who were among the first women to enter the profession, subsequent female medical doctors, like the assistant doctor, were empowered by the number of women entering medicine, which brought women's professional issues forward (Boulis & Jacobs, 2008).

Thus far, we have examined how women interviewees associated past gynaecological hospital practice with men and traditional, masculine connotations and how they, as women and medical doctors, experienced it negatively. In their narrations, we also observe discourses at the crossroads of feminity and embodiment:

"And of course I gave birth; I am in menopause. Everything I experienced is the subject of my profession." - Magda

"My own traumatic, gynaecological experiences: miserable treatment, brutal biopsies; I almost bled to death during delivery. Thus, I think gynaecology must not be this way." -Karla

Magda and Karla refer to their bodily experiences when elaborating what gynaecology is about. For Magda, experiencing her body includes experiences of bodily aging and life course events, which she understands as being central to gynaecology. She endows the gynaecological practice with femininity by adopting women's embodiment. In comparison, Karla fills her own bodily experiences with emotions, such as feeling traumatised and wounded by her perceived brutal handling as a gynaecological patient. Violence against women is seen as a feminine bodily experience rooted in a social order of unequal gender relations, which produces distinct discourses (Gahlings, 2006; Villa, 2006). These discourses lead to women's gender identity becoming associated with bodily, especially vaginal, vulnerability (Villa, 2006). It is important to note that these gendered experiences are socio-cultural features of gender inequality that produce bodily experiences and strong affective states (Gahlings, 2006; Villa, 2006). In this sense, Karla's depiction of harmful gynaecology reveals the perceived and physically experienced inequality between patients and gynaecologists. These experiences prompted her to derive her own understanding of good gynaecological practice. Karla, like Magda, locates her gynaecological identity in her feminine bodily experiences. Both create solidarity with patients, which counters past gynaecology practices portrayed as conflicting with and contrary to femininity, womanhood and women as patients and as medical doctors. The following excerpts

demonstrate how the lives of women and women's bodily experiences were used to negotiate a feminine way of doing gynaecology.

"Woman experience many...phases…these…are known by every woman…I think it is important that such states are not seen as a disease which is a danger posed by [biomedicine]" - Ingrid

"The lives of women play a great part in gynaecology and it is important to give special consideration to these circumstances…not purely establishing a [diagnosis]" - Magda

In the quotations we see how women's bodily experiences propel them to change and distance themselves from conventional gynaecological care approaches. Ingrid and Magda use women's lived experiences to establish a personal and bodily experience-based knowledge to counterbalance expert medical knowledge, which they portray as endangering and limited. Embodiment is not exclusively about the body, but likewise about culture and experience (Csordas, 1990). We thus can understand their accounts in the sense that they use women's lived bodily experiences to critique the culture of conventional biomedicine, while using feminine embodied knowledge as an alternative approach. In this way, they render gynaecology almost unattainable to men, as men, due to their physical materiality, are unable to experience and know what, in their view, gynaecology is about. Magda places conventional medical knowledge at a lower level, whereas she portrays the integration of lived experiences as a more sophisticated endeavour. Similarly, Karla and Nadja convey that gynaecology involves more than just 'doing medicine':

"I try to work out the subjective – what does it mean [for the woman] to fall ill… I do not believe that just because I am the medical doctor, I would know what it means for her…" - Nadja

"It is important that female patients feel reasonably comfortable…The basis is biomedicine which has to be done correctly…but in reality…I think the greatest influence on women's condition is the psychological or psychic, which is at times greater than the somatic aspects." - Karla

In their view, medicine is the basis, but practicing gynaecology for them is about the subjective lived experiences of women, which goes beyond medicine's focus on body and disease. By working with the subjective, Nadja decreases her expert status and produces a connectedness and closeness with female patients. She, like Claudia, elaborates as follows:

"It's the closeness. Certain words and experiences are very, very close, because I experienced them. Without such experiences some situations are indeed difficult to truly comprehend." - Nadja

"It is easier to talk to women…just because you easily enter certain topics…I think that women can better comprehend the typical anxieties of women – is it something serious? It hurts. What

does it mean?...I have the impression that this makes it easier for women to work as gynaecologists." - Claudia

They portray their bodily experiences as a means for promoting empathy with female patients. Claudia expresses that female gynaecologists better comprehend women's concerns and more easily relate to female patients than male gynaecologists. She adopts the dichotomy between 'us (women)' and 'them (men)'. Although the interviewed women established a gynaecological identity rooted in womanhood and feminine bodily experience and engaged in 'doing gender' as a means for separating themselves from past masculine hospital gynaecology, it became apparent when talking about present gynaecology that they were also engaging in forms of 'undoing gender':

"Formerly, medical doctors were often fast and disrespectful…I experienced a very rough female gynaecologist…she catheterised me without saying ´please use the toilet'. I was shocked. Later, I had a very kind female gynaecologist, she built confidence on a corporeal level…If you lie down on a gynaecological chair and there is a [male] guy below…It is quiet odd – there are very nice gynaecologists and very strange gynaecologists." - Magda

"I was a patient of this one male gynaecologist and he had towels available so that I was able to cover myself below to feel less exposed. I think about these things a lot, it is the corporality…and to approach women with tender hands… and not so plupluplu but what I am talking about is obvious." - Karla

For them, being a gynaecologist means being conscious about 'the corporal' during examinations. They draw on their own bodily experience as patients to specify what good gynaecological care is for them. These bodily experiences are presented as being connected to emotions. Whereas Magda expresses shock at the intrusiveness of a female gynaecologist, she does femininity as bodily vulnerability is coded feminine (Villa, 2006). Yet, she ascribes this behaviour to a woman, who becomes furnished with the culturally coded masculine connotations of aggressiveness and dominance (Davies, 2003; Villa, 2006). Thus, Magda is also undoing gender (Deutsch, 2007). Karla felt less exposed by a male gynaecologist who had towels on hand so she could cover herself. For her, gynaecology today is not dependent on the gynaecologists' gender, but on whether the practitioner adopts a more feminine practice, which she associates with the feminine norms of empathy and tenderness (Davies, 2003). It emerges that today, men and women may practice 'good gynaecology', but male gynaecologists may only do so if they adhere to the more feminine underpinnings evolving in the profession.

Men's perspectives

Men's narrations were mostly biographical reflections about what has shaped their current practice, wherein they are no longer the majority. In thinking about what made them specialise in gynaecology, the men recounted their hospital career paths. This is exemplified by Karl and Martin, who run their own practices today:

"Why I became a gynaecologist – pure chance – I was a surgeon and wanted to do surgery. And then I was offered a position as chief surgeon in X and I did not want to move there…then I changed to gynaecology, because here I was equally able to operate." - Karl

"I am doing 'core business' gynaecology, which means I am not doing anything additional – no nutritional or psychosocial counselling. – I have been working in the hospital for many years, longer than most colleagues…I had a leading position…deputy senior physician…senior consultant…From this results a specialisation in ultrasound diagnostics..[it] became my focus…besides the 'core business' of gynaecology." - Martin

They portray their success in following a hospital career by emphasising the leadership positions held or open to them. As careerism and leadership are associated with masculinity (Heikes, 1991; Mcdonald, 2013), they rely on traditional gender norms to construct their professional identity. Karl emphasises his preference for surgery, whereas Martin stresses technical work aspects (his ultrasound specialisation). Because these facets are coded as masculine (Cassell, 1998; Davies, 2003; Hinze, 1999), they reinforce their masculine gender identity. Martin simultaneously distances himself from aspects of nutritional and psychological counselling, which are considered more feminine in character (Eriksson, 2009; Löyttyniemi, 2009). He concurrently emphasises that he is doing 'core business gynaecology' and suggests that more feminine work aspects might lie outside this core. Because discourses around management and profits are culturally associated with masculinity (R. Connell, 2008), he underpins his understanding of gynaecology with masculine notions. Karl and Martin do not relate to the feminisation of gynaecology, but Jürgen, who had a leading position in the university's women's clinic at the time of our interviews, assesses the increase in women when recounting his career:

"When I started, the head of the hospital was a famous surgeon who had an excellent reputation and treated many international patients. The hospital was almost exclusively run by men and had a strong focus on surgery. Although the head…was broad in thinking, it was a man-dominated, competitive field with the focus: Who is the best surgeon?...later, we had a shift towards a younger head…which resulted in a change towards having more women…I think this was a significant change regarding the inner structure and working methods...I kind of survived

[several] changes and I introduced psychosomatics – through the support of the first hospital head,…although I was an absolute outsider…and as he left, I took over his position." - Jürgen

Jürgen does gender by portraying past hospital gynaecology as a surgical, competitive field, and by associating it with men and masculinity. He links its feminisation to changes in organisation and care approaches. He considers himself as an 'absolute outsider' to past hospital-based gynaecology, when men outnumbered women, thus distancing himself from its traditional norms. He continues by describing himself as having lived through the changes and introducing psychosomatics – a field associated with a more feminine coded medical practice (R. K. Thomas, 2000). According to Deutsch (Deutsch, 2007), he is undoing gender because he is reducing gender differences. What becomes apparent though is that the three men do not appear to show any certainty about choosing gynaecology. Their choices appear to be consequences of their professional biography, although decisiveness is culturally coded as masculine (Davies, 2003; Hinze, 1999). Their reluctance to express choice for gynaecology might be due to the challenging norms that male gynaecologists encounter. Gynaecology requires all medical doctors to perform pelvic examinations, which puts men in a difficult position. Men are caught between such institutional requirements as pelvic examinations and the social norms governing gender relations which oblige them to engage in heterosexual behaviours and show attraction to women (Galasiński & Ziółkowska, 2007; Schippers, 2007; Uskul & Ahmad, 2003). The same gender norms lead us to presume that women gynaecologists are not attracted to their female patients. It would seem that the male gynaecologists solve this challenge by not conveying any intention to follow a career in gynaecology. In contrast, women may express their attraction to the profession without arousing any suspicion.

Although Jürgen and Martin emphasise the profession's academic and technical dimensions and do gender in traditional ways, their reconstructions express different strategies. Whereas Martin abides by conventional masculine norms, Jürgen is doing and undoing gender in numerous ways, which becomes apparent when discussing how gynaecology has changed through women's entry:

"I think [gynaecology] has been changed by the increasing number of women. This does not mean, as a number of studies have shown as well…that women per se are more patient-centred...I do not believe this. I think gender has a substantial influence in so far as working women have families and kids. They know this side of being a woman. Earlier, with only male gynaecologists, this aspect was not tangible to the same extent. Female gynaecologists are close to the social reality of women, but this does not necessarily result in better or more women-friendly care." - Jürgen

Jürgen emphasises the change in gynaecology due to the influx of women, but stresses that he does not see patient-centeredness as a feminine trait. He verbally removes the traditional gender binary that sees men as being paternalistic and women as patient-centred (Davies, 2003; Löyttyniemi, 2009). While his narration might be understood as a form of undoing gender by minimising gender differences and subverting the dominant gender order (Butler, 2004; Deutsch, 2007), it may also be read as a process of appropriating feminine behaviours to re-negotiate his masculine position – a strategy that has been identified among men who have entered feminine-typed occupations (Simpson, 2004). Simultaneously, he stresses his academic position by referring to research, which enhances his masculinity. He reinforces his position by stating that women are closer to the private familial sphere than men. He does gender corresponding to discourses of heterosexual familial patterns, which usually maintain a work hierarchy that presents working women as mothers and less professional (Löyttyniemi, 2009). In sum, he concordantly challenges and maintains traditional masculine values. This duality allows him to relate to feminine ideals, while ensuring that he does so as a man. Likewise, Martin portrays certain women practicing gynaecology as less professional:

"Some patients referred to me for ultrasound…reply: 'yes, my female gynaecologist…"…there are female doctors who are not board-certified gynaecologists but provide gynaecological care and then I realise that their patients assume that they are board-certified gynaecologists who in fact have no such specialisation…they chose them because they believed them to be gynaecologists…and there are maybe around 20, 30, 40 women, which offer…gynaecological care and are assumed to be gynaecologists by their patients." - Martin

Martin expresses his reluctance to accept non-board-certified gynaecologists, whose work he has to support and who he sees as misleading patients. From this standpoint, only board-certified gynaecologists have sufficient knowledge to treat patients. To him, performing gynaecology without such certification seems unprofessional and a practice that he associates with some women. He creates collegiality between board-certified gynaecologists, while separating himself from non-accredited ones who he feminises, thereby engaging in doing gender. Both, Martin and Jürgen, use strategies to distance themselves from women gynaecologists. A number of authors (Mcdonald, 2013; Simpson, 2004; Williams, 1989) suggest that men use such strategies to protect their masculinity in female-typed professions. The interviewed men seem to struggle with the medicine's shift in sex-ratio. Despite this, the two differ in how they understand their present gynaecological practice:

"We have training programmes…we convey…that patient-centred and physician-centred communication exist…Patient-centred communication means listening, giving feedback,

summarising, hence certain communicative techniques which originate from the concept of appreciating the whole person, not just the disease of the organ or the uterus, but the person." - Jürgen

"I believe I treat patients very differently…to the extent of what is possible within the frame of the right medical care …the aim is to individually respond to customers' needs – just like a car salesman who needs to address the individual needs – one client needs…a bit more technical input and another one a bit more life-style counselling." —Martin

Jürgen expresses that patient-centeredness is an easy-to-learn communicative technique rooted in a holistic approach towards health and illness. He gives patient-centeredness, a behavioural pattern culturally associated with women and femininity (Löyttyniemi, 2009; R. K. Thomas, 2000), a touch of masculinity by recoding it as a technique (Cassell, 1998; Davies, 2003; Hinze, 1999). Martin, in comparison, sees himself as delivering tailored solutions to his patients, which he considers as customers. He transforms the physician-patient relationship into a salesman-customer relation, whereby dimensions of care associated with a more feminine style, such as psychological aspects, are lost (R. K. Thomas, 2000). We now turn to the third man interviewed, Karl. He differs from the other two as he uses his bodily experiences when considering what makes him a 'good gynaecologist':

"Every so often, women tell me that men are more subtle…than women when doing the pelvic examination. That's for sure. I worked together with many women and I think that for men…it is a foreign territory and we need to be cautious per se. And women to women, they know each other. They know what a vagina feels like and likely handle it in a more direct manner. We men, and I heard this of many male colleagues, - just do not hurt…many girls first go to a female gynaecologist and then they recognise the rougher manner of the examination and just, you know with X [a female gynaecologist] if a forty year old woman came to her and was pregnant – I felt utterly sorry for this woman and usually noticed that we must help this woman, as X was in serious competition with her." - Karl

According to Karl men are more subtle in doing pelvic examination, because men are unable to know what a vagina feels. Consequently, he sets himself apart from female gynaecologists, who he believes to be rougher during pelvic examinations due to having and experiencing a vagina themselves. He postulates that this may be due to female gynaecologists' corporal and biographical proximity to patients. He furthermore portrays a female gynaecologist to be a rival of female patients and unable to maintain an appropriate physician-patient relationship. Although he grounds his argument in women's bodily and biographical experiences, the characteristics Karl mentions, notably women being emotionally unstable compared to men being in control of

their emotions, corresponds to conventional gender norms (Davies, 2003; Eriksson, 2009). Karl follows this by introducing the topic of sexual assaults:

"I tell all patients: Never get completely naked. There are many 'willies' who ask women to get stark naked and sit on the examination chair…I tell them: If ever a male gynaecologists tells you to completely undress, turn around and walk out …this I try, because I hear about nasty fellows, one of whom I took to court where he had to take responsibility and then said: 'Dear gentlemen – you are also only men…' This is what he, as a gynaecologist, said to justify why he sexually molested a female patient! No – listen carefully – I have a daughter, so of course I prick up my ears" - Karl

Karl attributes sexual assaults to other male gynaecologists, of which he thinks there are many and who he presents as 'willies', an expression that stands for penis and a man with bad manners. He distances himself from 'those kind', criticising their behaviour as wrong and resorting to his role as a traditional paternal figure (Davies, 2003) who, though male, has no heterosexual desire for his daughter or, by extension, female patients. This allows him to do masculinity and medicine in traditional ways (Davies, 2003). He relies on reconstructions of his male bodily experiences, although [physical] masculinity is associated with heterosexual sexuality and desire (Schippers, 2007). We think that men in gynaecology occupy a distinct position, which they need to resolve: as men, they are required to do masculinity encompassing heterosexuality, while gynaecology as an organisation forbids them from acting out on this masculine aspect (Galasiński & Ziółkowska, 2007). The other two men resolve this challenge differently:

"The medical field clearly defines what a gynaecological examination entails." - Martin

"A pelvic examination should be conducted respectfully, not invasively, which means it should not hurt…it is an examination that puts women into a situation that is only otherwise permitted within an intimate context. This must be recognised. I still can recall from when I underwent training and when gynaecology was dominated by men that it was not unusual to call in other colleagues when there was a young pretty woman. Not because of medical reasons, but to satisfy a certain voyeurism. Today, it is taught that the crossing of boundaries is possible but must not be done." - Jürgen

Martin's narration indicates that the conduct of a pelvic examination is determined by the medical profession – it follows a specific medical purpose. He adopts a neutral position, which excludes heterosexuality but is implicitly filled with masculine connotations (Davies, 2003; Eriksson, 2009). In contrast, Jürgen places men's transgressive behaviours in a historical

context. The three are united by dissociating themselves from transgressive, sexualised behaviours, each through different strategies. They establish a masculine professional identity that is almost disembodied and sexually non-threatening towards female patients.

7.7 Discussion and conclusion

The study's objective was to provide insights into gynaecologists' professional identity constructions. It was vital to look at men and women simultaneously, as it helped to show that professional identity is a multiple, negotiated, fluid and gendered matter. If we would have given just one side of the story, either women's or men's accounts, the gendered differences would not have been so apparent.

Contrary to previous literature (Boulis & Jacobs, 2008; Cassell, 1998; Davies, 2003; Eriksson, 2003; Hinze, 1999; Löyttyniemi, 2009; Elianne Riska, 2001) that describes women in medicine, particularly surgeons, as challenged to unite their feminine gender identity with the masculine notions of the medical profession, our analyses reveal that female gynaecologists might have succeeded in forming a professional identity aligned with womanhood and femininity. The five women interviewed have adopted conventional feminine strategies to negotiate their professional identity. They use these to create group solidarity with female patients, while distancing themselves from what they perceive as an antithetical and culturally masculine-coded, past gynaecological practice. In so doing, they critique the way male medical doctors previously practiced gynaecology, while determinedly developing a more feminine way of practicing in the present. In fostering their feminine alternative, they challenge the past hegemonic masculine ideal underlying gynaecology, yet reproduce gender differences to engage in boundary work from within the gynaecological profession.

In comparison, our findings reveal that the three male gynaecologists might be challenged by the influx of women, as the strategies they employ correspond to previous findings on men in female-typed professions (Heikes, 1991; B. Lupton, 2000; Mcdonald, 2013; Simpson, 2011). These studies reported that men whose masculinity was challenged, sought to maintain their masculine values by distancing themselves from the female majority, gave a lower profile to work aspects associated with women and upheld traditional masculine values (Heikes, 1991; B. Lupton, 2000; Mcdonald, 2013; Simpson, 2011). As no research exists, to our knowledge, that examines the strategies by which men in male-typed occupations under feminisation might un/do the dominant norms of masculinity, we cannot provide comparisons. However, the findings are consistent with the gendered reasoning and practice differences we found among the same sample of gynaecologists (Schwind, Gross, Wehner, Tschudin, & Lagro-Janssen, 2015; Schwind, Gross, Wehner, Wegener, et al., 2015).

The analysis provides insights into how women and men as gynaecologists undo gender. We interpret the observed undoings as indications of current sociocultural changes underlying the gynaecological profession. The women emphasised that gynaecology with feminine connotations might be practiced by men today. By stressing commonalities between the genders, they engage in undoing gender (Deutsch, 2007). One male interviewee embraced traits associated with femininity, like patient-centeredness, which is consistent with the occupation's normative shifts in working approaches. Whether this strategy may be understood as doing gender in terms of formulating an alternative form of masculinity or undoing gender, if it is perceived as a new behaviour that destabilises gender norms, remains debatable (Deutsch, 2007; Mcdonald, 2013; Risman, 2009). Furthermore, the younger assistant doctor's excerpts appear to be less gendered. We think that our findings may be particular to the generation of interviewed gynaecologists who were trained in the 1970/80s. Future research should include younger gynaecologists to explore how they experience present gynaecology and renegotiate configurations of femininity and masculinity in their professional identities. This kind of research would be the key to understanding whether underlying normative changes are rooted in feminisation or whether younger generations of gynaecologists are un/doing gender in less conventional ways.

Embodiment added to understand the gendered negotiations of professional identity in gynaecology. Our results suggest that by incorporating a phenomenological perspective, gynaecologists' positions towards and within gynaecology could be better comprehended. In the women's narrations, bodily experiences and embodied knowledge were the basis from which they critiqued and distanced themselves from past hospital practice. They construct a more feminine way of knowing and counselling which unites femininity and conventional medical knowledge. This type of knowledge and practice appears to be almost unattainable for men due to their material inability to experience a woman's body. Being a woman, then, becomes a gynaecological competence which is not achievable through professional training. In contrast, the men's narrations were rather disembodied. This might result from the connection between physical masculinity and heterosexual sexuality (Schippers, 2007). A male gynaecologist relying on embodied masculinity possibly risks entering an ethical minefield at the edge of socially unacceptable behaviour that implies an unethical physician-patient relationship (Galasiński & Ziółkowska, 2007; Uskul & Ahmad, 2003). Men might therefore be hesitant to draw from their bodily experiences. Instead, the men interviewed used strategies to distance themselves from sexually transgressive behaviours, while resorting to the medical ideal, which might be considered as "an embodiment of the disembodied physician…permeated by implicit masculine

connotations" (Eriksson, 2009: p.93). An important point emerges: if women as gynaecologists use their lived bodily experiences to change the physician-patient relationship into a more subjective interaction and call into question the profession's masculine underpinnings, how could men as gynaecologists gain subjectivity, if not by their embodiment?

The analyses add to the current literature on masculinity and femininity in sex-typed occupations. Most of the existing literature on gender and professional identities focuses either on men or on women who cross into professions associated with the other sex (Boughn, 2001; Cassell, 1998; Davies, 2003; Díaz Garcia & Welter, 2011; Evans, 1997; W. Faulkner, 2009; Hatmaker, 2013; Irvine & Vermilya, 2010; Kyriakidou, 2012; Simpson, 2004; Snyder, Karrie. and Green, 2010; Wingfield & Myles, 2014). Just like the few exemptions that include both sexes (Boughn, 2001; Mcdonald, 2013; Simpson, 2011), we have shown the importance of looking at gendered professions through incorporating men and women. With this in mind, we recommend further research in this direction in the medical field to look into other specific subspecialties.

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8 Summary of main findings

This PhD thesis provides insights into the variations of working approaches, specifically in regards to empowerment and shared decision-making, between female and male medical doctors in different outpatient gynaecological settings, including a WHC. The findings suggest that the observed variations are rooted in the complex interactions between gynaecologists' gender, their past and present socialisation and clinical relationships. The study revealed that gynaecologists' gendered biographical and career paths influenced how fe/male doctors integrated into gynaecology and the different ways in which they practice medicine and approach contemporary women's care, while shedding light on the gendered constructions of professional identities in feminised gynaecology. Accordingly, the following sections summarise the main findings on variations in care approaches and review the central outcomes concerning professional identity constructions.

8.1 Variations in care approaches

Men and women as medical doctors differ in the way they understand and practice gynaecology. Female gynaecologists across all settings were more alike in terms of their described working approaches than male gynaecologists.

Female gynaecologists gave the impression of sharing power and knowledge with patients and of creating equal physician-patient relationships. Women practitioners valued the integration of patients' voices to facilitate new ways of understanding symptoms and to devise treatment options that extended beyond purely biomedical interpretations; in this way, doctors empower their patients. Female WHC doctors make additional efforts to integrate women's collective life experiences and to apply more holistic treatment approaches compared to the other female gynaecologists interviewed, who seemed to prefer a more individual understanding and a personalised treatment strategy. Women's stances towards medical reasoning were discerned by investigating the relational aspects of SDM. SDM was only practiced in the context of female physician/female patient relationships and was reportedly grounded in the sameness of being female, facilitating reciprocal exchange as well as producing feelings of closeness and empathy from the patient's point of view.

Male gynaecologists appeared to trust the power of their expert knowledge in diagnosing and treatment decisions, and engaged in more hierarchical clinical relationships with their patients, who in turn preferred male medical doctors' clear position and direct medical advice. Female

patients who did not receive medical advice reportedly considered whether a female gynaecologist with a more biopsychosocial working approach would be more appropriate for them, pointing to the importance of physicians' gender-congruent behaviour in gynaecology.

Gender-related socialisation appeared to account for the variations in working approaches of gynaecologists in outpatient private practice settings. In the hospital setting, however, female and male gynaecologists' care approaches seemed to be harmonised in a way that approximated those of male gynaecologists. The short-lasting clinical relationships in this context made patients feel alone, even though they considered the received advice as reasonable. Gender aspects appeared almost irrelevant in patient narratives. The female assistant doctor working in the hospital took a biomedical stance towards symptom interpretation and presented direct medical advice in observed consultations. She was exceptional in that she did not belong to the same generation as the other gynaecologists, presumably indicating generational and contextual effects on working approaches and on professional identity constructions.

8.2 Gynaecologists' professional identities

Fe/male gynaecologists draw upon very different experiences when recounting how their careers influenced their current working approaches.

Women doctors relied on their own (bodily) experiences as women, patients and medical doctors to create solidarity with female patients and to distance themselves from past hospital gynaecology practices, which they portrayed as not having treated women well. For that reason, they had decided to move into private outpatient practices where they were able to engage in a more feminine way of providing gynaecological care, uniting their own embodied knowledge with conventional medical expertise. Concordantly, female doctors gave the impression of having successfully formed a more feminine professional identity in outpatient private practice settings.

Male doctors recalled their past experiences as senior physicians, researchers and surgeons while discussing the increase of female doctors during their careers. They appeared to distance themselves from female doctors and maintained masculine values by giving work aspects associated with women a lower profile. Thus, men looked as if they were challenged by the feminisation of the profession. Compared to female doctors, male doctors made almost no reference to their own bodily experiences, hinting at men's challenging position in gynaecology wherein they are required to perform pelvic examinations; a task they cope with by taking the position of the neutral medical expert or the caring father figure.

The study showed how fe/male gynaecologists differentiate themselves based on gender difference, thereby engaging in intra-professional boundary work. The analyses also revealed a few forms of undoing gender in the present practice of gynaecology, implying the possible softening of gendered intra-professional boundaries due to current sociocultural changes within the profession.

9 General discussion and conclusion

This PhD thesis shows that gender is central to the variations in working approaches identified among surveyed gynaecologists. Female gynaecologists across all settings, including the WHC, appeared to be more alike in terms of sharing power and knowledge with patients than male gynaecologists. The findings are consistent with two Dutch studies (van den Brink-Muinen et al., 1998; van den Brink-Muinen, 1998) that also reported female physicians as more inclined to include patients' personal/social situations than their male colleagues across all study settings (including a WHC, like in the present study). These studies largely focused on physicians' communication style. Conversely, this thesis illustrates possible rationales for the differences in care behaviours between physicians of different genders in gynaecology. These underlying reasons are discussed in more detail in the sections below. First, the various ways in which fe/male doctors practice gynaecology are reviewed and put into a broader perspective (section 9.1). Second, the findings on professional identity constructions in gynaecology are discussed, particularly with respect to embodiment. After discussing the strengths and limitations of the study, the implications for research as well as for policy and practice are outlined.

9.1 Revisiting care approaches in gynaecology

We have shown that female gynaecologists were more inclined than male gynaecologists to mutually collaborate with patients in the diagnostic process and in decision-making, as it was evident in the findings regarding empowerment (chapter 5) and SDM (chapter 6). The findings are consistent with those of several communication studies in gynaecology (Christen et al., 2008; Janssen & Lagro-Janssen, 2012; A. M. Van Dulmen & Bensing, 2000) and primary care (Roter et al., 2002; Roter & Hall, 2004), which found that female doctors are more likely to explore patients' experiences and perspectives than male doctors. This work adds to the existing literature by exposing the processes that may underlie the differences in care approaches, while detailing the shortcomings of communication research.

The analysis of the pelvic pain vignette uncovered gynaecologists' variations in medical reasoning and their underlying disparate attitudes towards empowerment. However, empowerment is a complex, multi-faceted and debated concept (Holmström & Röing, 2010; Kirsti Malterud, 2010), as outlined in chapter 5. Conceptual debate means that empowerment in healthcare is currently largely understood as patient education, so that patients make healthy decisions and learn how to better manage their (chronic) diseases (Aujoulat et al., 2007; Edwards et al., 2009; Kirsti Malterud, 2010). However, early ideas of empowerment sought to

question and change power dynamics in healthcare, including positive health enhancement rather than disease prevention and management (Aujoulat et al., 2007; Holmström & Röing, 2010; Kirsti Malterud, 2010; J. E. Thomas & Zimmerman, 2007). Although the latter and more emancipatory approach towards empowerment is still considered important for healthcare (Aujoulat et al., 2007; Kirsti Malterud, 2010), the narrower educational approach is regarded as a proxy for quality in healthcare (May et al., 2004), which is assessed by outcome measures of patients' adherence to medication, knowledge about a disease and self-care behaviours (R. M. F. M. Anderson, 2000; M. Faulkner, 2001; Hernandez-Tejada et al., 2012). Accordingly, much of this kind of work depends on making normative judgements on right and wrong actions taken (Kirsti Malterud, 2010; May et al., 2004).

The intention of the pelvic pain study was to reveal what might underlie an empowerment perspective. The semiotic, interpretative perspective (Baron, 1990; Burnum, 1993; Leder, 1990; Kristi Malterud, 2000; Nessa, 1996) applied to the analyses of the vignette was useful for bringing out the sources of variation in gynaecologists reasoning processes. The gendered socialisations and (sub)specialisations of the gynaecologists surveyed served to organise their thought processes (and thus empowerment perspectives). Previous quantitative studies demonstrated that doctors' socialisation in medical subspecialties (K D Bertakis et al., 1998; Paasche-Orlow & Roter, 2003), gender socialisation (Roter et al., 2002; Roter & Hall, 2004) as well as socio-economic background (Waitzkin, 1985) influenced physicians' specific communication behaviours. Our qualitative results echo these findings, but indicate that the gender differentiation observed in work approaches permeates thought processes as well, as suggested by Joan Acker (Acker, 1990). Thus, the study provides first insights into the clinical reasoning processes assumed to underlie observable communication behaviours (Undeland & Malterud, 2008). It suggests subjectivity of gynaecologists' reasoning processes. Male gynaecologists treated their diagnosis as certain and rooted in their clinical knowledge and medical expertise ('everything is fine – do not worry', chapter 5), although it remained uncertain what caused the pain. Female gynaecologists integrated patient perspectives and did not differentiate so much between their professional knowledge and patients' (lay) interpretations as a means for arriving at new understandings of symptoms and functional pelvic pain. Accordingly, they were more open to an unpredictable end of the (fictitious) consultation. Small differences were observed with regards to empowerment perspectives among female gynaecologists. WHC doctors situated the experience in the social context and tended to promote a holistic, bodily-centred approach, while the other female gynaecologists integrated the women's particular perspectives to tailor support to individual needs. WHC doctors stressed to a greater extent the

importance of focusing on women's individual and collective life circumstances to better understand their health and illness. Although the differences are minor, mainstream healthcare might profit from applying such features of women's health care in a healthcare context that is increasingly privatised and restrains the opportunities for handling the genderedness of well-being from diverse viewpoints (Deccache & van Ballekom, 2010; Waaldijk, 2011). However, the study also brought to light the dangers of stereotyping patients (individualising, universalistic and psychosocial trap, chapter 5), by both female and male gynaecologists, whether more or less empowering.

Gynaecologists might benefit from acknowledging that their clinical reasoning processes are neither gender neutral nor objective. This is considered necessary so that doctors' adopt a self-reflective approach (Baarts et al., 2000; Kirsti Malterud, 2002; Kristi Malterud, 2000). A self-reflective perspective enables doctors to become more attentive readers of (medical) signs (Kristi Malterud, 2000), to accept the interdependence of personal thought processes and clinical behaviours (Cary & Kurtz, 2013), to acknowledge the construed nature of clinical knowledge as it is created in clinical encounters (Baarts et al., 2000), and to avoid categorising and disempowering patients (Kirsti Malterud, 2002; Kristi Malterud, 2000; Thesen, 2005). Self-reflection is not about discarding biomedical perspectives (Kirsti Malterud, 2002), but about enabling clinicians to see the(ir) forces at play by emphasising the narrow path between objectivity and stereotyping, which is, "on one hand an invaluable tool in diagnosis, on the other hand the point of departure for stigmatizing behaviour" (Thesen, 2005: 52). A self-reflective strategy contributes to empowerment and patient-centred attitudes (Aujoulat et al., 2007; Thesen, 2005; Wald & Reis, 2010; Zoffmann et al., 2008), while giving clinicians' the leeway to do it their own way (Thesen, 2005). This is considered beneficial to gynaecologists, as it helps them to see the boundaries of medical knowledge, giving them the opportunity to consciously go beyond these without prescribing them particular forms of good practice. This is important as a purely biomedical model of gynaecology is deemed insufficient because of the many healthy woman seeking counsel on matters of reproduction, sexuality and 'normal' life-cycle concerns (Alder, Christen, Zemp, & Bitzer, 2007; Janssen & Lagro-Janssen, 2012). A self-reflective strategy also accounts for the contextuality and inter-subjectivity of clinical encounters.

The triangulation of different data sources and perspectives allowed us to focus on the ways decisions are shared in clinical relationships, both in terms of meaning and practice. To date, such facets of SDM remain under-studied (G Elwyn et al., 2003; Melbourne, Sinclair, Durand, Legare, & Elwyn, 2010; Saba et al., 2006; Stevenson et al., 2000; Wyatt et al., 2014), even though further exploration is warranted to promote broader understandings of SDM (Cribb &

Entwistle, 2011; Entwistle, Cribb, & Watt, 2012; Entwistle, 2009). As far as we are aware, this is the first time that SDM was investigated by triangulating data sources to account for relational complexities in clinical encounters. Joseph-Williams et al. (Joseph-Williams et al., 2014) reported that patients and physicians develop covert contracts, which can be barriers to SDM when these cause patients to transfer the lead role in knowledge and decision-making to doctors and, in turn, adopt the role of the passive, compliant partner. They did not elucidate why such contracts may exist. We add to the idea of covert contracts but reconsider them from a different and more comprehensive perspective of establishing meanings and building relationships.

On-going relationships in gynaecology were conducive to making patients feel supported. The importance of continuity was exemplified by our findings in the hospital context. Hospital patients found the medical advice to be reasonable due to the perceived severity of their illnesses, a finding consistent with the reported increase in patient preference for medical advice in cases of severe illnesses (Arora & McHorney, 2000; Levinson, Kao, Kuby, & Thisted, 2005). However, although they perceived the direct medical advice to be justified, they felt unsupported and left alone due to the short-term character of hospital clinical relationships. Prior studies have reported that preference measures fall short of reporting emotional tensions, relational ambivalence or contradictions evolving in clinical relationships (D. Lupton, 1997), while emphasising the importance of on-going physician-patient relationships for establishing preferred decision-making styles (Murray et al., 2007a). Our findings substantiate this.

Our study shifts the focus to the importance of gender-congruent reciprocity in gynaecological relationships for making patients feel supported in decision-making. The finding is reflected by Street et al. (Street et al., 2007) who emphasise the strong effect of reciprocity and mutual influence on clinical relationships, however without taking into account aspects of gender. Gender aspects around SDM have hardly been studied (Wyatt et al., 2014), although the gender of physicians and patients are widely acknowledged as having an impact on physician-patient interaction (Klea D. Bertakis, 2009; Roter, Geller, Bernhardt, Larson, & Doksum, 1999; Roter & Hall, 2004; Sandhu, Adams, Singleton, Clark-Carter, & Kidd, 2009; Schmid Mast et al., 2007; van den Brink-Muinen et al., 1998; Wyatt et al., 2014). Communication research disclosed that the sex composition of the physician-patient dyad affects doctor-patient communication (Roter & Hall, 2004; Sandhu et al., 2009), with same sex dyads strengthening observed gender differences (Roter & Hall, 2004). Female-female constellations were the most patient-centred (Sandhu et al., 2009) and showed more equal contributions to discussions (Roter & Hall, 2004). Male-male dyads showed the shortest visit times and the highest level of dominance (Roter & Hall, 2004). Opposite sex dyads were characterised by unease (Roter & Hall, 2004; Sandhu et

al., 2009) as male doctors paid less attention to women's histories and made assumptions about them (Sandhu et al., 2009). Our findings reflect these outcomes in that the gender composition of gynaecological relationships affected the ways in which decisions were controlled. Male gynaecologists appeared to enact more decisive authority vis-a-vis their female patients who, in turn, felt supported by the medical advice received. Female gynaecologists collaborated in making decisions with patients who, in turn, felt emotionally supported. Thus, participants adhered to the conventional gender-congruent stereotypes that imply a hierarchy of gender, associating men with hierarchy and women with egalitarianism, as described by Mast (Mast, 2004; Schmid Mast, 2004). The importance of having male gynaecologists behave in a gender-congruent way by directing decisions was stressed by the group of female patients who did not receive medical advice and considered whether a relationship with a female gynaecologist would be more beneficial for them, implying that decision-making relies upon gynaecologists' gender-congruent behaviour in clinical relationships.

Similarly, patient feelings of support were rooted in different mutual constructions of meaning in clinical relationships, with content varying depending on different gender constellations. This finding implies that gender congruent meanings are deemed important so that patients feel good about decision-making in clinical relationships. However in communication research on SDM, good clinical relationships are presumed to facilitate patient involvement (Glyn Elwyn et al., 2012; Kiesler & Auerbach, 2006), denoting that those not engaging in SDM might not have good interpersonal clinical relationships. Such research rests on the assumption that what looks good to the observer feels good to patients and doctors, although 'good' relationships have been difficult to define (Salmon et al., 2011; Young et al., 2011). Prior studies (Saba et al., 2006; Salmon et al., 2011; Young et al., 2011) illustrate these misconceptions. Saba et al. (Saba et al., 2006) showed that a positive subjective experience of partnership may not necessarily be reflected in the observed communication. Salmon, Young and colleagues (Salmon et al., 2011; Young et al., 2011) reported that patients felt emotionally supported, although emotional talk was absent in observed communications. Salmon et al. (Salmon et al., 2011) assumed that authentic caring would be determined by the conscientious execution of the doctor's role rather than by overt emotional talk. Our analyses add a gender perspective that the previous authors did not consider. We stress the shared gender-congruent nature of joint meaning and knowledge production as essential for making patients feel supported rather than the observable decision-making style. Our results show that female patients of male gynaecologists only felt supported by medical advice that derived from a shared agreement on privileging medical knowledge. However, female patients were enthusiastic about their relationships with male gynaecologists

('it simply is well', chapter 7). It thus seems misguided to assume that these patients might not have good interpersonal relationships, as implied by the assumptions of SDM research (Glyn Elwyn et al., 2012; Kiesler & Auerbach, 2006). Gender-congruency in establishing meanings appeared to be equally important in female gynaecologist-female patient constellations but rested on very different understandings. In female gynaecologist-female patient relationships, SDM was practiced but patients' feelings of support were based on their preference for medical expertise combined with notions of femininity, which were mirrored in female gynaecologists' perspectives. The findings stress the importance of acknowledging that care approaches emerge from shared contextual and meaningful experiences and interactions that are not visible to the observer of videotaped communication fragments. This suggests that, in gynaecology, SDM is rooted in jointly uniting medical expertise with knowledge of what womanhood means in female gynaecologist-female patient relationships. However, these aspects are not contained in the present theoretical conception of SDM which is based on integrative communication acts (Charles et al., 1997; Charles, Gafni, & Whelan, 1999; Entwistle et al., 2012). In accordance with our findings, diverse forms of decision-making may be justified as respectful, but may only be better understood and valued when embracing more comprehensive and integrative research methods (e.g. interviews with observations of consultations) better suited to researching the complexity, situatedness and contextuality of working approaches in clinical relationships (Britten, 2011; Entwistle et al., 2012; Salmon et al., 2011; Young et al., 2011).

Differences in reasoning processes around empowerment converge strongly with the findings on SDM with regard to female gynaecologists' integration of women's perspectives and aspects of femininity. Thus, this thesis implies that care approaches might be intrinsically intertwined, complex and multidimensional in everyday practice, which might explain the current struggles to formulate a well-delineated theory and conceptualisation of empowerment (Aujoulat et al., 2007; Deccache & van Ballekom, 2010; S. Piper, 2010) and of SDM (Cribb & Entwistle, 2011; Entwistle et al., 2012; Entwistle, 2009). Moreover, previous literature suggested that clinical thought processes influence physicians' behaviour (Cary & Kurtz, 2013) and decisions (Entwistle & Watt, 2006). This PhD thesis suggests a similar idea, but stresses the importance of socialised gender differences influencing physicians' thought processes underlying their behaviours and medical practice.

9.2 Professional identities and the meanings of knowledge

Combining an embodiment perspective with theories of un/doing gender exposed how gynaecologists' careers shaped their integration into gynaecology and the ways in which they practice gynaecology, thereby revealing the gendered constructions of professional identities.

Studies on professional identities in the medical context exist (Aase, Nordrehaug, & Malterud, 2008; Apker & Eggly, 2004; Barr, Bull, & Rooney, 2014; Cruess, Cruess, Boudreau, Snell, & Steinert, 2014, 2015; McKenzie & Williamson, 2016; Pratt, Rockmann, & Kaufmann, 2006; Rodríguez et al., 2014) and are largely concerned about professional identity formation among medical students and residents (Barr et al., 2014; Cruess et al., 2014, 2015; Lindh Falk, Hammar, & Nyström, 2015; Pratt et al., 2006; Rodríguez et al., 2014). Few studies examine professional identity constructions among more senior physicians (Aase et al., 2008; McKenzie & Williamson, 2016). McKenzie and Williamson showed how working on a telephone helpline required GPs to realign their professional identity to this work context, which challenges the conventional underpinnings of primary care — the doctor-patient relationship and continuity in care. Aase et al. (Aase et al., 2008) reported that existential experiences early in physicians' careers influence how they deal with death and keep it at a distance in the present, suggesting that past experiences of vulnerability may be central to medical professional identity. These works did not include aspects of gender, unlike the few feminist-inspired analyses of health professions that concentrated on how women negotiate gender identity as medical doctors (Cassell, 1998; Davies, 2003; Eriksson, 2003, 2009; Löyttyniemi, 2009). With the exception of Eriksson's dissertation (Eriksson, 2003), which is not published in English, these works have not included the experiences of male doctors in the medical culture. This is an important shortcoming. Only by including men and women simultaneously can gendered processes around professional identity become comprehensible (Mcdonald, 2013; Simpson, 2011). The present study is novel in that it incorporates female and male gynaecologists simultaneously, while applying a theoretical perspective that unites an embodiment approach with theories of un/doing gender. Kristina Eriksson's work "The pregnant body at work" in the anthology, *Body claims* (Eriksson, 2009), is, to our knowledge, the only study apart from ours that combines aspects of gender with embodiment to explore how gender identity and professional identity in the medical profession interrelate. However, more authors are acknowledging the importance of an embodiment approach to better comprehend the effects of gender, but in the spirit of investigating the health of individuals and populations (Fausto-Sterling, 2005; Hammarström et al., 2014; Krieger, 2012). Palm (Palm, 2013) describes these approaches as 'biological embodiment' because they are concerned about how the social order is incorporated into the body and how it influences changes in health and health inequities. We shift the perspective towards physicians to discover how they incorporate the social order and what this tells us about medical identities in a feminised profession. In this way, the current study fills an important gap, as it is among the first to integrate women's and men's experiences in gynaecology to explore

medical professional identities through an embodiment perspective with theories of un/doing gender.

Our findings expose how female and male gynaecologists perceive and experience the male and masculine culture of (past) gynaecology. We see how they both internalised the hierarchical gender order in very different ways due to their different gendered experiences, rooted in body materiality. These processes set the course for the differentiation of female and male gynaecologists' career socialisations and care approaches. Male gynaecologists' gender identity aligned well with the (past) masculine underpinnings of the profession (referencing their positions as leading academics and surgeons, chapter 7). They tended to favour biomedical knowledge with an affinity to mainstream hospital gynaecology. In contrast, female gynaecologists experienced the (past) gynaecological culture as a practice transgressing the female body and being harmful to womanhood. These embodied experiences were crucial to their decision to consciously distance themselves from conventional gynaecology and to move into their own private outpatient settings. The finding is in line with those of Riska (Elianne Riska, 2001), who found that the flat organisational structure of health centre settings provided female doctors more professional space than the hierarchical structure of the hospital. In our study, female gynaecologists consciously moved into their own private outpatient settings to defuse the gendered tensions they had experienced and to practice gynaecology in a way that is compatible with their own ideas of how gynaecological care givers should treat women. Such a move appeared unnecessary for male gynaecologists. Thus, we may say that the settings included in the study reflect a distinction between women and men doctors that is consistent with the different care approaches.

While previous studies described women in medicine as challenged to merge their feminine gender identity with the prevailing masculine notions of the profession (Cassell, 1998; Davies, 2003; Eriksson, 2003; Löyttyniemi, 2009; Elianne Riska, 2001) — "possessing the wrong body in the wrong place" (Cassell, 1998: 44) — our analyses convey that female gynaecologists might have succeeded in forming a professional identity aligned with femininity within their own private gynaecological practices. With reference to men, our analyses show that they are challenged by the increasing number of women in the profession. The discursive strategies they employed seemed to help them maintain their masculine professional positions, and resemble the previously described constructive approaches applied by men in professions dominated by women (Heikes, 1991; B. Lupton, 2000; Simpson, 2004). Thus, the findings show how differently (past) experiences are processed by men and women in professions and rhetorically reconstructed so as to engage in intra-professional divisions based on gender difference.

Gynaecologists' (embodied) experiences were also crucial to determining how they perceived and related to women as patients. For female gynaecologists, it was important that they have the same gender as patients, through which they stressed the mutual character of the relationship, including their tendency to blur the boundaries between expert and lay knowledge and surpass the biomedical model which they perceived as a limited approach to women's health care. Male gynaecologists, in comparison, needed to deal with having the opposite gender as patients, especially during pelvic examinations. In this institutionalised situation, gynaecologists' male body appeared to be a possible sexual threat from which they ostensibly escaped by resorting to the disembodied and genderless professional medical ideal, as previously described by Eriksson (Eriksson, 2009). Likewise, Galasiński & Ziółkowska (Galasiński & Ziółkowska, 2007) reported the necessity for male gynaecologists to make their gender irrelevant during pelvic examination with the objective to bring the extremely threatening institutionalised situation of pelvic examination into accordance with the social norms managing gender relations. Our findings strengthen those of Galasiński & Ziółkowska by illustrating the importance of the female body as a central site upon which the gendered differentiation of gynaecology is constructed. In our study, men and women gynaecologists needed to position themselves towards women's (patients') corporeality, but within a social order that ascribes them different scope for manoeuvring. This is also why female gynaecologists, in addition to valuing medical expert knowledge, were able to integrate a perceived feminine stance towards producing knowledge in consultations by incorporating women's lay perspectives and bodily experiences.

Previous medical phenomenological literature (Goldenberg, 2010; Gordon, 1988; Hindmarsh & Pilnick, 2007; Leder, 1990; Nettleton, Burrows, & Watt, 2008) explored and reflected on what medical knowledge is. Gordon (Gordon, 1988) observed that experiential clinical knowledge is embodied knowledge as it is acquired by means of the body's senses. Hindmarsh and Pilnick (Hindmarsh & Pilnick, 2007) reported that anaesthetists achieve a sense of knowing that is rooted in feelings, e.g. positioning the laryngoscope with practical knowledge of the embodied work of looking at the vocal cords. Leder (Leder, 1990), from a theoretical point of view, stressed that to diagnose patients, physicians must physically engage with them and that their experiential knowledge would reside in the body as a corporeal wisdom, difficult to express. She likewise emphasised that the use of images, graphs and numbers, as produced by blood tests and x-rays, transform the medical practice into a more intellectual, disembodied endeavour. Nettleton et al. (Nettleton et al., 2008) conducted an empirical study to show that changes in the institutional and cultural context of medical work have altered the field of medicine by making medical knowledge increasingly disembodied. These studies share a focus on embodied clinical

knowledge gained through medical practice when engaging with patients' bodies (or in the case of disembodiment, as an abstraction of patients' bodies). The female gynaecologists in this study resorted to another form of knowledge. They made use of their own experiences in being and sensing a female body, passing through 'normal' life changes, to stress the importance of integrating patients' views in the consultation process, as a means of counteracting the medicalisation of women's life phases, and to produce empathy and solidarity with patients. These constructions resemble those of the women's health movement, which also scrutinized the power of medical knowledge, resolving intentionally the apparent opposites of lay and expert knowledge (Kuhlmann, 2009). They achieved this through combining medical knowledge with personal experiences and self-help approaches within the framework of a salutogenetic approach. While some of the female gynaecologists surveyed had been part of the feminist women's health movement, others of the same generation had not. Moreover, the younger assistant doctor reverted to her own bodily experiences to argue that female gynaecologists would better understand the anxieties of women patients, implying that younger generations of female gynaecologists also resort to their feminine embodied knowledge.

Gynaecologists concordantly used their different forms of knowledge (biomedical expert knowledge vs. embodied feminine knowledge) to establish professional identities and to distance themselves from each other within the profession. There is evidence that competing forms of knowledge are used to act out intra-professional boundaries in health care professions, such as those between nurses and nurse assistants (Dahle, 2003), between specialist nurses, cardiologists, general practitioners and geriatricians working on a team to manage heart failure management (Sanders & Harrison, 2008), between general practitioners and newly instituted general practitioners with a special interest in genetics (Martin, Currie, & Finn, 2009) and, historically, between male medical doctors and midwifes (Wetterer, 2002). The latter study analysed the historical division of work between male doctors and female midwifes to explore the constructions of gender in the health profession. She reported that male medical doctors successfully integrated obstetrics and gynaecology into medicine, transforming them into a special area of expertise, while at the same time devaluing the traditional knowledge of midwifes by equating it with lay knowledge about the female body and the birth process. We can see similarities in our studies, with male gynaecologists resorting to academic biomedical knowledge, while female gynaecologists distinctively relied upon their lived bodily experiences and thus, lay perspectives, to construct a more feminine way of practicing gynaecology that sets them apart from masculine (hospital) gynaecology.

The constructed gender differences in internal work divisions were not consistent throughout, as we also observed forms of undoing gender and of lowering intra-professional boundaries. The study's findings suggest that a socio-cultural change may be underway and that the relations between men and women gynaecologists are in flux. This might indicate that a strong maintenance of gender difference may no longer be necessary or that the construction of gender differences through boundary work may have taken on other forms. If we had included settings populated by younger gynaecologists, the combination of gender and work socialisation might look different. These aspects should be further investigated.

9.3 Strengths and limitations

This doctoral thesis has several strengths. Rigor was established through various measures (see chapter 4.7). Internal validity is high, as data analysis showed great consistency between interviews and observations. The findings of this thesis refer back to a previous quantitative analysis of the WAGE project, conducted by Gross et al. (Gross et al., 2013, see appendix 11), wherein discordance regarding actions taken during the consultation was only associated with practice characteristics. The WHC received the lowest discordance levels, possibly reflecting their pronounced stance towards involving women in the consultation process. Moreover, not all the material collected and analysed has yet been integrated into publications. This applies to the interviews conducted with practice staff members which focused on how they perceive their professional role in the settings. And, it is also valid for the patient information material collected to assess the health versus disease orientation of gynaecologists across settings. As patients in gynaecology are women, some researchers consider this to be a limitation to their study, arguing that the gendered results may be attributable to patient gender and gender concordance, regardless of whether male gynaecologists communicate in a patient-centred way (Christen et al., 2008). Because gynaecology is based on the idea of delivering care to women only, we cannot see this as a possible bias but only as a characteristic of this specific field. Thus, we acknowledge that the findings might look very different for other medical (sub)specialities. Almost all of the gynaecologists surveyed gained their first work experiences during the late 1970s and early 1980s. They were part of the initial feminisation of gynaecology and exposed to the explosion of care approaches between 1985 and 2000, which oscillated between evidence- and experience-based care approaches (Whelan, 2009). This generation is especially valuable for researching how women and men relate to the feminisation process in gynaecology and different working approaches.

Limitations of this thesis are to be recognised. Although the aim of qualitative research is not representativeness, the relatively small sample size is acknowledged. The WAGE project was

carried out in the Basel area, Switzerland. Comparisons within Switzerland and with other countries should be made cautiously. As knowledge on women's health care as delivered by WHCs is scarce, the findings need to be interpreted carefully. The sampling strategy was determined by the mixed methods approach of the WAGE project, which did not allow for theoretical sampling of gynaecological settings, as would have been necessary for a comprehensive grounded theory approach beyond data analysis. However, the trade-off between saturation and representativeness is intrinsic to mixed methods approaches (Creswell, 2003b; Teddlie & Yu, 2007). The fact that only two physicians were sampled in the university hospital context is a weakness. The time and resources required to incorporate more hospital gynaecologists were not available within the context of the project. Moreover, it may be assumed that observations were influenced by the presence of the observer, which might have made participants feel uncomfortable and lead them to adapt their behaviours (Kawulich, 2014). Due to gynaecologists' expressed concerns that observations of pelvic examinations might distress patients, this part of the consultation was excluded from observations. During data collection, a new hospital funding scheme was gradually implemented; the project did not take this into account. Such a reform might affect the relationship between work and (gendered) subjects (Leonard, 2003). The study of care approaches depends very much on context and situation, which could not be taken into account entirely. SDM might depend on the patients' health situation, health literacy, cognitive impairment and emotional stress (Entwistle et al., 2012), which we did not consider in this study. Pelvic pain may be useful to study empowerment, because it causes difficulties regarding the division of medical knowledge and psycho/social interpretations. It may be that the differences found would feature less obviously for a more clearly defined illness (Whelan, 2009). As almost all gynaecologists came from the same generation, the findings may not be transferable to younger gynaecologists today.

9.4 Implications for research

The thin base of evidence on professional identities and care approaches in gynaecology necessitates more research to validate and strengthen the findings of this PhD thesis. Following the results presented here, the implications for research are as follows:

First, the findings of this study suggest that more research is needed on professional identities in contemporary medicine and on how gender difference is used by fe/male medical doctors to engage in internal boundary work. As mentioned in chapter 8, works in this direction have almost exclusively focused on female physicians' experiences and on surgery (Cassell, 1998; Davies, 2003; Eriksson, 2003). Research should now be extended beyond gynaecology to other medical sub-specialities. It would be of major importance to include men and women doctors

simultaneously, as only then can one discern differences and similarities in how they engage in gender work. Such research would contribute to a better understanding of the ways in which the professional culture of medicine might (not) be gendered, what this could mean to fe/male doctors and how it affects their professional practice (Britton, 2000). The aim is to provide insights into the conditions and contexts under which men and women work as doctors and to use the results to foster an occupational culture that could offer greater sociocultural spaces for both (Britton, 2000) and to create awareness among the members of the medical academy on the impact of gender differences on medical practice (Carnes et al., 2008). This is warranted as the topic of gender, despite all progress made, faces on-going challenges to secure a place for itself in the medical culture (Carnes et al., 2008; Lagro-Janssen, 2010).

Second, although the embodiment perspective applied in this PhD thesis was very useful to research professional identities in gynaecology, it has hardly been applied to better understand meanings and practices in medical culture (Eriksson, 2009; Hindmarsh & Pilnick, 2007; Nettleton et al., 2008) and even less so at the crossroads of gender (Eriksson, 2009). It is worth applying this theoretical perspective in a more comprehensive manner, given that medical practice is essentially about the body and rooted in human embodiment (Eriksson, 2009). It is clear that the concept is suited to other medical areas and poses many research possibilities beyond gynaecology and professional identity.

Third, communication research on care approaches has given valuable insights into gender differences in practice patterns (Klea D. Bertakis, 2009; Cronauer & Schmid Mast, 2010; Janssen & Lagro-Janssen, 2012; Roter et al., 2002; Sandhu et al., 2009; Schmid Mast et al., 2007), but it does not sufficiently assess and understand the social complexities of care approaches in clinical relationships. To overcome the shortfall, triangulation of different data sources and perspectives and the use of qualitative approaches is suggested (Britten, 2011; Entwistle et al., 2012; Salmon et al., 2011; Young et al., 2011). The objective is to account for the tensions, ambivalences and ambiguities that patients and physicians experience in clinical relationships and to better understand what they mean to each group. In so doing, research may encourage doctors and patients alike to embrace and value varying positions in clinical relationships and not just the contemporary authorised places allotted to them by narrow understandings of care approaches.

9.5 Implications for policy and practice

Based on the findings of this thesis regarding care approaches, we offer the following suggestions for educational practice in (postgraduate) gynaecological training:

First, offer training courses on self-reflective approaches to foster physicians' self-reflective capacity. This should serve as a strategy for teaching physicians to think about the part they play in the consultation process and to recognise how their own socio-cultural and interpersonal backgrounds influence their position (Davidsen, 2009; Entwistle et al., 2012; Kristi Malterud, 2000). Careful thought ought to be given to how aspects of gender might influence this process so as to avoid possible gender traps in diagnosis and treatment decisions. This relevance and importance of such training is also indicated elsewhere (Stutz & Ceschi, 2007).

Second, offer clinical communication skills training but avoid a 'one size fits all' approach. It might be more important to support individual participants to learn certain skills in a targeted manner (Alder et al., 2007) while giving attention to the significance of gender. This implies the use of a self-reflective training method (Sandhu et al., 2009) to help reconsider how clinical reasoning processes affect behaviours. This is deemed relevant and beneficial for raising clinicians' awareness of the interrelatedness of thought processes and clinical communication (Cary & Kurtz, 2013).

Third, develop training programmes that specifically foster interpersonal and relationship building skills as well as relational autonomy competences (Atkins, 2006; Entwistle et al., 2012; Holmström & Röing, 2010; Sherwin, 2000). Doing so would serve to move beyond universal prescriptions for particular forms of communication behaviour. Relational skills and competences permit clinicians to use their professional knowledge and experience in line with patients' values, while supporting them to switch between different suitable forms of sharing decisions with patients (Entwistle et al., 2012).

Fourth, carefully consider concrete actions drawn from the findings on gender work and professional identity given the thin base of evidence with regards to professional identities in gynaecology. The findings might, however, serve to educate the medical academia to recognise the importance of socialised gender differences in medicine to establish a more favourable framework for implementing the recommendations and to foster awareness that more research is needed in this direction.

9.6 Conclusion

The differences in care approaches across settings depended on the gendered biographical socialisations of men and women as gynaecologists. Female gynaecologists appeared to be more alike in developing mutual relationships with patients than male gynaecologists. They integrated women's perspectives to a greater extent and showed a tendency towards lowering the boundaries between lay and expert knowledge. Although differences between female

gynaecologists were small, gynaecologists from the WHC showed a stronger empowerment perspective, the adoption of which could be beneficial in conventional healthcare settings as well. However, care approaches are the products of specific, complex and contextually distinct clinical relationships that have different meanings to physicians and patients alike. Female patients of male gynaecologists preferred and felt supported by the direct medical advice they received. Thus, training courses have to take into account the gendered and relational aspects of care approaches in gynaecology by integrating clinical reasoning and relationship building skills based on a self-reflective learning approach. This should help gynaecologists to offer the best possible and most responsive support to patients, while taking into account the intimate and sensitive nature of gynaecological practice.

10 References

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11 Appendices

Article 4: *Patient-physician concordance and disconcordance in gynecology: Do physicians identify patients' reasons for visit and do patients understand physicians' actions?*

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Communication study

Patient–physician concordance and discordance in gynecology: Do physicians identify patients' reasons for visit and do patients understand physicians' actions?

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ABSTRACT

Objective: To assess physician–patient concordance on reasons for consultation and actions taken during consultation in five different gynecological practices, and to investigate patient and physician factors influencing discordance in reporting.
Methods: 1667 post-encounter questionnaires completed by patients and physicians were compared in terms of reasons for consultation and actions taken during consultation. Patient–physician concordance was assessed using kappa statistics. Multivariable regression analyses served to identify determinants of discordance.
Results: A moderate to high level of patient–physician concordance on reasons for consultation and actions taken during the consultation was found. Discordance regarding reasons for consultation was associated with patient and practice characteristics, discordance regarding actions taken during the consultation only with practice characteristics. Counseling emerged as a particular source of patient–physician discordance.
Conclusion: In gynecological practices, discordance depends on the reason or action assessed, but is particularly pronounced when it comes to counseling. The influence of physician characteristics on patient–physician concordance needs more attention in research.
Practice implications: Gynecologists need to establish a mutual understanding with their patients about the reason of the consultation and the actions taken in the consultation, in particular with regard to counseling.

1. Introduction

Concordance is an important feature of the patient–physician interaction. Not surprisingly, a considerable body of literature has investigated patient–physician concordance with regard to symptom etiology [1–3], patients' health status [4–6], physicians' understanding of their patients' expectations and treatment goals [7–10]. Studies from different medical fields provide evidence that patient satisfaction, adherence to treatment and outcomes of care are higher when physicians and patients agree with each other [7,10–13]. Moreover, better understanding between patients and physicians is also related to a reduced need for further consultations [1] and better patient self-management of care [7], thereby decreasing health care costs.

Less is known on the degree of agreement between patients and physicians on why the patient consults the doctor and on what happens during the consultation itself. Studies showed that doctors and patients do not always agree with each other regarding the reasons for a specific consultation [14–16] and actions taken therein [15,17,18]. Using post-consultation questionnaires, Boland et al. [14] observed that although physicians were generally able to identify patients' reasons for seeking a general medical examination, in 20% of the visits agreement was low or absent. Family physicians and patients frequently gave discrepant reports of what had happened during the consultation [18]. As reported by Street and Haidet [19] physicians may misperceive how their patients understand clinical actions even for relatively common medical issues, such as blood pressure control.

So far, physician–patient concordance in gynecological care has hardly been addressed apart from studies which examined the validity of patient reports regarding preventive clinical interventions such as mammography and Pap screening in comparison to medical record data which were considered as gold standard [20–22]. However, in basic gynecological care, the ability to establish a

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mutual understanding regarding reasons and content of consultation may be of particular importance because, besides treatment, information giving, counseling and decision making involving patient preferences constitute a considerable part of a consultation, e.g. for contraception, pregnancy, or menopause.

Factors influencing patient–physician concordance are still not fully understood [5]. Several studies have examined how patients' socio-demographic characteristics such as socio-economic status, education, or ethnicity influenced patient–physician concordance. Results of these studies have been mixed. While some suggested that concordance might be negatively effected by lower socio-economic status [17] or ethnicity [18] through less effective patient–physician communication, others found no effect for patient education, income or race/ethnicity [5]. Again other studies showed that agreement rather depends on patients' health status [5,6], their active participation [7] or the continuity of the patient–doctor relationship [24]. Yet, few studies have investigated the influence of physician characteristics on patient–physician concordance [10]. According to an early study by Sawyer et al. [20], women who had been seen by nurse practitioners were more likely to report their last Pap smear more accurately than women seen by an internist or family practitioner. Rohrbaugh and Rogers [18] reported that discrepant physician and patient perceptions on what happened in routine family clinic visits could not be explained by patients' demographic characteristics but varied by visited physicians and were more pronounced if physicians minimized attention to psychosocial issues and/or felt confident about understanding the patient's problem.

In order to address the above mentioned lack of research with regard to patient–physician concordance on reasons and content of gynecological consultations, the aims of the study are, first, to compare patients' and gynecologists' reports of reasons for a particular consultation and actions taken during this consultation based on post-encounter questionnaires across five different gynecological practices, and to assess physician–patient concordance in these reports. Second, we sought for a better understanding of the factors influencing discordance in reporting. Based on the insights from other studies, we hypothesized, that discordance would not only vary by patient characteristics but also differ between the practices due to different working approaches. We also expected that physicians will have a better concordance with long-term patients than with patients with whom they have had only few or no previous visits.

2. Methods

2.1. Participant selection

For the analysis we used data from five private gynecological practices in the Basel region in Switzerland which were collected in the frame of a larger ongoing study on the impact of gynecologists' working approaches on their patients ("Women and Gynecology in Evaluation"). These practices – one group practice and four practices led by single gynecologists – were chosen to represent a broadly varying range of gynecologic working approaches. In the five practices, a total of 2154 women, 1226 long-term patients (attending their practice for at least 10 years) and 928 recent patients (attending their practice less than 2 years), had been recruited by the end of February 2012. Patients were eligible for the study if they spoke German and were above 18 years of age.

2.2. Data collection

Eligible women were informed about the study during the consultation by their physician and were invited to complete a self-administered questionnaire. The questionnaire included questions on women's reasons for the current consultation ("What was the reason for today's consultation?") and actions taken by the physician during the consultation ("What has been done today?"). Women could choose from 12 reasons for consultation and 9 actions taken during consultation, or alternatively write them as free text if not listed. Further information was collected on women's socio-demographic characteristics (i.e. age, marital status, education, income, nationality, mother tongue) and women's self-rated health (measured on a 5-level scale ranging from excellent to very poor). Additionally, the questionnaire provided data on women's medical history; use of health services (during the last 12 months); attitudes toward health; receipt of services and satisfaction with care received which will be subject of forthcoming analyses.

Out of the 2154 recruited women, 86% (1049) of long-term patients and 69% (642) of new patients had sent back their questionnaire by the end of February 2012. For all 2154 patients who had given their written consent to the study, physicians completed a short protocol immediately after the consultation. The protocol included information on the woman's socio-demographic characteristics, her reason for consultation and actions taken during the consultation (with identical items as in the patient questionnaire), the duration of consultation as well as few details of her medical history. After data cleaning, a total sample of 1667 sets of patient questionnaires and corresponding physician protocols were available for analysis.

2.3. Statistical analysis

Means of numbers of reasons for consultation and actions taken during the consultation reported by patients and physicians were compared using the paired t-test. McNemar's test served to compare frequencies of specific reports between patients and physicians. Because we compare reports of reasons for and actions taken during the consultation, we use the terms 'concordance'/'discordance' and not 'agreement'/'disagreement' which would require some sort of rating scales. Patient–physician concordance on the 12 reasons for the consultation and 9 actions taken during the consultation was assessed using the kappa statistic which quantifies concordance between patients and physicians in excess of what would be expected by chance alone. A kappa of 1 indicates perfect agreement, whereas a kappa of 0 indicates agreement equivalent to chance [23]. One difficulty of kappa is that, for low prevalence rates, κ may be low despite of high absolute agreement [23]. Kappa values are therefore provided together with overall agreement rates.

Two discordance indices were defined: (1) the number of reasons for consultation on which the physician- and patient-reports differed and (2) the number of clinical actions on which they differed. To analyze determinants of patient–physician discordance, multivariable analyses were conducted with the discordance indices as outcome measure. To account for the non-normal distribution of the indices, bootstrapped multivariable linear regressions were performed. In each model, we included patient characteristics as well as the practices.

Random effect models were run to assess the influence of specific characteristics of the practices, e.g. gynecologists' sex and mother tongue and mean unexplained consultation time (i.e. the difference between observed consultation time and time predicted based on reported reasons for consultation and actions taken). Given the small number of practices, these influences were assessed one by one. Furthermore, multivariable logistic regressions were used to analyze discordance on single reasons for consultation and actions taken during consultation. Differences in discordance rates across practices were again adjusted for potentially confounding patient characteristics. Moreover, we

Table 1
Practice characteristics.

	Practice 1	Practice 2	Practice 3	Practice 4	Practice 5
Year of opening of practice	1980	1992	1989	1991	1996
Number and sex of physicians (+lay experts)	5 (+4) all female	1 female	1 male	1 female	1 male
Number of board-certified gynecologists	1	1	1	1	1
Physician's mother tongue	All Swiss German	French	German	German	Swiss German
Characterization	Group practice for gynecology with integrated care, including psychosocial approaches	Practice for general gynecology including surgery, infertility treatment, obstetrics without delivery assistance; with a focus on psychosomatics, sexual medicine, children's gynecology	Practice for gynecology and obstetrics with a main focus on medical care for infertility patients	Practice for general gynecology, including endocrinology, treatment of infertility, psychosomatics, care of oncological patients, ultrasound, care of difficult pregnancies, crises-intervention and diet counseling	Classical gynecological practice specialized in obstetrics, prenatal and feto-maternal medicine and gynecological surgery
Approximate number of consultations per year	5937	4200	4000	5600	3800

examined potential interactions between practices and patient characteristics. Data were analyzed using Stata 10 (StataCorp, College Station, TX, USA).

3. Results

3.1. Patient and provider characteristics

The five practices differ in services offered, organizational aspects, gender and mother tongue of the gynecologists (Table 1). Practice 1, a gynecological group practice, was established in 1980 in the context of the women's right movement. It consists of five female doctors and four lay women with special expertise in women's health. Besides routine gynecological care, they offer psychosocial and complementary approaches to health care with a special focus on what they defined as women-friendly medicine. Practices 2 and 4 are led by female gynecologists with a special training in psychosomatics addressing a broad range of gynecology and obstetrics. Practices 3 and 5 are led by male gynecologists with a focus on care for infertility-patients and on prenatal and tumor ultrasound diagnostics, respectively. Consultations had a median duration of 20 min.

Characteristics of patients participating in the study are summarized in Table 2. Most women were married or lived in a consensual union, had a higher education, a household income of more than 6000 Swiss francs available per month, were German speaking and of Swiss nationality. The majority of women were long-term patients. Recent patients were more likely to be of younger age (mean of 36.4 vs. 49.0 years), to be single (29% vs. 10%), to have a low household income (23% vs. 10%), and to be of non-Swiss nationality (22% vs. 6%, results not shown).

3.2. Patient–physician concordance on reasons for consultation

Table 3 summarizes the frequencies of patient and physician reports on reasons for consultations and their respective concordance. Both, patients and physicians, reported annual check-up as the far most frequent reason for consultation (first two columns) followed by contraception, disorders, prescription, counseling and follow-up examination. Agreement between patients' and physicians' reports was high (>90%) for all reasons except counseling (80.6%), prescription (82.4%) and disorders (86.6%). Despite these high concordance rates, values of the Cohen's kappa varied considerably, ranging from 0.08 to 0.77. Among the six most frequent reasons, kappa values were poor for counseling (κ 0.25) and prescription of drugs (κ 0.32).

On average, physicians mentioned slightly more reasons than patients (1.61 vs. 1.49, $p < 0.001$). Among the six most frequently mentioned reasons for consultation, only annual check-up (73% vs. 68%, $p < 0.001$) and contraception (14% vs. 12%, $p = 0.006$) were mentioned more often by patients. While patients tended to indicate rather general reasons for consultation in the questionnaire such as contraception and annual check-up, physicians were

Table 2
Patient characteristics.

Categories	Total sample		
	N	*n*	%
Age (mean, SD)	1661	44.2	14.2
Marital status	1645		
Married/consensual union		1173	71.3
Single		280	17.0
Divorced, separated, widowed		192	11.7
Education	1650		
Higher education[a]		1037	62.9
Vocational training[b]		527	31.9
Low education[c]		86	5.2
Household income[d]	1396		
<4000 CHF		205	14.7
4000–6000 SFr.		301	21.6
>6000 SFr.		890	63.7
Nationality	1654		
Swiss		1458	88.2
Other		196	11.8
Mother tongue	1667		
German		1502	90.1
Other		165	9.9
Years of attendance	1667		
≥10 years		1036	62.2
<2 years		631	37.8
Self-rated health	1653		
Good (excellent/very good)		1448	87.6
Poor (fair/poor/very poor)		205	12.4
Practice visited	1667		
Practice 1		727	43.6
Practice 2		292	17.5
Practice 3		214	12.8
Practice 4		258	15.5
Practice 5		176	10.6

[a] High school, teachers' college, other higher educational formation, higher educational training (Master, Technical High School, etc.), university, and college.
[b] Vocational training.
[c] Obligatory school time without further education.
[d] Gross household income per month.

Table 3
Reasons for consultation: patient and physician reports (N = 1667).

Reason for consultation	Physicians' report		Patients' report		p-Value*	Agreement	Cohen's kappa
	N	%	n	%		%	κ
Annual check-up	1132	67.9	1213	72.8	<0.001	90.2	0.77
Contraception	204	12.2	228	13.7	0.074	90.0	0.56
Disorders	285	17.1	219	13.1	<0.001	86.6	0.48
Prescription of drugs	292	17.5	213	12.8	<0.001	82.4	0.32
Counseling	300	18.0	205	12.3	<0.001	80.6	0.25
Follow-up examination	174	10.4	141	8.5	0.006	91.9	0.53
Menopause problems	96	5.8	118	7.1	0.078	91.5	0.29
Antenatal care	80	4.8	82	4.9	0.688	99.6	0.96
Referral	48	2.9	28	1.7	0.012	96.5	0.22
Health promotion	47	2.8	18	1.1	<0.001	96.5	0.08
Fertility problems	29	1.7	17	1.0	0.043	98.2	0.34
Doctor's certificate	2	0.1	2	0.1	1.000	100.0	–

* McNemar χ^2 for comparison of physicians' and patients' reports.

more likely to report specific reasons for consultation such as disorders, counseling, and prescription. Physicians overestimated in particular counseling and prescription as a reason for consultation.

3.3. Predictors of discordance in reported reasons for visits

Based on the bootstrapped multivariable linear regression, practice as well as patient characteristics were found to be associated with patient–physician discordance in reported reasons for visit (Table 4). Among patient characteristics, low education, attending the practice for less than 2 years and poor self-rated health were significantly associated with higher patient–physician discordance. Moreover, the level of discordance strongly varied across practices and was most pronounced in practice 3.

Among the different practice characteristics considered, the physician's sex but not his/her mother tongue or unexplained average consultation time was significantly associated with discordance (regression coefficient = 0.44, $p = 0.02$). However, after excluding practice 3, this association also disappeared (regression coefficient = 0.08, $p = 0.45$).

Table 4
Reasons for consultation: effects of patient and practice characteristics on number of discordances between patient and physician reports (N = 1351).

Categories	Coeff.[a]	95% CI	p-Value
Age (in years)	−0.00	−0.01, 0.00	0.490
Marital status			
Married/consensual union[b]			
Single	0.06	−0.11, 0.23	0.463
Divorced, separated, widowed	0.01	−0.18, 0.20	0.932
Education			
Higher education[b]			
Vocational training	0.01	−0.13, 0.14	0.934
Low education	**0.31**	**0.04, 0.59**	**0.026**
Household income			
<4000 SFr.	0.09	−0.09, 0.26	0.334
4000–6000 SFr.	0.01	−0.15, 0.16	0.922
>6000 SFr.[b]			
Nationality			
Swiss[b]			
Other	0.01	−0.16, 0.18	0.891
Mother tongue			
German[b]			
Other	−0.07	−0.25, 0.12	0.485
Years of attendance			
>=10 years[b]			
<2 years	**0.15**	**0.02, 0.28**	**0.020**
Self-rated health			
Good (excellent/very good) [b]			
Poor (fair/poor/very poor)	**0.28**	**0.09, 0.47**	**0.004**
Practice visited			
Practice 1 [b]			
Practice 2	**−0.16**	**−0.32, −0.01**	**0.044**
Practice 3	**0.65**	**0.44, 0.86**	**<0.001**
Practice 4	**−0.18**	**−0.33, −0.02**	**0.029**
Practice 5	−0.01	−0.17, 0.19	0.942

Bold values indicate statistically significant results.
[a] Effect estimates obtained from a multivariable linear regression model.
[b] Reference category.

3.4. Patient–physician concordance on actions taken during the consultation

Physicians reported a mean of 3.68 actions taken during a visit, hardly differing from the mean of 3.63 actions reported by the patients ($p = 0.096$). As shown in Table 5, reporting frequencies were also very similar, except for the measurement of blood pressure and weight and for blood taking. There was consistently a high agreement between patients and physicians with values ranging between 87% and 94%. Kappa values for actions taken during consultation were considerably higher than for consultation reasons. The only exception was counseling, with an agreement of 65% and a low kappa value of 0.31.

3.5. Predictors for discordance in actions taken during the consultation

Table 6 presents the results of the bootstrapped multivariable linear regression analyses of the number of discordances between patient and physician reports regarding actions taken during the consultation. Practices rather than patient characteristics were found to be associated with patient–physician discordance. Compared to practice 1, the level of discordance regarding actions taken was significantly higher in all other practices. None of the patient characteristics turned out to be predictive. Differences between practices could neither be explained by the physician's sex nor by his/her mother tongue or unexplained consultation time.

3.6. Counseling – a source of discordance between patients and physicians

Due to the prominent role of counseling as a source of discordance, both in terms of reasons for visits as well as actions taken during the consultation, further analysis focused on counseling. As illustrated in Fig. 1, counseling was more often reported as a reason by the physicians than by the patients in practices 1 and 3, whereas in practices 2, 4 and 5, patients reported

Table 5
Actions taken during the consultation: patient and physician reports ($N = 1667$).

Actions taken during the consultation	Physicians' report		Patients' report		p-Value*	Agreement	Cohen's kappa
	n	%	n	%		%	κ
Gynecological examination	1207	72.4	1175	70.5	0.014	90.4	0.76
Breast palpation	1105	66.3	1119	67.1	0.243	92.6	0.83
Pap smear	994	59.6	1003	60.2	0.578	87.6	0.74
Counseling	766	46.0	809	48.5	0.080	65.5	0.31
Blood pressure measurement	751	45.1	661	39.7	<0.001	87.0	0.74
Ultrasound	441	26.5	434	26.0	0.547	94.1	0.85
Urine examination	404	24.2	429	25.7	0.033	92.4	0.80
Weight measurement	247	14.8	170	10.2	<0.001	88.9	0.50
Blood taking	98	5.9	173	10.4	<0.001	94.1	0.61

* McNemar χ^2 for comparison of physicians' and patients' reports.

Table 6
Actions taken during the consultation: effects of patient and practice characteristics on number of discordances between patients and physicians reports ($N = 1351$).

Categories	Coeff.[a]	95% CI	p-Value
Age (in years)	0.00	−0.00, 0.01	0.349
Marital status			
Married/consensual union[b]			
Single	−0.12	−0.28, 0.04	0.123
Divorced, separated, widowed	0.09	−0.09, 0.26	0.332
Education			
Higher education[b]			
Vocational training	−0.00	−0.13, 0.13	0.997
Low education	0.11	−0.22, 0.43	0.526
Household income			
<4000 SFr.	−0.06	−0.22, 0.11	0.508
4000–6000 SFr.	−0.07	−0.21, 0.07	0.322
>6000 SFr.[b]			
Nationality			
Swiss[b]			
Other	0.09	−0.13, 0.30	0.422
Mother tongue			
German[b]			
Other	0.14	−0.07, 0.35	0.204
Years of attendance			
>=10 years[b]			
<2 years	0.11	−0.03, 0.25	0.111
Self-rated health			
Good (excellent/very good) [b]			
Poor (fair/poor/very poor)	−0.08	−0.25, 0.09	0.369
Practice visited			
Practice 1[b]			
Practice 2	**0.76**	**0.59, 0.94**	**<0.001**
Practice 3	**0.18**	**0.01, 0.35**	**0.039**
Practice 4	**0.48**	**0.29, 0.66**	**<0.001**
Practice 5	**0.51**	**0.30, 0.71**	**<0.001**

Bold values indicate statistically significant results.
[a] Effect estimates obtained from a multivariable linear regression model.
[b] Reference category.

counseling as a consultation reason more often than doctors. The same holds true for counseling as an action. Reported frequencies of counseling as a reason for visit varied more strongly among physicians than among patients of the different practices (ranging from 2% to 44% vs. from 5% to 17%). This was even more pronounced for counseling as an action taken during consultation (ranging from 6% to 67% among physicians vs. 40% to 55% among patients), thus indicating that the definition of counseling varies more strongly across physicians than among patients.

Multivariable logistic regressions were performed regarding its discordant mention as a reason for consultation and as an action taken during the consultation. The level of discordance on counseling as a reason for consultation varied significantly across practices and was particularly high in practice 3 (Table 7). Only poor self-rated health was significantly associated with discordance. Patients who reported poor health were more likely to give counseling as a reason for consultation than their physicians.

In contrast, discordance on whether counseling occurred in the consultation was more strongly associated with patient characteristics: having a vocational training and being a recent patient were associated with less discordance, while having a low monthly household income was marginally associated with more discordance. Interestingly, counseling for recent patients took longer than for long-term patients (22.1 vs. 25.7 min, $p < 0.001$). Again, discordance on whether counseling was part of the consultation was highest in practice 3.

We conducted additional analyses looking at potential heterogeneity of effects across practices. The influence of having attended the practice for less than 2 years was different in one practice (practice 2), but otherwise there was little evidence of heterogeneity.

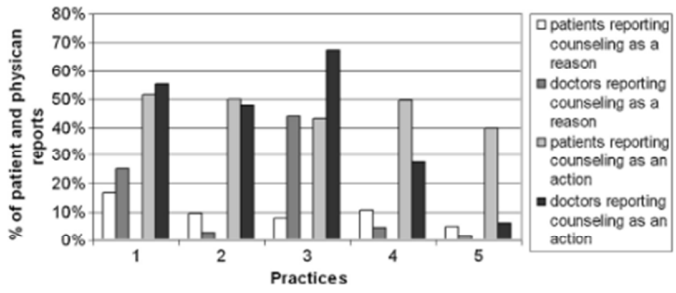

Fig. 1. Proportions of patient and physician reports on whether counseling was a reason for consultation and on whether counseling had occurred during consultation, by practice.

Table 7
Counseling as a reason for consultation and as an action taken during a consultation: effects of patient and practice characteristics on discordance between patient and physician reports.

Categories	Discordance on counseling as a reason for consultation $N = 1351$			Discordance on counseling as an action taken during consultation $N = 1351$		
	OR[a]	95% CI	*p*-Value	OR[a]	95% CI	*p*-Value
Age (in years)	0.99	0.98, 1.01	0.303	1.00	0.99, 1.01	0.644
Marital status						
Married/consensual union[b]	1			1		
Single	1.07	0.72, 1.61	0.731	1.07	0.77, 1.50	0.682
Divorced, separated, widowed	0.98	0.61, 1.58	0.932	1.13	0.77, 1.65	0.530
Education						
Higher education[b]	1			1		
Vocational training	1.11	0.80, 1.55	0.523	**0.67**	**0.51, 0.88**	**0.003**
Low education	1.37	0.66, 2.82	0.397	0.87	0.47, 1.63	0.670
Household income						
<4000 SFr.	1.31	0.85, 2.03	0.222	1.38	0.97, 1.98	0.078
4000–6000 SFr.	1.17	0.81, 1.70	0.403	1.14	0.84, 1.54	0.418
>6000 SFr.[b]	1			1		
Nationality						
Swiss[b]	1			1		
Other	1.23	0.77, 1.99	0.386	1.26	0.86, 1.84	0.234
Mother tongue						
German[b]	1			1		
Other	0.89	0.51, 1.57	0.691	1.24	0.83, 1.84	0.299
Years of attendance						
>=10 years[b]	1			1		
<2 years	1.37	0.97, 1.93	0.071	**0.63**	**0.48, 0.83**	**0.001**
Self-rated health						
Good (excellent/very good)[b]	1			1		
Poor (fair/poor/very poor)	**1.92**	**1.28, 2.89**	**0.002**	1.16	0.81, 1.64	0.420
Practice visited						
Practice 1[b]	1			1		
Practice 2	**0.33**	**0.20, 0.53**	**<0.001**	0.99	0.71, 1.38	0.942
Practice 3	**2.87**	**1.94, 4.25**	**<0.001**	**2.31**	**1.60, 3.34**	**<0.001**
Practice 4	**0.38**	**0.23, 0.63**	**<0.001**	1.07	0.75, 1.51	0.721
Practice 5	**0.13**	**0.05, 0.36**	**<0.001**	1.32	0.88, 1.99	0.180

Bold values indicate statistically significant results.
[a] OR (odds ratio) derived from a multivariable logistic regression model.
[b] Reference category.

4. Discussion and conclusion

4.1. Discussion

In the five gynecological care settings, a moderate to high level of patient–physician concordance was observed for the most frequent reasons for a particular consultation (ranging from 80 to 90%, Cohen's kappa being below 0.5 for counseling, prescription of drug and disorders) and for the actions taken during the consultation (ranging from 65 to 94%, low Cohen's kappa observed only for counseling). This finding is consistent with the high patient–physician agreement reported by other studies [12,14,24,25]. Yet, when considering that the physicians' and patients' reports refer to an identical, very recent consultation, one would expect concordance to be even higher. Overall, patient–physician concordance was higher for actions taken during the consultation than for reasons for the consultation. Similarly, Jackson [12] found high agreement for concrete actions, such as prescription writing, diagnostic test ordering, or providing a referral, alongside with a poor agreement between patients and physicians on communicative aspects of their interaction. These findings suggest that doctors' unawareness of patients' reasons for visit does not necessarily lead to a lower patient–physician agreement on actions taken during the consultation. However, it might potentially have a negative influence on patients' satisfaction with the care [10,12,26] or even their health outcome [11,12,26]. Further analyses of the collected data will investigate this potential association.

Consistent with other studies, concordance varied depending on the particular reason or action taken [9,18,27]. Discordance on reasons for visit was most pronounced when patients visited the practice for counseling or to receive a prescription because of physicians overestimating them as patients' reasons for consultation. According to a recent literature review on visit-specific expectations, patient–physician discordance regarding expectations is common due to physicians beliefs that patients expect specific actions, such as test ordering, medication prescription or referral [10]. In our study, agreement between patients and physicians on actions taken during the consultation was particularly low for counseling. Moreover, patients tended to overreport blood pressure measurement and weight measurement, whereas doctors overreported blood taking. These findings may seem surprising, but might arise from shared tasks between physicians and practice assistants.

In accordance with our hypotheses the results of the multivariable regression analyses suggest that discordance on reasons for consultation was associated both with patient and practice characteristics. Low education, attending the respective practice for less than 2 years, and poor self-rated health were factors found to be significantly associated with higher patient–physician discordance (Table 4). This is in accordance with the findings of Heiser reporting education as a predictor for patient–provider agreement [7], but contrary to most other studies [5,14,20]. Similarly, the importance of continuity of the patient–physician relationship has been emphasized by some studies [24,28], whereas according to other studies the number of previous visits was not related to physicians understanding of patients' health beliefs [19]. Our finding that recent patients had significantly less discordance with their physicians on whether counseling had occurred suggests, however, that not only the

content of the consultation, but also factors such as consultation length may be influential. Moreover, our study is in line with findings of Tisnado et al. [5] and Zulman et al. [6] who observed that patients with good self-rated health had a higher agreement with medical records. Yet, none of the demographic patient characteristic was found to predict patient–physician discordance on actions taken during the consultation (Table 6).

In our study, discordance between patients and physicians concerning reasons for or actions taken during the consultation varied strongly across practices. These differences could not be explained by average consultation time or the physician's mother tongue. Only male sex showed a statistically significant positive association with discordance on reasons for consultation. However, this finding must be interpreted with caution, given the small number of male gynecologists in this study and the fact that practice 3 is run by a male gynecologist. Instead, patient–physician concordance probably rather depends on physicians' individual attitudes and working approaches. Accordingly, Rohrbaugh and Rogers [18] showed that different ways of physicians' problem assessment were a major source of discrepancies and Sawyer et al. [20] reported that women seeing nurse practitioners were more likely to accurately report when their last Pap smear had been done than women seeing internists or family physicians. While this analysis cannot explain how individual approaches of the practices determine the interaction with the patients, this is investigated in the qualitative part of this study that will be reported elsewhere.

Counseling emerged as a particular source of discordance between patients and physicians. On the one hand, it was caused by physicians' overestimation of counseling as a reason for patients to attend their practice. On the other hand, discordance on whether counseling occurred during the consultation probably arose due to other reasons. In line with the conclusions of Rohrbaugh and Rogers [18] our findings suggest that patients and doctors probably differ in their definitions of what counseling is. Our practice-specific analyses showed, however, that meanings or definitions of counseling did not uniformly differ between patients and physicians but varied strongly between the practices. The fact that reported frequencies of counseling as an action taken during the consultation varied more strongly between physicians than patients (Fig. 1) points to different definitions among gynecologists. Comparing patient reports and medical records with direct observation, Stange et al. [27] similarly observed that the provision of counseling about health behaviors was more adequately reflected in patient reports than in medical records.

Several limitations must be noted. Although the practices represent a broad range of different working approaches existing within gynecology, they are not representative of all gynecologists in the region and their small number limits the generalizability of the findings. Moreover, because patients were recruited by the physicians and only eligible for the study if they were able to complete the German questionnaire, they are not representative of the general female population and may also represent only a selected part of their clients. This might explain why women participating in the study were more often better educated, living in a partnership, had a higher monthly household income, and were more often of Swiss nationality compared to the average female population in Basel [29]. However, while this selection may account for the relatively high level of concordance it does not explain the heterogeneity of discordance across practices. In fact, these associations might even be stronger with a more heterogeneous patient population.

No pre-visit questionnaire was completed to assess women's reasons for consultation. Thus, reasons reported by the patients in the post-consultation questionnaires might have been influenced by the patient–physician interaction during the consultation. Also, no definition of the reasons and actions listed were provided in the questionnaire, leaving space for different interpretations. We cannot exclude that this might have contributed to discrepant reports between patients and doctors. Yet, this would be true for women of all practices and may hardly explain why discordance is associated with practices.

In contrast to the physicians who filled in the survey immediately after the consultation, patients were allowed to complete the questionnaire at home. The answers of women who filled in the questionnaire only some time after the consultation might, thus, have been affected by a recall bias. However, as the monitoring of incoming questionnaires did not reveal any practice-related patterns of returning questionnaires, recall bias is unlikely to explain the observed differences between practices.

Finally, defining the length of the patient–physician relationship in terms of years instead of numbers of visits leaves room for variation in terms of total numbers of physician–patient encounters. Some patients having consulted their gynecologist several times within the first 1–2 years when they are a new patient in a particular practice may in fact have had a similar number of physician contacts as a person consulting only once per year or less frequently over 10 years, thereby leading to misclassification of the amount of physician contacts. Again, this would bias the results only if such variation would differ across practices.

4.2. Conclusion

In conclusion, our study provides evidence that physician–patient concordance in gynecology regarding reports of reasons for visits and of actions taken is moderate to high. Discordance was more strongly associated with practices than with patient characteristics, thus highlighting the importance of investigating physician characteristics and calling for further (qualitative) research on the impact of physicians' individual attitudes and working approaches on patient–physician discordance. Moreover, the study showed that discordance depends on the item assessed, but was most pronounced for counseling due to gynecologists' overestimating counseling as reason for visit and their differing definitions of what counseling is.

4.3. Practice implications

Given the fact that counseling alongside with information giving and (shared) decision-making is of high importance in basic gynecologic care, our findings may be of high relevance. In order to avoid unmet expectations and not to miss the patients' agenda for visit, gynecologists, thus, need to establish a mutual understanding with their patients of the reasons for the consultation and the actions taken therein. Moreover, there seems to be a need for more clarification among gynecologists about what counseling includes.

Conflict of interest statement

The authors have no conflict of interest to declare.

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