

Gender-Biased Diagnosing of Women's Medical Complaints: Contributions of Feminist Thought, 1970-1995

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ABSTRACT. With the advent of second-wave feminism during the 1970s, a significant body of literature emerged describing sexist practices in women's health care. Gender-biased diagnosing—the notion that somatic complaints by female medical patients are more likely to be labeled by physicians as psychosomatic—became a concern that garnered considerable attention in Europe and the United States because of the increased health risks it posed for women. This article examines the impact of feminist knowledge on this topic during the quarter century spanning 1970-1995. Analysis of the literature reveals feminist perspectives played a critical role in uncovering and problematizing gender bias in women's health care. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <http://www.HaworthPress.com> © 2004 by The Haworth Press, Inc. All rights reserved.]*

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Advances in the feminist movement since the early 1970s have led to transformations of knowledge in both clinical practice and scholarship on gender and health. One area in particular, gender-biased diagnosing—a tendency for physicians and other health care professionals to mislabel women's somatic complaints as non-serious and/or psychosomatic both in the presence of organic etiologic factors and when the underlying pathophysiological mechanism of the condition is unknown—has received considerable attention. The “default” toward psychogenic causal explanations particularly in instances of obscure etiology certainly affects both women and men; however, this seems to occur more frequently with female patients. This phenomenon is described as psychologization in which “female illness is socially constructed as erroneously or disproportionately embracing psychiatric or sociocultural contributors” (Richman, Jason, Taylor, & Jahn, 2000, p. 178). This article discusses the influence of feminist perspectives on gender-biased diagnosing of women's somatic complaints during the quarter century spanning 1970-1995.

Numerous medical conditions have historically been and continue to be targets of gender-biased stereotypes about women's nature and women's bodies. For example, women presenting with symptoms characteristic of interstitial cystitis (bladder disease) are frequently labeled with the psychiatric diagnosis of somatization disorder, which results in subsequent mistreatment of the disease (Webster, 1993). Women with fibromyalgia and chronic fatigue syndrome (CFS) find that their symptoms are often belittled or ignored (Clarke, 2000); the conditions are viewed as psychogenic in nature. Empirical studies have found that physicians pursue a less aggressive management approach to coronary disease in women (Steingart et al., 1991), and that hospitalized women receive fewer diagnostic and therapeutic procedures than men (Ayanian & Epstein, 1991). Women with reproductive disorders, in particular, experience the impact of gender stereotypes and attitudes, especially when medical professionals are unable to uncover the specific etiology of the condition (Laurence & Weinhouse, 1997; Stellman, 1990). Martin (1992) also detailed how language and metaphors are used in both medical texts and clinical practice to describe women's reproductive-related functions in terms of weakness and pathology. It is illogical to suggest that women's somatic complaints are never impacted by or a result of psychologic factors. However, HCPs who presume a psychogenic etiology may discount or minimize the severity of symptoms and overlook serious biological and psychological conditions, thereby impacting health outcomes (Council, 1991).

This article examines the role feminist thinking has played in contributing to our understanding of physicians' diagnosing of female medical patients. Undoubtedly, feminist theoretical contributions to questions such as the duality of biological or psychogenic etiology have been thoroughly critiqued in the feminist literature. This article does not try to reinvent the wheel on feminist contributions to the social realm of health. Rather, through a synthesis of the literature, the article charts the evolution of how gender-biased diagnosing became identified as a "problem"—a problem that perhaps we need to revisit because it persists today. Since the focus is about gender-biased assumptions being made about the causes of women's somatic complaints, issues pertaining to men are not addressed. The central question of the inquiry was what was the impact of feminist knowledge on this topic during the quarter century spanning 1970-1995? To this aim, an examination of the literature was conducted using Medline and other medical (Cinahl, Web of Science) and social science databases (e.g., PsycInfo, Social Sciences Abstracts, Social Work Abstracts, Sociofile). Questions guiding the inquiry included (a) what was the state of knowledge before the feminist knowledge revolution of the 1970s (b) what is the current thinking on the subject (c) what social "truths" have been altered (d) what debates have emerged and what conceptual transformations have occurred (e) how have research directions changed and (f) to what extent does feminist questioning and research in this area incorporate race, class, and other structural inequalities? Analysis of this body of literature posed a challenge in that although numerous authors clearly aligned themselves as "feminist scholars," it was often unclear whether some health researchers considered themselves such. Therefore, a broad definition of feminism was used in this study to connote writers/theorists/authors who have identified, exposed and documented gender-biased diagnosing in order to promote and advance equitable treatment in women's health care. My interpretations of the era's thinking about this topic draw upon scholarly literature across disciplines and lay publications, and are shaped by feminist theoretical perspectives.

Results of the analysis reveal that feminist perspectives held by both women and men played a critical role in uncovering and problematizing gender bias in physicians' diagnosing of female medical patients. Yet, the existence of gender-bias in physician diagnostic practices was based on scant empirical evidence, such that indirect "evidence" was used to make inferences that sexist diagnosing occurred in physician offices and health care settings. Despite a lack of empirical evidence, there was remarkable agreement among scholars and laypersons that this problem

existed. Phrases such as sex-biased diagnosing, gender-biased diagnosing, sexist diagnosing, sexual prejudice, sexual stereotypes, and gender disparities permeated the literature. Results further reveal that second-wave lay feminist activism and feminist scholarship spanning disciplines such as medicine, sociology, nursing, psychology, social work, history, literature, anthropology, and public health challenged the prevailing beliefs and attitudes about women's bodies and women's health of both conventional medicine and western society.

***SOCIAL CONSTRUCTIONS OF THE FEMALE
REPRODUCTIVE SYSTEM AND WOMEN'S NATURE:
PRE-FEMINIST THEMES***

Pudendum or *Pudenda*: also known as vulva from the Latin *Pudere*, "to be ashamed of."

Estrogen: from the Greek *oistros*, "insane desire."

Hysterectomy: from the Greek *hysteria*, "belonging to the womb."

(Women and Language News, 1984, cited in Todd, 1989, p. 27)

The most common form of gender-biased diagnosing occurred with illness or disease associated with the women's reproductive system. Prevailing attitudes about the female reproductive system and women's nature prior to feminist theory were influenced by at least three factors. First, the early Greeks believed that their womb caused women's emotional "nature." Second, proponents of classical psychoanalytic theory maintained that women's physical complaints were often symbolic rejections of the "feminine role." Lastly, the myth of "female invalidism" permeated sociocultural notions about women's nature.

Very early on there was a connection between women's physiology and women's psychology. Historically, the female reproductive system has been cast in intrapsychic terms originating from early conceptualizations of the uterus. Bachmann (1990) argued the psychosexual and sociocultural significance of the uterus can be traced to ancient times. The term *hysteria* is derived from the Greek word, *hystera*, and "came to have negative connotations because the uterus was felt to be central to diseases of women" (p. 41). *Hysteria* means "wandering uterus" (Nadelson & Notman, 1990), and is based on the connection between the mind and the body in women. Bachmann stated, "The condition of hysteria was attributed to the wandering of the uterus to different parts of a woman's

body, causing a variety of symptoms and erratic behavior” (p. 41). The author concluded that although the notion of a wandering uterus had been discarded, many still considered the emotional outbursts and sensory disturbances associated with hysteria to be more common in women.

Similarly, psychological theories explained various reproductive disorders and related phenomena as “psychogenic”; considered related to conflicts about femininity or childbearing. Sigmund Freud described somatization with his metaphor “the mysterious leap from the mind to the body” (Nadelson & Notman, 1990), and theoretical concepts of classical psychodynamic theory attempted to explain certain reproductive related phenomena in terms of psychoactive forces. For example, their physicians often told women that emotional changes associated with their menstrual period (currently known as premenstrual syndrome) were “all in their heads” and not due to any physiologic change (McIlhany, 1985). Women enduring dysmenorrhea (menstrual pain) were also suspect for psychiatric disturbance. In the 1971 textbook, *Office Gynecology*, J.P. Greenhill stated, “functional dysmenorrhea is generally a symptom of a personality disorder, even though hormonal imbalance may be present. Therefore, a thorough study of the woman’s attitudes toward femininity is often necessary” (cited in Corea, 1977, p. 75). Theories of psychogenesis surrounding pregnancy and childbirth have also been rooted primarily in psychoanalytic theory. Infertility, without clear organic pathology, was understood to be related to a woman’s ambivalence about childbearing (Nadelson & Notman, 1990). The 1972 textbook, *Gynecology and Obstetrics, Current Diagnosis and Treatment*, indicated that nausea may be the result of resentment and ambivalence of women ill prepared for motherhood (cited in Corea, 1977). Psychodynamic theory purported that a pregnant woman’s vomiting may represent various intrapsychic conflicts, such as hysteria, sexual frigidity, psychological immaturity, and a rejection of femininity (O’Brien & Newton, 1991). Further, women who experienced difficulties with labor and delivery were thought to be immature or emotionally disturbed. The 1951 natural childbirth theory developed by Grantly Dick Read postulated that labor, as a “physiologic function,” should be painless (Lennane & Lennane, 1973).

Ehrenreich and English (1973) described yet a third factor that contributed to physicians’ and societal beliefs about women’s nature. Female invalidism was a phenomenon prevalent during the mid-nineteenth century, and pervasive among the upper and upper middle class female culture. Their physicians characterized women as sickly and weak; there

was the societal belief that women were more ladylike if they were pale and faint in appearance. In addition, retiring early to bed due to “sick headaches” and “nerves” was viewed as fashionable. By 1910, this condition began to fade but was replaced with the new disease of “hysteria.” Thus, during the mid-twentieth century physical sickness was no longer viewed as “feminine.” However, the myth of female emotional frailty continued to seep into medical paradigms, as physicians were quick to suspect a psychogenic etiology when they were unable to ascertain the biological cause of a woman’s physical symptoms.

FEMINIST CONTRIBUTIONS TO THE FIELD OF GENDER-BIASED DIAGNOSING

The Evolution of Identifying the Problem

With the advent of second-wave feminism, feminists responded to the prevailing beliefs about women’s bodies and women’s health and some began to expose sexism in medicine. Documentation in the literature specifically challenging the practice of gender-biased diagnosing of female medical conditions began in the early 1970s. In the prestigious *New England Journal of Medicine* (February 1973) psychiatrist K. Jean Lennane and her physician husband, R. John Lennane, of the Renal Unit at Prince Henry Hospital in Australia, raised their concerns about possible “sexual prejudice” in disorders including dysmenorrhea, nausea of pregnancy and labor pain. For instance, the Lennanes reported that the relationship of dysmenorrhea and ovulation was first demonstrated in 1940, without evidence of a failure to adapt to the feminine role. However, they observed “thirty years later, standard gynecologic textbooks still emphasize a psychogenic cause” (p. 291). The authors claimed that the ready acceptance of a psychological origin of these conditions occurred without scientific evidence and postulated an underlying sexual basis for this prejudice. Although other works were published during this same time period, particularly in medical sociology, the Lennane’s article was the seminal documentation of gender-biased diagnosing that penetrated the literature. The authors were cited in virtually every book or article written on this and related topics. Their work was a bold challenge to the long-standing conceptualizations of women maintained by many members of the medical profession. This article was a catalyst in altering existing “truths” about women’s medical conditions and opened the floodgates for debate across disciplines.

Much of this scholarly work was in the discipline of sociology, and to a lesser extent in general medicine and obstetrics and gynecology. Yet as more women entered medicine, female physicians began to publish nationally (Hamilton, 1993) and internationally (Malterud, 1993), particularly in the specialty of psychiatry (Nadelson & Notman, 1978, 1990).

Only two empirical studies specifically addressed the topic of gender-biased diagnosing of female medical conditions. Armitage, Schneiderman and Bass (1979) investigated physicians' responses to five common complaints in a sample of 104 men and women. In each of the five complaints they found that men received more extensive work-ups than did women. Although speculative, the authors concluded that male physicians in their study tended to take illness more seriously in men than in women and that "they [physicians] might be responding to current stereotypes that regard the male as typically stoic and the female as typically hypochondriacal" (p. 2187). Conversely, Verbrugge and Steiner (1981) replicated the Armitage et al. study utilizing national data and a considerably larger sample size. They found few significant sex differences in the extent and content of diagnostic services given for the five common complaints. The authors concluded that this topic poses an important hypothesis for research and public discourse; however, "despite the issue's prominence in public and political debate, there is scant scientific evidence for, or against, physician sex bias" (p. 609).

Feminist Explanations of the Problem

With such limited scientific evidence to substantiate the existence of physician sex-bias, how did scholars come to perceive this topic as a pervasive problem that required attention? Essentially, the early feminist literature presumed that gender-biased diagnosing existed. These assumptions appear to be based upon inferences drawn from related research rather than from empirical evidence specific to sexist diagnostic practices. Numerous factors shaped the shift in the discourse in this body of knowledge, from early beliefs that many complaints by women were psychogenic to identifying that these beliefs were the result of gender bias. Initially, feminist scholars began to challenge traditional psychodynamic beliefs that women's biology determined a natural female role and that many reproductive-related complaints were a rejection of femininity (Chodorow, 1989). Women scholars found these beliefs to be inconsistent with their experiences and began to question the merit of various aspects of classical psychoanalytic theory, thereby

expanding upon theories of adult female developmental psychology (Berzoff, 1989; Gilligan, 1982).

The presumption of the existence of gender-biased diagnosing also arose as a natural consequence of political action by the women's movement. Political efforts of those in the women's movement in the 1970s and early 1980s focused on issues of equal rights, pay equity, reproductive freedom, and the election of women to public office (Bass & Howes, 1992). Feminist political attention to women's health issues gained momentum in the mid to late 1980s as attention focused on women's experiences as recipients of health care, and, to a lesser extent, their work as providers of health care (Lewin & Olesen, 1985). Thus, it was a logical step for authors to surmise that since women were oppressed in U.S. society, medicine as a hierarchical, patriarchal structure of that same social system could also be suspect in contributing to women's oppression in health care practices; that one can "expect a sexist society to produce sexist science" (Fee, 1983, p. 22).

Next, advances in medical technology afforded feminists a prime opportunity to study sexism in medicine. Some concluded that medicine medicalized female conditions such as childbirth (Rothman, 1991) by labeling natural biological responses as "disease." In addition, Physician Charles King (1992) stated: "Somehow facts produced by technological feats are seen as more accurate than are subjective signs and symptoms" (p. 3). That is, as women's health issues became medicalized the credibility and reliability of women's self-report became overshadowed as physicians paid greater attention to laboratory values and machine read-outs. For example, unless the fetal monitor documented contractions pregnant women were frequently told that their complaints of labor were unfounded (Rothman, 1991).

Furthermore, despite the lack of empirical evidence demonstrating that physicians diagnose female patients differently than male patients based on gender stereotypes, there was an abundance of anecdotal accounts, supporting empirical literature (Chesler, 1972; Colameco, Becker & Simpson, 1983; West, 1984; Redman, Webb, Hennrikus, Gordon, & Sanson-Fisher, 1991), major conceptual works (Oakley, 1993) and historical analyses (Ehrenreich & English, 1973) related to this topic. It was this indirect "evidence" that was used to make inferences that sexist diagnosing occurred in physician offices and hospital settings. Thus, despite the lack of empirical evidence, there was remarkable agreement among both scholars and lay community that this problem existed. For example, scholars directed their attention primarily to aspects of the

doctor-patient relationship, sociocultural beliefs about women, and medicine as a social institution.

Feminist scholars of this era began to document that problematic diagnosing of women's physical problems stemmed from conceptualizations of what constituted appropriate roles of doctor and patient, and were exacerbated by stereotypic beliefs about women's "natural" role rather than on scientific facts about psychology, biology and anatomy (Foster, 1989). Feminist theory challenged the 1951 Parsonian model of functionalism that posited an asymmetrical role relationship between physicians and patients as a requirement for optimal functioning (Zambrana, Mogel & Scrimshaw, 1987). Parson's model asserted that physicians' authority is essential to the sick person's recovery and the patient is obliged, as a function of the definition of the sick role, to trust the physician and accept the asymmetry of the relationship. Conversely, Todd (1989) argued this idealized version of the powerful godlike doctor, who knows best and cures the passive patient, was outdated. Moreover, the notion of gender as power addressed concerns involving micro-level interactions. For example, in her ethnographic study Todd (1989) explored the various ways that power was manifested in conversations between doctors and patients. And, using a stratified random sample of 336 tape recorded interactions between physicians and their female and male patients, Wallen, Waitzkin and Stoeckle (1979) found that physicians were more likely to see female patients' illnesses as psychologically caused. In addition, the authors reported that although women received more explanation time from their doctors than did men, the explanations received were not as extensive and were less likely to match the level of technicality of the women's questions. They concluded that in the "micro-politics" of the information process "withholding of medical information from women must be considered in connection with the question of power" (p. 145). Unlike male patients, female patients were not only exposed to expert power, but to gender power as well (Malterud, 1993).

Further, studies addressed stereotypes arising from beliefs about women's "nature" and their impact on sex-role socialization, communication patterns between women and men, and the androcentric bias in medical education (Weiss, 1977). For instance, Corea (1977) explained the phenomena of male physicians perceiving female patients as hysterical by stating that women are conditioned to more freely acknowledge and express their emotions, whereas "men are trained in the stoicism of the masculine stereotype. . . ." (p. 78). Todd (1989) purported that studies found women seek medical care more than men, which maintained

the assumption that women were the more sickly, weaker sex. Todd questioned whether the frequency of women's medical visits are better explained by the fact that sex-role socialization leads to women's greater willingness to admit a problem and seek help. Phillips (1995) argued that gender stereotypes permeated medical pedagogy and practice, and noted the influence of sex-role stereotypes in physicians' assessments, hypothesis generation, diagnoses, treatments and conceptualizations of health and illness. Scully and Bart (1978) analyzed 27 general gynecology texts published in the U.S. from 1943-1972 and found that gynecology emphasized traditional female sex-role stereotypes, describing women as "anatomically destined to reproduce, nurture, and keep their husbands happy" (p. 283). This reflected the belief that the "normal, adult woman" was one who was in the role of a marriage relationship. In the related field of mental health, Chesler (1972) contended that although traditional roles have been emphasized in the professions of psychiatry, sexist notions of what constituted a healthy female psyche were being criticized. Early psychiatrists, more so than gynecologists, historically maintained sexist tenets that women were fundamentally defective. Ambitious women, in particular, were often viewed as infantile and rejecting of their "role." Moreover, sex-role stereotypes were implicated as a factor in the ways that physicians prescribed psychotropic medication differently for women and men (Anon., 1984).

Similarly, authors rejected the notion of biological determinism resulting in stereotypic beliefs about women's inherent biological differences portrayed in medical textbooks. For example, in the 1971 text, *Obstetrics and Gynecology*, Wilson is quoted as stating, "The traits that compose the core of female personality are feminine narcissism, masochism and passivity" (in Scully & Bart, 1978, p. 288). Corea (1977) found that in the 1971 textbook, *Office Gynecology*, J. P. Greenhill observed "many women, wittingly or unwittingly, exaggerate the severity of their complaints to gratify neurotic desires" (p. 75). Corea documented that 72% of physicians in 1971 referred spontaneously to a woman when asked to describe the "typical complaining patient." Also, medical lecturers typically referred to patients exclusively as "he" except when discussing a hypothetical patient with a psychogenic disease—then they automatically shifted to using "she." Female medical students in 1973 reported that lecturers frequently referred to women as "hysterical mothers," "hypochondriacs," and "old ladies."

Although many feminists rejected the notion that biology determines female and male personality characteristics, there was debate regarding the issue of "difference." Minimalists (persons who believed there are

little or no differences between women and men) contended that women have no special physical liabilities—that menstrual cramps and nausea of pregnancy, for example, are culturally induced. Whereas, maximalists (persons who believed that women and men are fundamentally different based on biology) focused attention on the discomforts of such conditions. Ehrenreich and English (1973) asserted that either position could be used against women. If the discomfort and pain of menstruation was acknowledged, then women may be excluded from positions that require concentration and responsibility. Yet, if these physical realities are denied, “women will be required to work the same long hours as men regardless of the degree of discomfort” (p. 88).

In addition to the doctor-patient relationship and the culture of women, other authors explained sexist diagnostic practices in terms of the patriarchal and hierarchical structure of medicine as a social institution. Some approached the topic of sexism in medicine by universalizing the male domination of medicine (Corea, 1977) and seemed to view the principles of patriarchy as of the utmost importance in the system of medicine (Dreifus, 1977). Medicine was described as an institution developed by men, dominated by men, serving men’s interests and interpreted from the standpoint of men. Using a macro structural analysis, Todd (1989) explained that the structure of medical care mirrored the structure of American society such that “it is hierarchical in the organization of its professional workers and in its delivery of health care; it is based on profit and functions through inequity.” However, most authors avoided utilizing a reductionistic view of patriarchy, and tried to identify how, when and why men dominated within the social institution of medicine. Many authors provided accounts of “gendered institutions” (Acker, 1988)—gendered aspects of the institution of medicine. Ehrenreich and English (1973) provided a powerful analysis of how, why, and in what historical contexts gender had various meanings. For instance, gender was socially constructed in the medical realm by and through its intersection with the social construction of illness. The social construction of illness refers to the idea that individuals and groups of individuals construct determinants of health, illness, and disease within their particular culture at various points in history (Kleinman, 1980). Eliot Friedson identified the medical profession as one agent of a culture’s “social construction of sickness” (Ehrenreich & Ehrenreich, 1974). In western cultures, it is the medical profession that defines illness in theory, identifies illness in practice, and oversees those identified as “sick.” That is, it determines which biological phenomena admit one to the sick role and which are regarded as minor, psychosomatic, or other-

wise ineligible for medical treatment. For example, Scully (1980) explained that early nineteenth century physicians found vaginal examinations distasteful and believed that women were merely seeking sexual gratification in their requests for the examination; today, medical professionals view women who do not obtain regular pap smears as acting irresponsibly with regard to their health maintenance. Thus, what counted as health and illness was often defined in the absence of women and other subordinate groups.

Furthermore, the institution of medicine as a social structure not only defined illness, but also was an agent of social control. Ehrenreich and English (1973), in reference to the historical period of the late 1800s and early 1900s asserted: "The doctor's view of women as innately sick did not, of course, *make* them sick, or delicate, or idle. But it did provide a powerful rationale against allowing women to act in any other way" (p. 22). The authors suggested that these early physicians had a stake in women's illness. For example, medical arguments were used as justifications for not allowing women into politics or medical school. And, the myth of female frailty helped the American Medical Association (AMA) physicians to ward off competition from non-traditional healers, particularly female midwives, who were disqualified as healers due to their "nature." Moreover, this myth qualified women as patients, especially affluent women whose husbands' income could support the physician's career. The authors concluded the possibility remained that some women did use sickness as an escape from their oppression as workers or wives. However, to assume this was always the case when a woman presented with medically unexplainable symptoms would be erroneous. In sum, feminist contributions enhanced our understanding of the ways in which knowledge about women and female medical diagnoses were constructed by society in general, and medical professionals in particular, and conveyed important implications for women's health care.

Intersections of Gender, Race and Class

Despite the advent of literature addressing the impact of racism and social class on health disease and well-being in general (Krieger, Rowley, & Herman, 1993; Office of Minority Health, 2003), the gender-biased diagnosing literature of this era was limited in its analysis of how gender interacts with other systems of social relations. Returning again to the historical analysis by Ehrenreich and English (1973), this key work asserted that gender was socially constructed through class and race hierarchies. The affluent white women were deemed frail and, hence, feminine;

they received the attention of the paternalistic doctor. Lower class and minority women were neither allowed the “luxury” of idleness nor viewed as feminine. Moreover, early medicine viewed “ladies” as inherently sick and, thus, deserving of medical attention. Medical neglect of poor women, however, was justified by the belief that poor women had “coarser” natures. Ehrenreich and English argued that medical racism overshadowed medical sexism for black women. Similarly, there was some evidence to suggest that women of color and impoverished women were viewed by physicians as more “difficult” when they asked questions (Todd, 1989).

Epistemology, Methodology and Methods

Feminist scholars argued that prevailing attitudes about the female reproductive system and women’s nature prior to feminist revisions were based on flawed epistemologies, methodologies and methods. What counts as knowledge and how knowledge is produced have been topics of intellectual discourse for centuries. The epistemology of a discipline is characterized by the way it conceptualizes problems (the problematic), the sources of evidence, and the methods of analysis and inference (Hahn, 1995). Moreover, scholars conduct research based on their assumptions about people and the ways in which social reality is constructed. Knowledge of the researcher’s methodological stance, then, is essential in understanding all aspects of the research, from hypothesis generation to data analysis and conclusions. What was viewed as knowledge and the forms of knowledge that were valued changed dramatically during this period as women—the “others” who were differently positioned in the social order—began to contribute to the body of knowledge regarding sexist health care practices. Despite scant literature specifically addressing gender-biased diagnosing, problems of epistemology and biomedical research were echoed internationally. Kirsti Malterud, (1993) a family practice physician in Norway remarked, “Unfortunately, women’s voices are often silent in the factory where medical knowledge is produced” (p. 365).

Nevertheless, much of what counted as knowledge was knowledge that originated from “pure” and “objective” science, albeit conducted from the standpoint of male physicians and scientists. Medicine developed its knowledge from men who studied men, and applied newfound information and technologies to women. Feminists objected to medicine’s methodological assumption that biological and psychological theories could generalize from men to women. In this regard, medicine

had taken a minimalist approach—that men and women were basically the same (e.g., both are human beings) and women were merely a variation of men. Yet medicine often contradicted itself when on the one hand the male model was sufficient for studying disease because men and women were perceived “same” in terms of their humanity, yet on the other hand the biology of females was essentialized (that women and men are inherently different) in order to account for women’s “madness” (Chesler, 1972). The social location of the producers of knowledge influenced the kind of knowledge produced. Sociologists Scully and Bart (1978) explained:

. . . gynecologists are overwhelmingly male (93.4% [Time 1972, p. 89]); and the tools of the sociology of knowledge suggest that one’s perspectives are constrained by one’s place in the social structure and thus gynecologists may not adequately represent the worldview and the interests of the group they are supposed to attend and advocate. (p. 283)

The epistemological lens and methodological stance of feminist empiricism influenced the scientific methods used particularly for the non-medical literature on sexism in medicine. Although quantitative methods had been utilized for investigations regarding the differential use of medical procedures (Ayanian & Epstein, 1991) and retrospective medical chart reviews (Armitage, Schneiderman & Bass, 1979), ethnographic fieldwork was the most common research method utilized. For instance, the treatment of women in particular medical specialties such as childbirth (Rothman, 1991) and obstetric and gynecologic surgery (Scully, 1980) was investigated. Other qualitative examples included tape recorded interactions of the discourse patterns between doctors and male and female patients (Wallen, Waitzkin & Stoeckle, 1979), and sociolinguistic methods to study the communication patterns and power relationships between physicians and women patients (Roter & Hall, 1992; West, 1984).

Deliberation arose regarding how to proceed with a feminist epistemology (Harding, 1991). Some argued that traditional, positivist methods generated useful information, however, they reinforced existing power relations between women and men because they do not include the analysis of the inferior status and societal oppression of women. Dorothy Smith (1990) argued for Feminist Standpoint Theory as an alternative to empiricism, recognizing that those in power have distorted views of reality because they do not experience the “felt experience” of

pain and suffering from the oppression. Furthermore, the dominant group (e.g., male physicians) distorted reality because they had a vested interest in protecting the social order. Malterud (1993) pushed for the “construction of a feminist medical epistemology—a path toward medical knowledge that reflects women’s reality” (p. 371). Others argued that research studies ought not only place women at the center of the research but also should use an egalitarian methodological stance, such as involving respondents in the data analysis and report writing aspects of the research (Macpherson, 1988). Feminist scholars claimed that research designs were often constructed merely to confirm preexisting gender stereotypes; gender, like race and class, was entrenched in the questions asked by clinical and scientific researchers. For instance, Rothman (1991) criticized research designs based on retrospective studies that found women suffering from severe nausea of pregnancy as more ambivalent about their pregnancies than women who did not experience severe nausea. She concluded, “It is as if these studies were designed to prove that the attitudes *cause* the physical condition, such as nausea” (p. 250). Rothman argued that prospective studies that start with women’s beliefs and attitudes may more accurately portray the relationship, if any, between nausea and ambivalence. That is, being ambivalent about pregnancy may cause one to become sick; however, it is at least equally plausible that experiencing severe sickness during pregnancy causes one to feel ambivalent. Finally, the complex field of gender-biased diagnosing branched off into various sub-debates, such that exposure of gender bias in biomedical research led to national policy changes. Events detailing how feminist perspectives during this twenty-five year period catapulted women’s health issues to the forefront and dramatically shaped women’s health care policy in the United States is documented elsewhere (Munch, 2004; Lorber, 2000; Morgen, 2002).

DISCUSSION

Knowledge is constructed based on ever-changing conceptualizations of gender, medical technologies, theories of human development, sophistication of research methods, and the epistemological stance of the researchers. Advocates for women’s health care during the quarter century spanning 1970-1995 played a critical role in altering these conceptualizations, contributing greatly to our understanding of physician’s diagnosing of female patients despite a lack of empirical research on this topic. Feminist transformations of knowledge occurred as evi-

denced by the large body of literature by feminist scholars and grass roots lay groups such as The Boston Women's Health Book Collective (Norsigian, Diskin, Doress-Worters, Pincus, Sanford, & Swenson, 1999) who worked diligently to reconstruct this body of knowledge by addressing the androcentric bias in traditional, allopathic medicine. Knowledge was transformed, for example, as few today would characterize the pain of labor as a rejection of femininity. Many of our pre-existing "truths" were transformed and this new awareness of the problem continued to foster efforts to address it. During this period, studying women was not new methodologically speaking. What *was* new was the study of women from the perspective of their own experiences; the practice of "studying up" versus "studying down" was innovative in the gender literature (Harding, 1987). For example, physicians had long studied the "peculiar" behaviors of women with premenstrual syndrome, but women were only then beginning to study the peculiar characteristics of physicians and the nature of their interactions with women patients. The problematizing of women's experiences as acceptable issues and sources of answers were posited by some as a practice unique to feminist research (Allen & Baber, 1992), and conducting research *for* women rather than *on* women altered the purpose of research from one that primarily sought knowledge generation to one that attempted to conduct research in the interest of women. This period set the stage as proponents of women's health care developed innovative theories and asked new questions (Schiebinger, 1999). Studies since 1995 placing women at the center of analyses have flourished, addressing disease and illness affecting women with breast cancer (Thorne & Murray, 2000), chronic fatigue syndrome (Hart & Grace, 2000) and women's perceptions of the patient-physician relationship (Munch, 2000), for example. Furthermore, transformations occurred in women's health in general as evidenced by the surge of scholarly journals devoted to women's health issues, recent accomplishments in governmental agencies, and professional organizations with female physicians in leadership positions.

Still, implications for contemporary women's health care research are evident. Further inquiry might include a follow-up study to Scully and Bart's that reexamines medical school textbooks. Participant observation research of medical school lectures would also reveal current trends in instructors' portrayal of women's psychobiology. Innovative medical education programs that emphasize attitudes about the patient-physician relationship (Wolf, Ingelfinger, & Schmitz, 1995) and reexamine stereotypical attitudes about women (Phillips, 1995) are needed. Growing numbers of women physicians and their organized ef-

forts have brought attention to many gender gaps in medical research and practice (Lorber, 2000). Still, further research is needed to understand whether female physicians actually contribute to the elimination of sexist practices, and to what degree they are socialized by the patriarchal nature of medical training (Hamilton, 1993; Richman & Rospenda, 1992). Patient satisfaction surveys and observational studies exploring the impact of the patient-physician relationship on women may be beneficial. And, micro-level analyses addressing the social agency of women are needed. There is some evidence to suggest that women have “scaled the walls” by establishing women’s health clinics and grassroots health organizations, and by recent political gains at the national policy level. However, information is lacking about ways in which women subvert perceived oppression of the medical system. The research to date implies a structural deterministic perspective suggesting that women have been completely victimized by gender-biased diagnosing. It may be useful to investigate if, and in what contexts, women actually “buy into” and internalize being mislabeled. Similarly, research questions might address how often women seek second opinions when their complaints are erroneously labeled psychosomatic. Or, in what ways do women use their unique internal dialogue and psychological processes to refute physicians’ diagnoses? Finally, greater consideration of gender, race and class is needed to more fully understand social constructions of illness (Lorber, 1997; Office of Minority Health, 2003) and the dynamics underlying gender-biased diagnosing.

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