MODELS OF GENDER PERSPECTIVE IN WOMEN'S HEALTHCARE NARRATIVE

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Abstract: *The narrative of women's healthcare structured and mapped can be useful for scholars interested in the cultural dimensions of gender and feminism in order to analyse the social context of disease and illness. Healthcare reflects cultural models of health and care (Gadow, 1994) and for the purpose of more effective medical services recognizing women's patterns of illness, the narrative could be very helpful to medical practitioners and medical professionals. The medical narrative is mainly composed of scientific and political metaphors (Gadow, 1994). These can can be translated into objectifying, and the exactly opposed, depending on each feminine story of illness, as offered by the patient and embraced and understood by the doctor. What makes feminine stories relevant is not just to one voice, but a whole group of potential voices and this is the question that might be answered through the analysis of women's narrative in medical care. Narrative medicine is generally defined as elements of narratives set in a narrative order, with beginnings, middle narratives, and ends, which usually falls into the task of the medical professional to arrange and depends on the narrative skills pertained. The paper will analyse the relationship between the women's health narratives and the ways in which medical professional perceive and act upon their health complaints and concerns, aiming at better healthcare and more accurate and timely prevention of illness. The paper will stress the peculiarities of the female pain, especially the thesis according to which women's pain is often misunderstood and disregarded until they prove as sick as a male patient, complaining of the same subjective level of pain. We shall show that womanhood has been subjected to pain in social history and deeply rooted in different cultures as to be embraced and natural. Such an embodied misconception of the relativity of pain in women along with narrative gender specifics could make a useful perspective, especially if there can be identified narrative models with concrete outcome in medical practice as teachable and comprehensive to medical professionals.*

Keywords: *women, narrative medicine, healthcare*

Narrative medicine theory

The narrative has always been a key-component in medicine. There is no medicine without a story, depleted by pure narrative, which usually can be found in patient's story. (Aronson, 2000, 1) The patient's story is always developing, regardless of his gender, usually in the form of storytelling during the physical exam, and the object of this development is the history of the patient, as performed by any former medical student, who can (or not) be currently a doctor. (Schleifer and Vannatta, 1996).

Crossing the line between a patient and a provider has taught several lessons to medical doctors, who found themselves to be patients and, as such, they were self-located in vulnerable situations. Before a person acknowledges the medical situation, the vulnerability and gender narratives, eventually, she or he acknowledges of how little medical experience

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can help. Psychiatrist Robert Klitzman documents his own depression following the death of his sister during the 9/11 events and offers a different perspective as a patient in his book „When doctors become patients ".

As a concept Narrative Based Medicine has been just recently developed into a scientific research discipline, that has to offer meaning, context, and perspective to patients discourse in patient-doctor interaction. Narrative-based medicine offers such a context richness that be deciphered in any other way just through patient's story analysis. It follows in the footsteps of case history, first invented by Hippocrates (Aronson, 2000, 1), striving to emphasize the patient's own narrative, which was somehow overwhelmed by new technologies, a mediated rapport with his doctor. Autopathography, as defined by Aronson, has become one way of expressing himself as a patient. The study has concluded that from all the illness writings and stories, men are more keen on telling their stories, compared to women.

As for the gender distribution of autopathographies, Aronson has studied over 270 of patient stories to be able to identify a certain gender pattern in describing own illness.

Feminine narratives are encountered mostly in gender specific pathologies as related to birth, cardiovascular diseases, cancer and mental illness.

Narrative medicine as a tool

Narrative medicine is teachable to medical students, who in their practice must learn not to reduce a patient to the illness he or she exposes to his doctor[1]. The doctor, as defined by Scheifer and Vannatta (1966), is the one privileged individual, who has access to the most intimate and vulnerable moments of someone who became a patient at some point in his or her life. „That privilege is based on the fact that the physician encounters almost daily what James Joyce[2] calls "whatsoever is grave and constant in human suffering" (Schleifer and Vannatta, 1966, 204).

A special mention has to be made about doctors who had been, at some point, patients, and, as such, they have been more or less seriously ill. From such a perspective, illness, bears a very important learning experience, as Robert Klitzman reveals in his book" When Doctors Become Patients"[3].

[1] "It's easy for patients to get reduced to a specific illness. (…) Narrative medicine is a way of integrating everything back together; it's a way of staying curious about people. Ultimately, it's a form of love." In Narrative Medicine: Every Patient Has a Story. (2017, March 28). Retrieved July 26, 2017, from https://news.aamc.org/medical-education/article/narrative-medicine-every-patient-has-story/

[2]"Pity is the feeling which arrests the mind in the presence of whatsoever is grave and constant in human sufferings and unites it with the human sufferer. Terror is the feeling which arrests the mind in the presence of whatsoever is grave and constant in human sufferings and unites it with the secret cause.", *Joyce's Portrait of the Artist as a Young Man,* 1990

[3]" In the end, all of us—including doctors—will one day be patients. Wemay not want to fully realize or acknowledge that fact—to do so challenges our denial of death. But such realizations can go a long way in narrowing the widening chasms in our lives. Not all doctors are, or will soon be, patients. But those who have been seriously ill themselves can inspire and teach others." (Klitzman, 2008, 321)

"Doctors make the worst patients" says Robert Klitzman, MD, in his book. Nevertheless their experience as patients are unique, by being forced to move" at the other end of the stethoscope". The book is based on interviews with seventy doctors who became ill, revealing the experience and made a case about" how their medical training gave them strong sense of meaning and self-esteem"[1]. Relating to own experience is empowering, yet painful, but which can offer a better perspective of teaching every person involved with the health system a lesson, whether this is about those related to the suffering one: the doctor, the patient, the family or friends.

Gender narratives in health studies

Focusing on cardiovascular diseases, Carol Emslie's research on patients with coronary disease shows that in the 70's and 80', studies were conducted mostly on men (Emslie, 2005, 6), a situation which began to gradually change. Only in 1990 a research study on heart illnesses was conducted exclusively on a female sample. The limitations of these studies were revealed by Emslie, showing that in qualitative studies of CHD results tend to be generalized from "man" to "human experience", disregarding the female population data. According to Carol Emslie's research on women and men with coronary heart disease, women perform differently in their interaction with their physician, usually fearing that symptoms might be attributed to hypochondriac behaviour, rather too true medical issues. Studies on female and men population with CHD showed a differentiated behaviour of subjects in relation to their disease and in addressing it by seeking medical help. Women tend to seek medical help at a later stage of their illness than men. The increased delay in taking up the decision to see a medical professional show that women tend not to prioritize their health issues compared to those of their family members (Foster, Malik, 1998). Women's roles within the family, as a cultural trait and as it is related to mentality, are perceived as to prioritize the input they have within their family (taking care of the children, the husband, the relatives, and, generally, of the household), so women tend to seek medical help at a later moment than men (Zuzelo, 2002).

As for the social role women take, studies showed that they are unwilling to make significant changes in their lifestyle even if the medical indications point to that after an episode, especially in heart-related diseases. Especially women tend to disregard changes in lifestyle imposed after an episode, being unable to give up their roles in the family and society, fearing that this might be a sign of weakness, usually in the paradigm of a" man" preponderant disease, such is the case with CHD. This behaviour relates to a cultural belief that women sit and do nothing while their family life unfolds, they contribute at this common life as they did before the CHD episode.

Male patients in cardiovascular diseases are also disadvantaged by the gender-neutral approach (Emslie, 2005, 14). The study states that while extrapolating the" men" perspective to "human" in general, while caring for male patients there has to be considered roles, participation, mentality, and gender specific issues . As the theory of narrative medicine, applied in qualitative research, pointed out, the aim is a better medical practice, a

[1]Klitzman, 2008, book abstract

more appropriate and humane medical care, eventually with a better therapeutic decision for the patient.

In other areas of medical care, shame is often related to female medical discourse. The saying „I am not the kind of woman who complains of everything" (Werner, Isaksen, Malterud, 2004) explores the issues of shame and self-exposure of women suffering of chronic pain. Chronic condition is unfolding and is affecting differently women's lives, generating a special and continuous relationship with medical practitioners[1].

Women's health stories enhanced by their own medical experience

In her book "Incidental findings-lessons from my patients in the art of medicine", MD and writer Danielle Ofri offers to the readers her own experience as being herself a patient, with a very personal perspective on being vulnerable[2] and disoriented by the medical environment. Ofri recollects her pregnancy experience, while having to attend a amniocentesis at her own place of work, but nevertheless being disoriented as a patient. Her narrative brings forward both a patient perspective and a woman's point of view placed in a vulnerable position of disorientation and guilt, being late for her medical appointment, overwhelmed by the otherwise very familiar place, which is the hospital. Being herself a patient helps Ofri to follow the road and to search on the anxiety and fears her patients experience. In the first chapter of "Incidental findings-lessons from my patients in the art of medicine " Ofri offers a very rich, ethnographic description of the vulnerabilities experienced as a patient and as a woman, during her third pregnancy.

Conclusions

Women's narratives in health studies have just been recently considered as a resource in research. The qualitative analysis of women's discourse in relationship with her doctor or health practitioner is still to be considered. Gender and health discussions have brought to light several issues. One is summarized by Annandale, trying to emphasize the consequences of undifferentiated approach to female and male health.

[1] "In various studies during the last decade, woman with chronic muscular pain such as fibromyalgia, and chronic fatigue syndrome have reported negative experiences during medical encounters: They repeatedly find themselves being questioned and judged either to be not ill, suffering from an imaginary illness or given a psychiatric label" (Werner, Isaksen, Malterud, 2004, 1036)

[2] "Where is the damn room and why isn't there anyone to help us? It is already 8:45, and my stomach is tightening as I realize that weare making my doctor wait. I hate it when my own patients arrivelate and have sworn never to be late myself. We try the eleventh floor. Same carpeting, same doorways, sameoffices. The gray is making me nauseated. I will never decorate anyroom of mine in gray. My child will never wear gray. I will dye myhair black or green or orange or anything before it goes completely gray, though time is already running out on that one. I spota familiar name on a door, a gynecologist on the medical schoolfaculty with whom I've consulted once or twice. My heart jumpsan extra beat. The familiarity of a name, any name, a gynecologist no less, makes me exhale balloons of tension. I burst in and am surprised that my voice won't come so easily. Amnio, I pant.Where's amnio?" (Ofri, 2005, 3)

> "Patriarchy has carried with it an ironic twist: by creating history as an ungendered and universal process, it has not only concealed female oppression, but also sidelined men's experience as men. This has meant that it has been difficult for men to appreciate the gendered character of their experience" (Annandale, 1998, 140)

Bibliography

Annandale, E., *The Sociology of Health & Medicine*, Polity Press, Oxford. Barbour,1998

Aronson, J. K. *Autopathography: the patient's tale,* BMJ:British Medical Journal, 321(7276),1599–1602, 2000

De Haes, H. and Bensing, J.,*Endpoints in medical communication research, proposing a framework of functions and outcomes. Patient education and counseling*, 2009, 74(3), 287-294.

Emslie, C., Women, men and coronary heart disease: review of the qualitative literature. *Journal of Advanced Nursing*, *51*(4), 382–395. 2005,https://doi.org/10.1111/j.1365-2648.2005.03509.

Foster, S. and Mallik, M.,*A comparative study of differences in the referral behaviour patterns of men and women who have experienced cardiac-related chest pain. Intensive & Critical Care Nursing*, 1998, 14(4), 192-202

Foucault M., *Nașterea clinicii*, București, Editura Științifică, 1998.

Greenhalgh T., Hurwitz B., *Narrative based medicine: dialogue and discourse in clinical practice*, London: BMJ Books; 1998. p 3-16.

Johnson, J. L. and Morse, J. M.,*Regaining control: the process of adjustment after myocardial infarction.* Heart & Lung, 19(2), 1990, 126135.

Kalitzkus, V. PhD, Matthiessen Peter F, MD, PhD, *Narrative-Based Medicine: Potential, Pitfalls and Practice*, The Permanente Journal, 2009.

Klitzman, R.,*When doctors become patients*, 2008

Ofri, D., *Incidential findings lessons from my patients in the art of medicine*, 2005.

Schleifer, R., & Vannatta, J. B. *The Chief Concern of Medicine. The Integration of the Medical Humanities and Narrative Knowledge into Medical Practices*, 2013

Lowe-Evans, M.,*Joyce's Portrait of the Artist as a Young Man*. *The Explicator*, *48*(4), 275–277. https://doi.org/10.1080/00144940.1990.9934028, 1990

Zuzelo, P. R., *Gender and acute myocardial infarction symptoms. MEDSURG Nursing*, 2002, 11(3), 126-136.

Online references

What Is Coronary Heart Disease? (2016, June 22). Retrieved July 30, 2017, from https://www.nhlbi.nih.gov/health/health-topics/topics/cad