

**Literature, Medicine, and Misogyny: A Collection of Narratives**

by

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## **Literature, Medicine, and Misogyny: A Collection of Narratives**

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Emerging from previous research through the Medical Humanities Undergraduate Research Fellowship, the purpose of this project is to examine the healthcare experiences of contemporary women to discern how the themes visible throughout medical history regarding gendered experiences with healthcare are still evident, have changed, or are less prominent. Over the course of two-thousand years of medical practice, beginning with the ancient origin of Hippocratic medicine to contemporary medical science, many themes regarding the treatment of women have been prevalent. These themes include the dismissal of women's suffering under the guise of raging hormones or dramatism, a misunderstanding of women's anatomy and its medical implications, and fear of women's sexuality. The biases grounding these themes are perpetuated through the analysis of scientific evidence and in interpersonal interactions between women and their providers. The word 'woman' as used here is defined as any individual who identifies as a woman.

As previous research into these themes was performed through the lens of English literature and narrative, this project will be firmly grounded in the narratives of individual women regarding their experiences with healthcare in the United States, as well as the collective narratives of medical history.

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## Preface

In a thesis about the experiences of women spanning time, cultures, and generations, I find it pertinent that I must therefore thank the many women in my life who have inspired me, motivated me, and made me into the woman I am today.

Firstly, I must thank my thesis advisor, Uma Satyavolu Rau. Thank you for finding me, a girl struggling to find her place in academia, and for giving me the knife to carve out a space for myself.

Thank you to the women in my family, to whom I owe everything in terms of genetics, birth, and courage. Thank you to my mother, to Non, to Grandma, to my aunts. Thank you to Sofia, my toughest critic, and the person to whom all I want is to be a good big sister to. Thank you to Nan. To her I owe my stubbornness—the same stubbornness that got me here.

Thank you to my friends who sat patiently for my wild ranting about Aristotle and Freud.

Thank you to the women who shared their stories with me. I hope that I have done you proud with the work that we created.

And finally, thank you to the men in my life—particularly Dad, Pap, Grandpap—who have supported me always.

## 1.0 Introduction

One may consider it unfair to craft a piece on the narratives of women when the author herself will not share her own narrative. In every intention of fairness, I will first begin with the narrative of how such a thesis came to be.

I was built by stories. Whether they be the Little Golden Books on my childhood bookshelf, the bedtime stories told by my mother of her girlhood pets, the novels I stayed awake under my covers reading, or the soap operas my great grandmother watched despite my asking if we could put Disney Channel on instead—I, and I suspect many of us—was formed by the narratives that I have spent my life immersed in. These narratives turned me into a writer. My first works were picture books hand-drawn by crayons on many-time folded printer paper, but still, I was a writer. Writing was my first occupation, and I suspect it will be my last.

With adolescence came an acute awareness of my own physiology. I sometimes still stayed awake reading novels, but sometimes I stayed awake with menstrual cramps, finding comfort in the medical articles that explained how prostaglandins were wreaking havoc on my uterus. Though I had always loved science, this was truly the first time that I realized my interest in and passion for medicine, specifically women's health.

For years, these were separate interests. I lined my shelves with novels and my backpack with science textbooks. I entered college and declared microbiology and English writing as majors, but I kept them perfectly separate for three semesters.

The first day of Literature and Medicine in the second semester of my second year, Professor Uma Satyavolu Rau walked into a University of Pittsburgh classroom with an armful of books and began the first lecture of Literature and Medicine. She introduced me to the



*Hippocratic Writings* and its “Fourteen Cases,” and I took notice of the fact that male patients were referred to by their names, but women were referred to by their husband’s or father’s names. I found comfort in the humors of *The Anatomy of Melancholy* and analyzed my anxieties in the context of Seneca. For the first time, I understood medicine in the context of narrative, and found that it deepened my understanding to a degree that I then realized how deficient my understanding had been in the past.

When the semester ended, Professor Satyavolu Rau presented to me the opportunity for a new way to understand medical narrative through a new program in the English Department. As part of a Directed Research project through the Medical/Health Humanities Undergraduate research fellowship, I spent a semester reading texts of my own choosing, learning about the ways that narrative intertwines with medicine and gender and identity. As it ended, I craved the chance for more—to form my own project that centered the narratives of women within the context of their medical experiences.

When designing a project centered around the experiences of women, one must first ask oneself: what is a woman? This question is made all the more complicated by the time span of the project given the ever-changing definition of gender which varies not only by time period, but also by geographic region. In many of the ancient and medieval texts read as a part of this research, woman may have simply been defined as an individual with estrogenized anatomy containing a uterus, vagina, and ovaries. Therefore, many of the following historical texts discussed in section 1 refer almost exclusively to women who are cisgender and to individuals who were assigned female at birth (AFAB).

However, over the last few decades, current Western concepts of gender have come to recognize the separation between biological sex and psychosocial gender identity. In the

recording of these narratives, the only requirement was self-identifying as a woman. Future inquiries into the subject may be able to take both a broader and a more specific approach in investigating the intersecting and diverging experiences of cisgender women, transgender women, and AFAB non-binary individuals.

Medical history has been thoroughly shaped by the attitudes and beliefs of the people who provide and receive medical care. These beliefs are both social and medical. The focus of this project is to examine gendered experiences and phenomena in the medical field across time, as well as the commonalities that may be found among women in regard to these experiences. This investigation is best undertaken when it is led by these women's own words; for this reason, I have chosen to conduct this project in a narrative format. It is through these narratives that I hope to find common threads among the stories of these women linking them to the stories and experiences of women in the past. This may permit both the women who participated in this research and the women who read this research to find solidarity and commonality in their experiences, as well as a way to observe the way that themes regarding women's health evolve and affect the lives of women today. In this project, the women studied were incidentally all white women under the age of thirty who have resided in Pennsylvania. Therefore, the experiences shared in these narratives may be most relevant to women who are similar to the participants.

We, as women, share many collective experiences, and I hope to find some of these collective experiences in this research whether they be positive, negative, or neutral. It is through the sharing of stories that women for millennia have shared their knowledge, kept one another safe, and assured one another that we are not alone. Research like this is only the natural extension of such a community.

In analyzing the experiences of people who identify as women, one must be conscious of the diversity of experience of these women and the factors that influence these experiences. Kimberlé Crenshaw's concept of intersectionality acknowledges the way that a woman's other identities shape her experience with gender and the way that they shape her gendered experiences with society. Factors such as race, class, sexuality, and ability may affect both the way in which a woman interacts with healthcare providers and the way that she and others understand with her gender identity (Crenshaw).

Health humanities is a field which intrinsically encourages interdisciplinary analysis and methodology. My initial interest in health humanities came from the way that it was able to blend multiple fields of interest: creative non-fiction, historical analysis, intersectionality, scientific literature. I was intrigued by Rafael Campo's poetic explorations of his experiences as a physician. I viewed Gilgamesh through the lens of mortality and our beliefs around death in medicine. I analyzed *The Anatomy of Melancholy* in conjunction with psychological research regarding mental health stigma. These texts and many more gave rise to the development of my eclectic, experimental methodology<sup>1</sup> in writing this thesis.

As this thesis is in the field of English Writing, I paid close attention to language and narrative prose in both the following literature analysis and participant narratives. In the literature review portion, this manifests in the inclusion of long quotation from the text in the interest of letting the author's words speak for themselves. I took a more interventionist approach in writing the participant's narratives in the interest of clarity and continuity, but regardless, the

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<sup>1</sup> My thanks to Dr. Jacquelyne Luce for elucidating the perfect descriptor for the approach that I took in crafting this thesis.

formulation of these women's narratives was strongly guided by the words of the women themselves. Through a narrative basis in the art of writing and informed by scientific literature, medical history, narrative medicine, and nonfiction creative works, my interdisciplinary approach is in keeping with the field of health humanities health humanities. This approach will also allow for new perspectives on women's experiences and new approaches to administering and receiving healthcare.

In crafting these narratives, I was struck by the way in which the creative non-fiction aspect of this thesis lent itself to advocacy. Through connecting the narratives of women to historical narratives and themes regarding women's health, I intend that the acknowledgement of these connections and patterns may allow for a more comprehensive understanding of women's health and also lend themselves towards improvement of the field. The historical literature provided context and proof of pattern. The incorporation of social scientific methodology gave me a basis for understanding the living experiences of my participants. The narratives themselves provided depth, vitality, and connection between the experience of one to the experiences of many. I hope that the sharing and collection of the narratives themselves may be empowering to both the women who share them and to the individuals who read them. The acknowledgement of shared experience (as will later be discussed in regard to a participant's narrative) can be a source of empowerment both on an individual and community level.

It is also my intention that this information may be valuable to healthcare providers, employees, volunteers, students from the past, present, and future. Though medicine is moving past its days of paternalism, control, and distrust of patients in regard to authority of their own bodies, there is still much to learn and much to be gained from patient experiences. Many of the narratives included in this thesis indicate that this is the case. Medicine is an ever-evolving field,

and it is through research like this that medicine becomes more patient-focused, compassionate, and humane.

## **2.0 Historical and Contemporary Medical Literature**

The literature analyzed as a prelude to presentation and analysis of the narratives spans nearly 2500 years of human history and focus primarily on the Western world. Some texts are primary medical texts (*Hippocratic Writings, The Trotula, The Canon of Medicine*), some are historical analytical texts written by scholars (*Medicine, Religion, and Gender in Medieval Culture; The Female Body in Medicine and Literature*), and some report academic research (*Sexual Behavior in the Human Female, The Hite Report*). This somewhat eclectic array of texts is meant to apply a wide breadth of history, perspective, and viewpoints to frame my research.

### **2.1 Early Medical Literature from Hippocrates to the Middle Ages**

This preliminary literature analysis begins with the works of Hippocrates and his students, which arguably serve as the foundational texts of Western medicine. The Ancient Greek scholar Hippocrates is most well-known in the medical community for writing what has been embraced and adapted as his oath sworn by many physicians as a statement of their standards and moral code. The most basic standard set in the “The Oath” is that a physician is not to cause harm to a patient in any way. Hippocrates writes, “I will not give a fatal draught to anyone if I am asked, nor will I suggest any such thing. Neither will I give a woman means to procure an abortion” (Hippocrates 67). Prohibited harm also extends to sexual abuse; he states, “I will not abuse my position to indulge in sexual contacts with the bodies of women or of men, whether they be freemen or slaves” (Hippocrates 67). This statement to “do not harm the patient” is restated at the beginning

of “Epidemics, Book I” which is particularly notable for its descriptions of patients’ symptomatic presentation over a course of days (Hippocrates 94). The women described in these fourteen cases are consistently identified by their closest male relation (“wife of Epicrates”; “the unmarried daughter of Euryanax”) rather than their names as most men were identified. Throughout “Epidemics, Book I” and “Epidemics, Book III,” only one woman is referred to by name (Melida in case xiv of the “Fourteen Cases”) and many others are kept anonymous. This identifies one of the themes prevalent throughout medical history in the experiences of women: the tendency for a woman’s identity to be dependent on that of a man.

Another of these themes exhibited in Hippocrates’ work include the strict enforcement of gender roles. This is especially present in “Airs, Waters, Places,” in which Hippocrates discusses various cultures and their health ailments. One of these is the Scythians. A sub-group of Scythians, known as the Sauromatae:

Their women ride horses and shoot arrows and hurl javelins from horseback and they fight in campaigns as long as they remain virgins. Nor do they lose their virginity until they have killed three of their enemies and have offered such sacrifices as are prescribed by ritual law. But once a woman has taken to herself a husband she does not ride again unless military necessity should require their total forces to take to the field. The women have no right breast since their mothers heat a specially made iron and apply it to the breast while they are still children. This prevents the breast from growing and all the strength and size of it go into the right arm and shoulder instead. (Hippocrates 162-163)

Other Scythian tribes also defy gender roles in both behavior and physiology, which Hippocrates credits to their tendency toward riding horses. The Scythians’ treatment for the disabilities that

come from frequent horseback riding is bloodletting. Hippocrates disagrees with this treatment, stating:

My own opinion is that such treatment is destructive of the semen owing to the existence of vessels behind the ears which, if cut, cause impotence and it seems to me that these are the vessels they divide. Consequently when they come into the presence of their wives and find themselves impotent, they do not perhaps worry about it at first, but when after the second and third and more attempts the same thing happens, they conclude that they have sinned against the divinity whom they hold responsible for these things. They then accept their unmanliness and dress as women, act as women and join with women in their toil.

This is the fate of the Scythians. They are the most effeminate race of all mankind for the reasons I have given, and because they always wear trousers and spend so much of their time on horseback so that they do not handle their private parts, and, through cold and exhaustion, never have even the desire for sexual intercourse. Thus they have no sexual impulses in the period before they lose their virility. (Hippocrates 166-167)

Hippocrates' descriptions of the Scythians implies that the defiance of the gender roles set by traditional Greek society is a shameful thing with dire consequences to the health of the community. It is especially shameful for men to be associated with femininity in a way that it is not reciprocal for women who align themselves with masculinity. For both parties, there are substantial consequences, particularly in the areas of sexuality and fertility.

One physiological phenomenon which greatly influences both the medical and social treatment of women is pregnancy. Hippocrates primarily discusses pregnancy in childbirth in "The Seed," in which he discusses his theories on sexual intercourse, conception, and the development of pregnancy. In this chapter, Hippocrates writes that a woman's health is better if she has



intercourse with a man than if she does not. He attributes this to two things: that the womb is moistened by intercourse preventing painful contractions caused by uterine dryness and that intercourse heats the blood, making it more fluid and therefore easier to be expelled during a menstrual period (Hippocrates 320). The implication is that women's sexuality—and therefore their health—is dependent on men. However, this is not the only theme that may be gleaned from "The Seed." Hippocrates' theory on conception states that both male and female parents emit sperm during sexual intercourse. The sex of the resultant offspring is dependent on this sperm:

if (a) both partners produce a stronger sperm, then a male is the result, whereas if (b) they produce a weak form, then a female is the result. But if (c) one partner produces one kind of sperm, and the other another, then the resultant sex is determined by whichever sperm prevails in quantity. (Hippocrates 320-321)

This implication of masculinity's association with strength and femininity's association with weakness may be connected to the previously discussed theme regarding gender roles. While modern medical science has been enlightening in many of Hippocrates' theories wrong, his proposal that reproductive biology be adherent to societal gender norms illustrates the possibility for bias to leak into medical and scientific practice.

Hippocrates was, of course, not the only ancient scientist to propose theories on reproduction. Aristotle's *On the Generation of Animals*, one of his biological texts, describes the process of reproduction in humans and other animals. Overall, Aristotle has very similar views to Hippocrates, though he postulates two possible hypotheses for human reproduction:

For thus we shall make it clear (1) whether the female also produces semen like the male and the foetus is a single mixture of two semens, or whether no semen is secreted by the female, and, (2) if not, whether she contributes nothing else either to generation but only

provides a receptacle, or whether she does contribute some-thing, and, if so, how and in what manner she does so. (Aristotle 27)

Aristotle's text supposes that menstrual blood, which he calls catamenia, is analogous to semen in its biological purpose (Aristotle 28). He concludes this due to the fact that menarche occurs around the same age in females as the production of sperm begins in males. Because females have menstrual periods, Aristotle concludes that they cannot provide semen for the development of offspring. This is in clear opposition to his first proposed theory and to Hippocrates' theory of reproduction. The comparison of menstrual blood to sperm is also indicative of a theme found throughout medical history and literature: the comparison of female bodies to male bodies. In fact, later in *On the Generation of Animals*, Aristotle writes, "Now a boy is like a woman in form, and the woman is as it were an impotent male, for it is through a certain incapacity that the female is female" (Aristotle 31). While Aristotle makes comparisons between male and female physiology, he consistently reinforces the superiority and normativity of male bodies and their superior functions to that of the female body. He suggests that it is the male's contribution to reproduction which provides a child with higher functioning, whereas the female's contribution provides only the material. "But the semen of the male differs from the corresponding secretion of the female in that it contains a principle within itself of such a kind as to set up movements also in the embryo and to concoct thoroughly the ultimate nourishment, whereas the secretion of the female contains material alone" (Aristotle 124). These discussions of gender superiority provide further context to the previous discussion of gender roles and the shame that accompanies men who participate in femininity. If masculinity and masculine physiology is superior to femininity and femininity, then it serves to police the ways in which individuals of different sexes present their gender.

In Ibn Sina's medical text *The Canon of Medicine*, he agrees with Aristotle's proposition that male semen provides the soul and that female reproductive materials provide the matter of a fetus (Avicenna 359). Ibn Sina integrated and extended Aristotle's scientific understandings of the human body and Hippocrates' treatment methods. Ibn Sina's text emerges over one thousand years after Aristotle's and is one of the most well-known Islamic medical texts of the Middle Ages. Book I, Part III of *The Canon of Medicine* discusses in-depth guidelines for lactation, weaning, and the selection of a wet nurse for an infant. Another Medieval medical text is *The Trotula*, a text on the medical care of women written by a 12<sup>th</sup>-century female physician in Salerno, Italy. *The Trotula* contains multiple descriptions and treatments for various ailments. While it largely focuses on female anatomy and pathology, the *Trotula* includes treatments for male reproductive maladies as well as other somatic conditions. This text describes menstruation as a "purgation," necessary because women's bodies lack the heat necessary to evaporate excess or toxic humors (Green, *The Trotula* 73). *The Trotula*, like the *Hippocratic Writings*, describes diseases that occur from lack of sexual intercourse with men (Green, *The Trotula* 85). It also describes various methods of promoting conception in infertile couples, preventing conception, and easing difficult births. Despite the scientific and often compassionate way in which *Trotula* describes her recommendations for the treatment of female patients, other entries in *The Trotula* clearly imply a sense of societal shame attached to pregnancy and female sexuality. In regard to assistance with difficult births, *Trotula* recommends that "those men who assist [the patient] ought not look her in the face, because on account of this women are accustomed to be shamed by that during and after birth" (Green, *The Trotula* 101). The text also describes methods for "dirty and corrupt prostitutes" and other women who are not virgins to falsify their virginity. For this, *The Trotula* suggests that a woman place leeches into her vagina to cause openings in the skin which will bleed upon sexual

intercourse (Green, *The Trotula* 147). This sense of sexual and reproductive shame is prevalent throughout many texts and throughout history.

In the Middle Ages, some European Christian women mitigated this shame surrounding virginity and sexuality by seeking solace in the Virgin Mary (Watt 35). Middle Ages women also took comfort in the Biblical figure of Mary during the ritual of Purification:

For ordinary women the rite of purification concludes a period of physical recovery of the newly delivered mother who was considered unwell. This notion of the newly parturient mother's sickness was related to the ceasing of menstruation, something which was considered to affect her humoral balance. Closely associated with women's health, the Purification is thus a symbolic threshold which readmits women to receive the sacramental Host, for medieval canon law prohibited women after childbirth from receiving the sacraments because they were considered symbolically and ritually impure. In addition to the physical trauma of childbirth, women had to endure the spiritual trauma induced by the virtual exclusion from the Christian ritual. (Watt 38)

Many medieval women reportedly took comfort in the fact that the Holy Mother would also have been required to undergo such a ritual in order to be cleansed in the eyes of the Church.

Other sources of societally-induced shame on mothers came in the form of blame for their children's congenital abnormalities. A text titled *De secretum mulierum* (meaning "On the Secrets of Women") suggested three reasons for birth abnormalities in infants:

firstly, if the woman did not lie absolutely still but actually moved during intercourse, the male seed 'might be divided and a defective child conceived'; secondly, the woman should not let her thoughts wander during intercourse, but she should concentrate on what is going on, otherwise if at the critical moment she thought of something else, e.g. some animal like

a cow, the child might turn out to resemble one; and thirdly, any non-standard coital position might result in birth defects in those children who were the results of their parents' experiments in the conjugal bed. (Metzler 166).

While both parents could potentially be implicated in the outcome of a birth that was considered to be undesirable, "If a parent was particularly blamed for inappropriate behaviour that negatively influenced the development of the baby, it was the mother" (Metzler 169).

Through these primary documents and historical analyses, one may notice five primary themes evident throughout many of the texts described: (1) the subjugation of a woman's identity to that of a man, (2) the enforcement of gender roles inherent to the hierarchy of masculinity over femininity, (3) the dependence of women's sexuality and health on men, (4) the belief that female bodies are simply a modified and inferior form of the male body, and (5) the embrace of shame as inherent in pregnancy, childbirth, and the expression of female sexuality.

## **2.2 Gender and Medicine in the Early Modern Era to the Mid-20<sup>th</sup> Century**

Although already inaugurated by the Hippocratic philosophy of medicine, the shift from birthing care being primarily provided by female midwives to its provision by male physicians took hold in Europe slowly over the course of the Middle Ages, with the majority of births being attended by women up until the eighteenth or twentieth century (Green, "Women's" 472). Efforts by male-dominated medical societies resulted in the passing of laws which imposed licensing restrictions on medical practitioners as well as a 1329 Valencian law which outright banned women from medical practice with the exception of limited care for women and young children (Green, "Women's"). Historian Monica H. Green has suggests that these laws may have been

introduced in order to limit the practice of female Muslim metgesses who cared for patients within Christian communities (“Women’s” 448-449). These restrictions also coincided with the beginnings of European witch trials, as many of the women who were targeted by these laws were local ‘wise women’ practitioners (Green, “Women’s” 451).

The exact motivations for men’s insistence on participating in birth care may have come from many factors. According to Green:

Women’s health was women’s and men’s business, the latter being interested if for no other reason than their concern as husbands and fathers for the production of healthy (and legitimate) heirs or, as medical practitioners, for the potential profit to be made in treating the wives and daughters of their wealthier clients. As many other studies in the history of women have shown, the superficially simple dichotomies of sex and gender often mask very complex and tension-fraught realities of the relations between women and men. (Green, “Women’s” 472-473)

Some historians argue that class tensions also had a great influence on this shift. Upper-class women insisted on their births being attended by male physicians rather than less-trained female midwives as a matter of distinguishing themselves from lower-class women (Sommers 91). This shift in the control of women’s reproductive health care is an example of the historical trend and belief that women’s health and sexuality are reliant on male control and oversight. It was also used by many Victorian physicians as a way of enforcing gender roles on their patient population. Emma L. E. Rees writes:

The foundation of much Victorian gynaecological praxis was not objective fact but rather a theory of social and moral control, and ‘there were big disparities in the medical

sophistication' of Victorian doctors to the extent that medical science was 'a weapon used by men to rationalize the perpetuation of traditional sex roles.' (Sommers 120).

The change from community-based, female-led reproductive healthcare to paternalistic, male-led care was guided by a variety of social and economic causes and perpetuated many previously seen themes in the realm of gendered medical care. However, the ways societal belief affected the practice of this new form of care is an equally complex and fascinating subject.

Though men made efforts to control and lead obstetric or gynecological care, they often experienced difficulty actually performing the care needed:

Carl Rosenthal notes that, although male physicians considered themselves competent to treat the full range of gynecological disorders (even to the point of instructing the midwife!), he was able to find no instance of a man manually examining a woman's vagina for a gynecological disorder. This deeply ingrained social taboo would have insured women a place in the medical care of other women, if only in the role of manual assistant to the male physician (as can be seen in Guainerius and other writers) and in the rarely challenged role of birth attendant. (Green, "Women's" 468)

These stigmas and fears surrounding modesty and shame were carried into the Victorian age. Women's sexuality and the existence of female sexual feeling was particularly controversial in this time period. In the 1857 book *Functions and Disorders of the Reproductive Organs* by William Acton, the author particularly struggles to reconcile the fact that women experience sexual urges with his preexisting moral beliefs (Garrison 153). One fear of the time, particularly related to masturbation was that "masturbating women or otherwise sexually abnormal women may seek sexual partnerships with other women, but also that if this occurs the whole moral order may be under threat. If women create sexual partnerships with other women, then male sexual partners

may well become unnecessary and male roles in society may be taken over by women” (Garrison 156). These anxieties about female sexuality often took the form of pathologizing, a factor in the much-debated medical phenomenon of hysteria.

The phenomenon of hysteria has roots in the ancient world and the middle ages as a disease of the womb. Plato believed that it originated from the uterus wandering around the body and causing trouble with other organs, and referred to the uterus as “an animal inside an animal” (Maines 23-24). This motif of the female body as a wild, difficult, and untamable thing completely separate from male bodies is related to the theme of comparison between male and female bodies. Hysteria was believed to have many causes, with belief in many of them persisting into the twentieth century. It was largely believed to be a disease caused by lack of sexual activity (Maines). This may be connected to the previously mentioned assertions by Hippocrates and *The Trotula* that women who do not have sexual intercourse with men are prone to worse health than women who do. Another suggested cause was the retention of fluids in the uterus, whether those fluids be sperm, menstrual blood, or one of the four humors. Hysteria was linked to other conditions such as nymphomania, hypochondrium, and neurasthenia and had a wide array of both physical and psychological symptoms (Maines). For the treatment of hysteria, physicians often recommended marriage and sexual intercourse. If this treatment were unsuccessful, physicians would take it upon themselves to complete the dreaded job of stimulating a woman’s genitalia in order to produce the “hysterical paroxysm,” which many scholars believe may have simply been an orgasm (Maines). According to Rachael P. Maines:

Because the androcentric model of sexuality was thought necessary to the pro-natal and patriarchal institution of marriage and had been defended and justified by leaders of the Western medical establishment in all centuries at least since the time of Hippocrates,



marriage did not always “cure” the “disease” represented by the ordinary and uncomfortably persistent functioning of women’s sexuality outside the dominant sexual paradigm. This relegated the task of relieving the symptoms of female arousal to medical treatment, which defined female orgasm under clinical conditions as the crisis of an illness the “hysterical paroxysm.” In effect, doctors inherited the task of producing an orgasm in women because it was a job nobody else wanted. (Maines 3-4)

At its heart, the existence of hysteria is a case study in the historical theme of the societally imposed shame attributed to female sexuality, born from the patriarchal fear of loss of male control over the female body. Through the work of neurologist Jean-Martin Charcot and psychiatrist Sigmund Freud, new theories for the cause of hysteria began to include lack of sexual satisfaction in marriage and childhood sexual trauma (Maines 42-44). The existence of hysteria is also indicative of a new theme: the pathologizing of women’s emotions.

Prior to Freud and Charcot’s work, other research into the female reproductive system was occurring in America under physician James Marion Sims. Sims is well-known in the medical world for his work on the repair of the vesicovaginal fistula and has been called the “Father of American gynecology,” however, most of his research was completed on women who were enslaved. The named of only three of these women are known: Anarcha, Betsey, and Lucy. In addition to the lack of informed consent inherent in this research practice, Sims subjected these women to experimental surgical procedures without the use of anesthetic (Cooper Owens).

Sims held fast to the practice of restraining surgical patients because he knew so many of them would physically resist being cut by his surgeon’s blade, even black women who were allegedly impervious to surgical pain. The hypocrisy of medical and scientific racism allowed doctors to write about black women’s supposed bravery and silence in the face of

life-threatening and painful operations while also describing how they were restrained physically. The reality is that medical men, based on their experiences with black patients, did not believe that black people did not experience any pain. Instead, they believed black people experienced pain that was not as severe as white people's pain. (Cooper Owens 112-114).

These forced and painful medical experiments were not the only reproductive trauma that women in bondage were made to endure. According to Dierdre Cooper Owens in her book, *Medical Bondage: Race, Gender, and the Origins of American Gynecology*, enslaved women were often forced to undergo rape by their owner or by enslaved men in order to become pregnant and produce children who would then also become slaves. These horrific practices are of course indicative of other themes previously discussed, such as the subjugation of women's bodies and sexuality to male control. They are also suggestive of the theme of marginalization and its effect of transforming an individual's identity and experiences both inside and outside their existing experiences of womanhood. Sentiments regarding the way in which race affects the way a woman is viewed and treated can be seen throughout thousands of years of human history. In his *On the Generation of Animals*, Aristotle associated a lighter skin tone with femininity and a darker skin tone with masculinity (Aristotle 30). This sixth theme will see further discussion in the next section as this analysis moves further into the twentieth and twenty-first centuries.

### **2.3 Understandings of Gender and Health into Present Day**

In 1953, Alfred Kinsey and his colleagues published *Sexual Behavior in the Human Female* following the publication of a similar volume on human sexuality in males. Kinsey's

groundbreaking research into sexual behaviors and attitudes in the mid-twentieth century involved data from nearly six thousand white females on topics such as masturbation; dreams; “petting”; pre-marital, marital, and extra-marital coitus; as well as sexual activity with members of the same sex. Kinsey further stratified the responses he received within a given category by marital status, education level, parental occupation, rural-urban background, and religious affiliation. Aside from the numerical data presented in Kinsey’s report, *Sexual Behavior in the Human Female* also comments on the societal stigma’s surrounding sexuality, especially female sexuality. In his chapter on pre-marital coitus, Kinsey writes:

Many a male, particularly in certain social levels and in certain parts of the United states, is prone to seek coitus from every available girl, while insisting that the girl he marries should be virgin when he first has coitus with her. It is the male, rather than the female, who imposes this incongruity on the social code. He will defend his right and any other man's right to try to secure coitus from another man’s sister or wife, but he may fight or kill the man who attempts to secure a coitus from his own sister, fiancé, daughter, or wife. (Kinsey 323)

There are many suggested reasons for this double-standard in *Sexual Behavior in the Human Female*, including Christian religious beliefs, the historically economic nature of marriage, and behavioral differences between adolescent men and women (Kinsey 322-324). The implications of these stigmas permeate Kinsey’s data. He states that in their late teens, 99% of males achieved orgasm on average 2.2 or 3.2 times per week depending on marital status, while 47% females in the same age range still had yet to have their first orgasm (Kinsey 373). This is in contrast to data that females have a similar sexual response to males, leading to Kinsey’s condemnation of the term “sexual frigidity,” which, reminiscent of the diagnosis of hysteria, “connote[s] either an

unwillingness or an incapacity to function sexually” (Kinsey 373). Ultimately, the Kinsey reports show how the historically present theme of the shame inherent in female sexuality affects sexual behavior and beliefs into the twentieth century.

Following the Kinsey reports, Shere Hite’s 1973 *The Hite Report* approached research into female sexuality by asking women about their feelings about and experiences with sex in a fifty-eight-question questionnaire published in various women’s magazines. Hite then categorized and analyzed these responses not only in numerical data, but also through publishing direct quotations from participants. Hite stated in the preface of her book that:

Women have never been asked how they feel about sex. Researchers, looking for statistical “norms,” have asked all the wrong questions for all the wrong reasons—and all too often wound up *telling* women how they should feel rather than *asking* them how they do feel. Female sexuality has been seen essentially as a response to male sexuality and intercourse. There has rarely been any acknowledgement that female sexuality might have a complex nature of its own which would be more than just the logical counterpart of (what we think of as) male sexuality. (Hite *xi*).

This statement is supported by the responses Hite received to the final question of her questionnaire: “Why did you answer this questionnaire (*thank you!*), where did you get it, and how did you like it?” (Hite *xviii*). Many echoed Hite’s statements on the importance of studying women’s sexuality from the perspective of women, with some even expressing distrust in the United States medical establishment, particularly with male practitioners (Hite *xxxiii*). These opinions provide context to women’s views on the theme of male control over women’s health and sexuality.

While Kinsey's work was incredibly informative and groundbreaking at the time of its publication, it has the notable limitation of its sample only consisting of white women. The differences in how white women and women of color experience the world, particularly in relation to their gender and the oppressive systems that act on both gender and race, are seen in both historical and contemporary literature. In her book, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*, Dorothy Roberts discusses feminism in relation to race:

A caucus of Black feminists at a 1994 pro-choice conference coined the term "reproductive justice," a framework that included not only the human right not to have a child, but also the right to have children and to raise them with dignity in safe, healthy, and supportive environments. For too long, the rhetoric of "choice" had privileged predominantly white middle-class women who have had the ability to choose from reproductive options that are unavailable to low-income women and women of color. (Roberts xx)

In her book, Roberts discusses the eugenic origins of the modern movement for birth control access. Margaret Sanger, the famous founder of Planned Parenthood and staunch pro-birth control advocate of the early-twentieth century aligned herself with eugenics movements that advocated for the sterilization of low-income and Black individuals (Roberts). Into the late-twentieth century, many Black women were pressured or forced into sterilization by their physicians and social workers. When one woman named Dorothy Waters insisted to her physician that she would not be sterilized after the birth of her child, her obstetrician, Dr. Pierce stated, "Listen here, young lady, this is my tax money paying for this baby and I'm tired of paying for illegitimate children. If you don't want this sterilization, find another doctor" (Roberts 92). Dr. Pierce was the only obstetrician in the county who accepted Medicaid patients. In the 1990s, a new birth control implant called the Norplant was heavily promoted to poor women and women of color. A 1993 Tennessee law

mandated that all women receiving public assistance be notified in writing that the state would provide them with a free Norplant implant. A bill passed by North Carolina required that all women who receive a state-funded abortion be implanted with the device if medically safe (Roberts 108-109).

While many women of color were fighting for the right to have a child, many white women were fighting for the right to be sterilized. In regard to physicians who refuse to perform permanent sterilization on women who request it, law professor Ruth Colker stated that their “actions reflect the dominant social message – that a healthy (white) woman should want to bear a child” (Roberts 95). Ultimately, this control over women’s reproductive decisions is inherent to the belief that women do not know their bodies and that they must be controlled. These beliefs are affected by systemic inequalities and individual biases among healthcare providers, which in turn, has dire consequences for women, particularly in the realm of maternal mortality for women of color. According to the Centers for Disease Control and Prevention, Black women in the United States are three-times more likely to die from a pregnancy-related cause than white women (“Working”).

Dismissals of women’s interests, preferences, and statements regarding their own bodies affect their experiences not only in obtaining reproductive healthcare, but also in other areas of medicine. One 2019 study of negative healthcare experiences of patients with myalgic encephalomyelitis (ME) and chronic fatigue syndrome (CFS) found that female participants reported higher instances of physicians believing that ME or CFS was not real or being subject to degrading or rude behavior from physicians when they reported their symptoms (McManimen). This dismissal of pain and symptoms in women, particularly in sufferers of chronic illness, has been frequently discussed and studied within recent years and is closely tied to historical themes of the untamable female body as well as to diagnoses such as hysteria.

## **2.4 Themes Throughout the Eras**

The preceding analysis has identified six prevalent themes in medical history and literature.

The themes are:

1. Women's identity is connected to and dependent on the men in their lives.
2. Gender roles are enforced in greater society, including in the contemporary United States medical establishment.
3. Women's health and sexuality is widely believed to be dependent on men and men's control.
4. Female bodies are consistently compared to male bodies and are viewed as a modified, inferior, and uncontrollable version of the default male body.
5. Shame is inherent in female sexuality and in conditions associated with it, including pregnancy.
6. Race and other marginalizing identities greatly affect how individuals are treated in the medical care that they receive.

The following narratives of contemporary women will be analyzed with these six themes in mind.

## **3.0 Why and How**

### **3.1**

#### **3.2 Research Question**

This project seeks to examine the experiences of contemporary women in the context of the historical themes identified in previous literature research. Through analyzing the stories of these women, this thesis seeks to determine how these themes have persisted throughout history and affect the medical interactions of women.

#### **3.3 Participants**

Participants were either self-selected or contacted by the principal investigator due to a previous acquaintance or indication that they may be interested in discussing their medical experiences. They were primarily recruited through social media posts or email. Participants were required to be over the age of eighteen and non-European Economic Area citizens, and to self-identify as a woman.

In total four women chose to tell their story. All identified as white, and one identified as queer. All participants were also under the age of thirty and had lived in Pennsylvania.



As would be suggested by Crenshaw's concept of intersectionality, the experience of women is highly individualized and dependent on their other identities and the way that those identities intersect with their identity as a woman. Therefore, and especially due to the incidental homogeneity of the women who participated in this project, the results of this study cannot be said to be representative of all women. The analysis may be more relevant and applicable to women similar to the women studied: white women under thirty. However, these four women still describe varied experiences in their narratives, and each of their stories deserves to be told. As previously stated, each woman's experience is unique, and it is impossible to apply broad statements about the experience of obtaining healthcare in the United States to all women, even for all women who are demographically similar to the women described here.

### **3.4 Methods**

Participants were interviewed via HIPAA-compliant Zoom. Interviews took between thirty minutes and two hours, with one hour being the average time. Participants were asked the questions listed in Appendix A. Their answers were recorded both through written notes, and the audio of the interview was recorded via digital recorder. Data from the interview were then written in a narrative format and analyzed for the presence of themes identified from previous historical medical research.

## 4.0 Sarah's Story

*“[T]hey don't believe you. They think you are overexaggerating.”*

Sarah describes herself as a person who has “a lot going on.” This is true in more ways than one. Her hobbies include architectural design, reading, embroidery, sewing, calligraphy, and more, many of these hobbies being self-taught: “I switch from hobby to hobby. I've been teaching myself hobbies forever.” Academically, she has a passion for history that has inspired her to self-proclaim seven specialties in the field. This wide array of passions and interests align with the way that she describes her brain: “all over the place,” something that she attributes to her ADHD. She finds her ADHD hyper-focus to be a “superpower,” though sometimes it causes her to forget to eat. Aside from hobbies and academics, she also has a lot going on in terms of her health history. In fact, she sees eight different medical specialists.

She was diagnosed with type 2 diabetes at the age of nine and saw her childhood endocrinologist from that age until she was eighteen: “She tried her best for me.” Upon her diagnosis, Sarah was prescribed medication for her type 2 diabetes that caused her to gain weight despite being an active child. Any time she had an appointment with her physician, the endocrinologist observed her weight gain and accused her of not taking the prescribed medications properly because of it. Tired of feeling sick due to the adverse effects of her medication, Sarah stopped taking the medication. This cessation of her medication caused her to lose weight, and only then did her physician believe that she was taking her medications. At the age of eighteen, weight loss caused her to lose her diabetic symptoms. By this point, she had not been taking her medication for a year. She eventually switched to a different endocrinologist: the colleague of her

childhood physician. The main concern she expressed to this physician was that she experienced severe weight gain during the COVID-19 pandemic quarantine due to stress, despite the fact that she was barely eating. By then, Sarah had been diagnosed with gastroparesis by a gastroenterologist, which causes delays in food digestion. However, this endocrinologist dismissed her gastroparesis diagnosis as a possible reason for her weight gain or lack of eating. She stated that Sarah needed to eat three meals a day, and that she was responsible for causing her symptoms.

She now sees a different endocrinologist who found that she had elevated cortisol levels, which likely caused her previous weight gain. This new physician validated her experiences: “She was the first one to tell me that my weight gain was not my fault.” Now, her diabetic symptoms come and go and are regulated through diet and medications. Her diabetes is not the only medical diagnosis for which Sarah has had varied experiences with medications.

Sarah describes being prescribed medication for her attention-deficit/hyperactivity disorder (ADHD) as “liberating.” She no longer felt stupid for being bad at certain subjects, like math: “History majors and English majors are notoriously horrible at math...I’m a history major with a [literature] minor.”<sup>2</sup> Whereas before, she and others believed that she simply was not trying hard enough at the topics that she performed poorly in, but her ADHD diagnosis, she was able to acknowledge that her school performance had a lot to do with how her brain works. She needed to be interested in a topic to perform well in it, as with history, but was unable to focus on the subjects that she was uninterested in. She took stimulant medication for her ADHD from age of sixteen until she was twenty and found herself to be consistently maxing out on the dosage of medications before they stopped working and needed to be switched to a different medication. At the age of

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<sup>2</sup> As an English major, I concur.

sixteen, Sarah wanted to lower the dosage of the ADHD medication that she was prescribed at the time because she was unable to eat while she was on them.

Even at the age of sixteen, Sarah came to the appointment with her primary care provider armed with knowledge of her body and of her condition. She states, “I do my research... Even back then, I did my research on ADHD, especially the medication I was taking.” Despite the fact that Sarah had lost twenty pounds since being prescribed this medication, her physician convinced Sarah’s father to agree to increase the dosage instead due to her grades. She describes this physician as a “mansplainer” and a “jerk,” who cared little for her opinion and experiences. With the increased dosage, Sarah’s trichotillomania increased tenfold, and she began experiencing what she describes as “jitter spells” or fits of irritability: “If you touched me, I would have a full-on breakdown.”

Eventually, Sarah stopped seeing Dr. Mansplainer and switched to a new primary care physician, who changed her ADHD medication to one that she was more comfortable with. She stayed with this new physician until she aged out of the practice, then began seeing a psychiatric advanced practice provider at the age of nineteen. This new provider wanted to put Sarah back on the medication that caused her to lose weight and develop psychological side effects at the age of sixteen. This time, Sarah refused to agree to the provider’s plan: “I told her ‘absolutely not.’” She reminded the provider that she had had a bad experience with that medication previously, but the provider dismissed these concerns as it had been several years since Sarah had had that negative reaction. Sarah stopped seeing that provider. From Sarah’s perspective, this provider was not necessarily bad at her job. She simply did not listen: “She was good and bad. She wasn’t all bad.” At the time of her interview, Sarah had been off medications for her ADHD for one year. She

believes that part of these issues in finding the right medication may be due to comparisons to the male standard of ADHD<sup>3</sup>.

Sarah's trials and tribulations with ADHD medications also extended into experiences in the emergency department (ED). As she rotated through multiple types of stimulants when the previous one stopped working, Sarah found herself in the emergency department for withdrawal symptoms and panic attacks that sometimes lasted three days straight. These symptoms were often aggravated by generalized anxiety. In her trips to the emergency department, Sarah notes a few trends. She felt that many of the male physicians who treated her dismissed her because of her medical history and because she is a woman, with male health professionals going so far as calling her "honey" or "sweetie" as a form of condescension while she is seeking care. Sarah also notes that emergency physicians administer Ativan to her more often than she likes. She links this to her history of anxiety, as many doctors seemed to believe that she could not handle herself or her medical care due to her generalized anxiety. In an emergency room, Sarah feels as though she has "little to no control" over her body and her care.

In a healthcare setting, Sarah feels the most control when she is one-on-one with a provider she trusts. One such provider is her rheumatologist. He diagnosed her with lupus at the age of nineteen after she began noticing symptoms at the age of seventeen. She states that this diagnosis

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<sup>3</sup> Women's internalizing symptoms of ADHD (such as inattentiveness and low self-esteem) tend to be more prominent than externalizing symptoms (such as hyperactivity and impulsive behavior). Women also tend to have the inattentive subtype of ADHD whereas the predominant subtype in men is the hyperactive-impulsive subtype. The female hormonal cycle may also affect ADHD presentation and response to stimulant treatment. Women are also more likely to have a comorbidities of anxiety disorders. This varied presentation compared to males with ADHD may result in underdiagnosis of women with ADHD (Quinn and Madhoo).

was quick compared to the average amount of time it takes a Lupus patient to be diagnosed.<sup>4</sup> “He’s amazing. He’s kind of cold and [surly], but he’s a really nice guy...He’s very straight-to-the-point and he knows, he knows me well enough by now at least that I have a really high pain tolerance. If I’m calling and crying, that means there’s some real shit going on, and it’s really bad.” Not only did he provide good care and an efficient diagnosis, but Sarah feels believed by him.

Overall, Sarah’s vast experience with the medical field has led her to have both incredibly good and incredibly bad experiences with medical professionals. When asked what makes her comfortable in her interactions with a provider, Sarah said that nothing could really make her comfortable. She always wonders, “Is this gonna be another one that screws me over and doesn’t listen to me?” Her gender, she believes, especially plays a part in this. In regard to being a woman with majority male physicians: “Most of the time, they don’t believe you. They think you are overexaggerating...They second-guess us on everything.” She acknowledges that she has “been through too much,” but has learned to laugh at her circumstances in order to desensitize herself to them. Despite this, she does not delay seeking medical care due to her bad experiences, even if she admits to sometimes delaying care because of her own stubbornness. She is still learning to advocate for herself as a patient, a skill that she is learning from her mother, a nurse. However, with her history of picking up hobbies and skills and learning to excel at them, there is no doubt that this is just another skill she will gain with practice.

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<sup>4</sup> According to the Lupus Foundation of America, it takes nearly six years on average for individuals with lupus to be diagnosed from the first time they recognize their symptoms (“Lupus”).

## 5.0 Anonymous Story

*“Is that your only solution?”*

Growing up, she was always around boys due to spending a lot of time with her brothers. She was always small in stature, and knowing the way her small size would make her be perceived by others, she always made an effort to pay attention to her body in order to grow strong: “I paid a lot of attention to my body because I knew how I was perceived by other people.” As an adult, she prides herself on prioritizing preventative care and lifestyle choices in order to delay or prevent the need to seek medical care: “I’m very in tune with my body.” When asked if her experiences with medicine since childhood have driven her to be more in tune with her body, she admits that she never really thought of it, but it could be a factor.

While this next participant chose not to have a name associated with her story, she describes herself as being a patient for her entire life. She was born with brachial plexus palsy, a condition caused by an injury to the brachial plexus nerves that can occur during birth (“Brachial”). As an infant, she could not crawl or move. Symptoms persisted throughout her life and were mainly treated by physical therapy. At the age of eighteen, she and her parents made the choice to move forward with a surgery to correct the range of motion in her left arm. Surgeons cut her bone in half and rotated her arm. She now has a metal bar and six screws in her arm, which she describes as feeling attached to her, rather than a part of her: “I almost feel like it’s like a different arm...It almost feels like it’s attached to me whereas any other body part it’s just you, it’s a part of you.” For her, the surgery feels like it was a fifty-fifty trade rather than a full victory, something that she attributes to a lack of understanding of what she was to reasonably expect following the procedure:

“I had this expectation that my arm would be 100%, and they [the medical team] told me it would probably never be 100%, but I still had that idea of what—I think they said 75%.” While the surgery was overall successful, it was the first of several medical experiences in which she experienced an issue of differences in expectations between the patient and provider.

In healthcare settings, she admits that she relies on her providers to tell her what she needs to know. She wants not only the opportunity not only to ask questions of her physician, but for her doctor to be proactive in addressing the questions that she would not know to ask: “Sometimes I don’t know what I’m going into, so I don’t know what questions to ask.” She frequently finds herself leaving medical appointments with thoughts of questions she wished she had asked or issues she wished had been addressed. Why can’t we run more tests? Are there other treatment options? “Hindsight is twenty-twenty,” and once she has left her provider’s office, it is often too time consuming to make another appointment and wait several weeks just to have those few points addressed. At one appointment in particular, she remembers asking a question to a staff member who stated that they were not allowed to answer that question and that she should ask her doctor. When she finally got to speak with the doctor, there was no opportunity to ask the question: “This is a big deal for me, like, I don’t know what’s happening. So, I felt kind of, like, brushed off a little bit. And I’m sure that wasn’t their intention, but...I need to talk to someone.” However, she does note a recent experience in which a provider was proactive in asking questions that she would not think to ask: “Thank you for telling me that without me having to ask.”

Even when physicians try their best to answer her questions, miscommunications can still occur. Following the end of a pregnancy, she reached out to her physician with concerns that she had seemingly been on her period for three weeks. Her doctor said to give her body more time to go back to normal, however there seemed to be a miscommunication in which the doctor believed



that the patient was calling to confirm her miscarriage. Overall, the participant wishes that there would be more communication between herself and her physician regarding what to expect in regard to less serious symptoms, similarly to the extensive information that she received immediately following her miscarriage: “I’m a fan of preventative care. I don’t want to wait until something is wrong to fix it.”

However, this participant’s struggle to get answers on her health is not always due to a lack of physician-patient communication. In her opinion, there is simply not enough information out there on the female body. In one instance, she was experiencing menstrual bleeding every other week. Her physician could not find a reason for the irregular bleeding despite a series of tests and imaging but did prescribe her birth control to regulate the bleeding. She remembers wondering, “Is that your only solution?” She had not previously tried to avoid hormonal birth control but has since come to expect it as a proposed solution to gynecologic problems: “I know that when I walk in here, if they don’t have any answer for me, they’re gonna prescribe birth control.” She recognizes that this is often not the fault of a physician, but “I just don’t think they have much out there for us.” This is also especially frustrating because many providers do not ask her about her lifestyle nor suggest lifestyle changes to affect her health, something that she places heavy importance on in regard to her own health.

Throughout her history of medical experiences from birth injury to surgeries to pregnancy, one thing that she seeks in a provider is humanity: “I feel more comfortable when they feel more human.” This is especially true when it comes down to the hard conversations, as in medicine it so often does. She feels comfortable when she feels cared for.

## 6.0 Jessie's Story

### *"Shared Experience"*

Jessie grew up in a small, rural, gated community that she considers to be relatively homogenous in terms of religion, but her mother encouraged her to explore different religions and belief systems outside of the Christianity that was dominant in her area. She and her mother even practiced Wicca for a time, and she did not know what the concept of hell was until she went to elementary school and got in trouble for jokingly calling a girl "Helly" as a wordplay on her name. She also grew up with allergies and anxiety. Some allergies she has had since she was a baby, causing her to require itchy skin prick tests on her back with Webkinz as an incentive.

Throughout Jessie's life, these allergies have manifested in different ways, including in gastrointestinal issues. At the age of 19, she sought the care of a gastroenterologist who was a male. This is strange for Jessie as she notes, "Most of my physicians have been women, and when they have been men I remember almost always having a negative experience. But this one takes the cake for sure." He asked her to tell him about what brought her in, but before Jessie even had the chance to explain her symptoms and what she thinks is going wrong, he interrupted her. She remembers that he used medical jargon frequently when he spoke and did not thoroughly explain the terms that he used. At one point, he even joked about drinking bleach when discussing triggers of her symptoms, and he used his cell phone during her appointment. Any time she asked questions to clarify his jargon, he answered like a scolding professor as he began, "As I explained..." Though he ended up being correct with respect to his diagnosis, Jessie left the appointment feeling "not well cared for." She requested not to see him for her follow-up appointment and left a bad review on his quality-assurance survey. Searching this physician online later, she found that he studied at

Ivy League institutions and touted his technical skills, but not any interpersonal skills. When it comes to regulating these types of skills in healthcare professionals, Jessie recognizes that it is more difficult to quantify communication skills than it is technical knowledge, which makes them easier to overlook.

However, interpersonal skills are especially vital in the setting of behavioral healthcare. For as long as Jessie can remember, she has been anxious. She saw therapists throughout her childhood for bullying and was always particular about the counselors she saw, whom she trusted, and with whom she would be candid. Eventually, she was referred to the school counselor in middle school for symptoms of depression and self-harm. These symptoms led her primary care physician to refer her to a holistic psychiatrist who offered acupuncture and vitamins in addition to traditional therapy and psychiatric drugs. She believes that her own internalized stigmas about mental health caused her to be hesitant about taking psychiatric medication and becoming reliant on it, though she was reliant on medication for other physical health conditions. Over the past three years, she realized that she was tired of “choosing to suffer,” and has recently been making an effort to participate more vigorously in therapy and to care for her mental health.

This stigma has also extended into Jessie’s relationship with the family medicine primary care physician (PCP) who has been caring for her since she was a child. In discussing her mental health with her PCP, Jessie states, “I felt guilty when she heard about it.” She worried that this doctor who had known her all her life would feel bad for her. When she spoke to her PCP about her mental health, Jessie refrained from going into too much detail. On one occasion when she did discuss her mental health with her PCP more extensively in order to ask for a letter of approval for an emotional support animal (ESA), Jessie felt “brushed off.” She confided in her physician that she felt her mental health getting worse during the COVID-19 pandemic but recognized that she

felt better in her parents' home when she was with her cat. While Jessie remarks that she may not have explained her symptoms very well over electronic message, her physician replied that she did not write ESA letters due to controversy in the medical community with people misusing their ESAs. Her PCP recommended other resources, which also proved to be futile, and Jessie became frustrated due to repeatedly hitting dead-ends when it came to seeking out this mental health resource. Even in advocating for herself to her physician and in explaining her struggles, Jessie was unable to feel heard in this experience.

After this, Jessie wondered if the fact that she had previously not fully confided in her PCP about her mental health contributed to her lack of a satisfactory outcome. Outside of mental health, Jessie says that she is comfortable with her family care physician. She finds mental health to be unique, especially because this physician has known her since she was a child and also sees her parents. Jessie compares her to an elementary school teacher or a family friend for whom she wants to preserve the image of Jessie when she was younger. This is exacerbated by the worry that her physician may reveal something about Jessie to her parents due to her unique position of being connected with the whole family. Overall, she finds that she can be more candid with providers who have only known her as an adult: "They can objectively look at me as I am now. They don't have these memories of who I was." These sentiments have also extended into a hesitation in conversations regarding sensitive topics like alcohol use and sexual activity. While Jessie states that her PCP has never broached these topics with her, Jessie would be nervous if she did.

When it comes to comfort with confiding in a provider, familiarity (or lack thereof) is not the only thing that affects her. She also finds a physician's gender to strongly affect how readily she accepts care, especially when it comes to gynecologic care. In the past, she has refused to see a male OB/GYN when her usual female physician was not able to see her. This strict preference

is specifically because it was in the setting of reproductive healthcare. She does not trust cisgender male OB/GYNs from a biological standpoint, “They don’t have the parts that they’re working with. They cannot experience...will not experience the things that I see them for.” For things like IUD insertion, “a man can say, ‘You’ll feel some cramping,’ but he doesn’t know what that feels like. He’ll never know what kind of cramping.” She finds solidarity and comfort in the fact that she and a female physician may have some shared experiences when it comes to conditions like menstrual cramps or pain with sex: “Because of that shared experience, I feel a lot more comfortable, and I feel like I can trust the care that I’m receiving a lot more.” For Jessie, this experience is unique to the field of gynecology. Though she generally prefers female providers, she would not refuse to see a male provider if a female one was unavailable in any other specialty with the exception of mental health and gynecology. Shared experience matters less in seeking care for allergies because such conditions are public (the waiter who serves Jessie at every restaurant has to know about her allergies), whereas reproductive health is private. Not only is it privatized, but also stigmatized and politicized. She associates reproductive health with sexuality and intimacy and emotion, associations that she feels affect how she receives care and what she expects from it.

In seeking care in any specialty, Jessie states, “The personality...of a provider can really affect how I disclose information to them.” Jessie feels that physicians are not well-trained enough in the humanities and in areas like cultural competence. She believes this to be especially relevant in her interactions with men, as she has found that women are socialized to develop interpersonal skills such as emotional intelligence and communication aptitude. She relates this even to the way

that men and women interrupt conversations, as Jessie expresses her opinion that men tend to interrupt at inopportune times whereas women interrupt less harshly.<sup>5</sup>

Still, in our conversation, Jessie notes that she has had both positive and negative experiences with providers, but that the negative experiences come more readily to her mind when asked to share her story. She considers herself privileged to be able to trust in a provider's knowledge, to always receive the care that she needs, and to always receive treatment that improves her conditions. Her dissatisfaction with past experiences comes from the emotional side of her interactions with health professionals.

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<sup>5</sup> Interestingly, some research has shown that women's interruptions in conversation are viewed as being more intrusive than men's interruptions. However, the data on whether one gender interrupts more than the other have been heavily criticized and are not conclusive (Orcutt and Mennella).

## 7.0 Claire's Story

*“Thank you for trusting me.”*

Claire's first concussion came at age ten. The frustration began there, as many of her physicians acknowledged that they did not know much about her symptoms, nor what to do about them, because the research on the human brain was just too sparse. They noted that such research was especially lacking in women.<sup>6</sup>

When in high school she began to experience symptoms such as abdominal pain, nausea, loss of bone density, and nutritional deficiencies due to an inability to absorb nutrients, she suspected that they might be related to her history of concussions. This culminated in Claire breaking her hip due to running track, and the MRI showed inflammation in her colon. She visited a gastroenterologist in her hometown of Philadelphia who examined her with a popsicle stick. He said that at the age of eighteen, she was too young for a colonoscopy and recommended that she simply take a Colace. After that, she swore that she would never see another gastroenterologist again.

This statement was soon complicated by symptoms of lower right abdominal pain that got worse upon release of pressure on her abdomen. She went to the emergency room in her college

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<sup>6</sup> In 2017, the National Institutes of Health hosted a workshop titled “Understanding TBI in Women” to discuss the underrepresentation of females in traumatic brain injury (TBI) research in both the clinical and pre-clinical setting. This workshop was meant to discuss the knowledge gap provided by this gender disparity in TBI research, as well as to form recommendations for the formation of future research to address this knowledge gap (“Understanding”).

town where they performed a CT scan. Whatever radiologist looked at her scan confused the IUD in her uterus for a tampon, and the emergency room physician did not do much better. He declared that she was experiencing menstrual cramps, and that she was “literally and figuratively full of shit.” In his note, he stated that Crohn’s disease was one of his differential diagnoses, but that he had ruled it out. He sent Claire home on a Tuesday. She continued to experience symptoms throughout the week but avoided going back to the emergency room both because she was in the middle of finals week, but also due to her previous bad experience: “I felt like if I went back...they’d just decide it was hysteria.”

The next Monday, Claire was septic and had an appendectomy. When the surgeons opened her abdomen, they noticed that there was excess inflammation. They hypothesized that it may be due to the extended amount of time that her infected appendix was left in her body. Claire’s GI issues did not end appendicitis and excess inflammation. She began going into random anaphylaxis, leading to Claire seeking the care of an allergist-immunologist. This allergist-immunologist was a woman of color, and Claire describes her as, “a huge rock for me.” She suggested that Claire’s symptoms were caused by gastrointestinal inflammation inciting allergic reactions and was met with contradiction from other physicians who claimed that such a thing was not possible. Despite being the head of her department, she was continuously contradicted and talked down to by physicians with significantly less expertise, yet Claire remembers, “She never gave in, and that is just so powerful to see...that kind of drive in somebody.” The racism and misogyny that she experienced did not prevent her standing her ground and ultimately being correct, leading Claire further down the path of understanding her symptoms and getting better.

Claire was finally diagnosed with Crohn’s disease in July of 2020 by a GI physician in her hometown. After her previous negative experience with a gastroenterologist, Claire was worried



that she would not be taken seriously by this doctor either, but he believed her. He knew how to listen, and he also knew when to say, “I don’t know.” This led Claire to visit a gastroenterologist in her college town who became the first person to understand the complexities of her condition. She describes this as a relief. Following her Crohn’s diagnosis, Claire underwent an ileocecal resection surgery as treatment.

Right before her surgery, Claire had an experience with another physician that she says she will “always go back to.” The hospital staff was struggling to place an IV due to the anatomy of Claire’s veins. After several attempts and painful pokes, she was hungry and angry and frustrated, then into her room walked the anesthesiologist. From previous experiences, Claire had been expecting a white guy with attitude, but this anesthesiologist was a young, Black woman. She saw her patient in pain and distress and asked Claire if she could attempt to insert the IV needle. The two struck a deal: she would administer lidocaine to ease Claire’s pain and Claire would allow her one poke. With that one poke, she inserted the IV. Afterwards she said to Claire, “Thank you for trusting me to do that.”

Even following multiple great experiences, Claire has still had negative experiences in healthcare settings. One GI doctor in particular that she saw post-surgery stated that he did not believe Claire actually had Crohn’s disease. Despite previous surgeries and tests, he believed that her gastrointestinal ulceration was actually due to overuse of NSAIDs. When she told him that pain and nausea prevented her from taking in fluids, he told her to drink more water. She told him that drinking water only made her symptoms worse, but he did not have an answer. In speaking with other patients, Claire recognized a pattern. Women consistently felt invalidated by him, but men loved him. Claire believes, “had I been a guy...he would have been diagnosed as soon as he

saw the GI [physician] the first time. They would have done all the testing. They would have worked him up...They could have started treatment earlier.”

The dynamic between Claire and her concussion specialist had a rocky start: “One of the best doctors I’ve ever seen...but it took us a long time to kind of get to that point.” When she first saw him as a teenager, he told Claire, “I’m going to kick your ass,” but that she would get better if she listened to him. At the time, she had personal circumstances in her life that led her to react negatively to this approach. She also found it difficult to follow the regimen that he set for her, causing him to feel negatively toward her as a patient: “I thought [he was] sexist. [He] thought I was hysterical.” When she saw him again as an adult without a parent, both of them were nervous to see each other again. This time, Claire walked into the appointment knowing how he operated as a physician and was prepared to take a more active role in her health. She was also more open to his suggestions and able to complete his recommended lifestyle changes, as well as coming armed to their appointments with questions. With attitude changes and growth on both sides, their relationship slowly grew to one of mutual respect and teamwork oriented toward improving Claire’s health. The last time she saw him, he walked into the appointment in tears because there was nothing else that he could do to help her. Claire reported that he said, “I had grown on him, and that I was going to...be much more successful based on some of the experiences that I’ve had.” The dynamic between the pair was unique, but human relationships like these have a large effect on the way that an individual can interact with their provider.

Building relationships with healthcare professionals is especially important when it comes to discussing difficult or sensitive topics such as sexual assault. While seeking medical care, Claire notes that she sometimes has to share her experiences as a survivor with her provider. When it comes up, “doctors sometimes just see you as that.” In one instance, she remembers disclosing her

experiences with a provider due to medical necessity. Following her disclosure, the provider began to suggest that her symptoms could be attributed to stress. When it comes to having these conversations, she states that feeling comfortable is essential.

Throughout the years, Claire has grown to advocate more for her comfort and care as a patient. While she now feels as though her care is a collaboration between herself and her provider, it took a long time to get to that point. Much of that change happened with age and with the increasing agency over her own health that she has gained through the years. Education has also empowered her to take charge of her own health. While she acknowledges that this may seem “dorky,” Claire has taken to printing out and annotating PubMed articles related to her condition and bringing them to medical appointments. She uses these to spark conversation, and when doctors see her effort, their attitude toward her changes. Overall, she feels more comfortable when medical visits feel like conversations rather than lectures, when the provider shows her what they are looking at on their computer screen, when they leave time for questions, when they are able to joke around. Even with Claire’s efforts, she says that feeling invalidated by a provider “happens all the time.” Still, remembering the concussion specialist who ended up having a huge impact on her life, she states, “Doctors can change too.” We are all capable of growth in all areas of our lives, and we should all continually strive to be better.

## **8.0 Connecting Threads**

The preceding narratives I have gathered contain many connections to the themes explored in the literature review section of this thesis. Some themes were more prevalent than others, and some were explored in some narratives but not addressed in others. However, it is important to keep in mind that the participants of this study skewed young and that all participants were white. Therefore, some themes may be more emphasized in these narratives or not seen at all due to experiences that depend, in part, on the demographics of the participants. A more extensive future study with a wider breadth may find that different themes are more prevalent in their narratives than the ones in these, or that the most common themes in these narratives are not present at all in some populations.

### **8.1 Women's identity is connected to and dependent on the men in their lives**

The theme of women's identity and its connection to or dependence on the men in their lives is one that is not seen represented in these four narratives. Though I was not expecting to see Hippocrates-esque experiences of women being referred to exclusively by their fathers' or husbands' names, the stories shared in casual conversation among women and on social media that initially inspired me to undertake this project often included this theme specifically in relation to sterilization. Specifically, women described experiences where they sought tubal ligation from their physician and were told that the physician needed permission from their male significant other before they would undergo the procedure. In the case of single women, physicians were

concerned that these women would regret their decision to be child-free.<sup>7</sup> This policy is however not reinforced by the American College of Obstetrics and Gynecology, whose committee opinion states:

It is ethically permissible to perform a requested sterilization in nulliparous women and young women who do not wish to have children. A request for sterilization in a young woman without children should not automatically trigger a mental health consultation. Although physicians understandably wish to avoid precipitating sterilization regret in women, they should avoid paternalism as well. (“Sterilization”)<sup>8</sup>

The topic of consent and coercion regarding sterilization was also addressed by Dorothy Roberts in *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. As previously discussed, Roberts explained how these attitudes regarding sterilization were different for white women and women of color. While privileged women were dismissed and discouraged from preventing pregnancy, marginalized women were encouraged to undergo permanent sterilization (Roberts). This theme may also be relevant in the case of the “husband stitch,” a procedure in which a physician adds an extra stitch to the vagina after tearing or episiotomy as a result of birth (Dobbeleir et al.). In general, much contemporary discussion in which this theme is relevant seems to occur adjacent to pregnancy and childbirth.

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<sup>7</sup> Many of these stories have been shared on social media and have been covered by journalists (Feder).

<sup>8</sup> In the same committee opinion, ACOG recognizes the importance of utilizing the framework of reproductive justice when helping patients make decisions about contraception. It addresses many of the same concerns as Dorothy Roberts in her previously-discussed book, *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty* with regard to coercion towards sterilization in vulnerable women.

None of the women I spoke to mentioned having sought permanent sterilization or had a similar experience. This may be due to the age of the participants in this study, as all participants were under the age of thirty and only one reported ever being pregnant. While there may be instances aside from sterilization in which contemporary women may have their bodily autonomy rejected in favor of deferring to a man, I was unable to identify these in the four narratives that I analyzed. This may be a subject for future research in a similar, expanded study with a larger group of participants.

## **8.2 Women’s health and sexuality is widely believed to be dependent on men and men’s control**

Similarly, the theme of women’s health and sexuality being dependent on male control is not explicitly included in these narratives. In the cases where this may be true, the man on whom this woman’s health is dependent is her physician. According to the Association of American Medical Colleges, the 64.1% of practicing physicians as of 2019 were male and 58.6% of medical school faculty were male (“Diversity”). However, recent medical school matriculation data have shown that the majority of recent classes of medical students have been majority female (“Diversity”). Though similarity in gender does not guarantee that physicians may provide better, more empathetic care to a woman patient, Jessie’s narrative emphasized the comfort women associate with receiving medical care—especially reproductive healthcare—from a woman. While the culture around medicine was not perfect for women in the age of women community healers and physicians like Trotula, only time will tell if returning to an age where female providers

predominate will change the culture of medicine and change the patient narratives that will be collected in the future.

### **8.3 Gender roles are heavily enforced in greater society, including in the contemporary United States medical establishment**

Regardless of shifting tides in the medical gender divide and increased awareness of gender disparities in medicine, gender roles still very much do play a role in contemporary culture and medicine. This often takes the form of female patients being expected to present or to not present in specific ways. Claire specifically cites a fear of going to the emergency room for treatment of her pain because she was initially dismissed and essentially accused of exaggerating due to a physician's preconceived notions of how she should conduct herself in situations of distress. This led to her being incorrectly diagnosed with menstrual pain instead of appendicitis, a stereotypically female ailment, while her actual, non-gendered pain was not addressed. She specifically worried about being viewed as hysterical by physicians. It was fascinating to hear a contemporary woman use the language of an ancient diagnosis in reference to the way she feared she would be treated by a physician. Though we are far from the days of the wandering womb, the catch-all diagnosis for a myriad of symptoms, and the Freudian accusation of the hysterical woman, the marks of this diagnosis and the ways it was used to dismiss and pathologize women's emotions have clearly left their mark on contemporary medicine.

Claire again encountered dismissal by a gastroenterologist whom she noted through conversations with other patients tended to treat female patients differently from his male patients. Jessie also discussed feeling dismissed by a gastroenterologist who spoke over her and left her

feeling unsatisfied in her care. In discussing this physician, she wondered whether he would have treated her differently had she been a man. Sarah's experience in the emergency department mirrors Claire's in feeling as though she is not listened to, partially due to her history of generalized anxiety. Sarah also discusses feeling as though her issues with ADHD diagnosis and treatment stem from being compared to the male standard of ADHD, and Claire cites similar reasoning when discussing her physicians' struggles with treating her concussions due to a lack of research on women's brains and their response to brain injuries.

These experiences may be linked to the history of hysteria and its association with womanhood. Though this diagnosis is no longer considered legitimate, young women are still feeling dismissed when they confide in providers about their pain or suffering.

#### **8.4 Female bodies are consistently compared to male bodies and are viewed as a modified, inferior, and uncontrollable version of the default male body**

This particular theme can take two forms: one being the body of a person assigned female at birth being assumed to be similar to that of a person assigned male at birth, even when this is not the case. Such was previously noted in relation to Sarah's story as she discussed her suspicion that her troubles with her ADHD diagnosis and treatment may be due to the expectation of providers for her ADHD symptoms to represent the male paradigm of this diagnosis. As stated before, some researchers suspect that ADHD is underdiagnosed in women because ADHD in women tends to present differently than the same condition in men (Quinn and Madhoo).



The second form of this theme is seen in the view of female bodies as distinct from male bodies, often in the form of viewing them as wild and even “wandering” in the case of Plato (Maines 23-24). Even today, there is concern in both the scientific community and in patient populations that there is not enough research on bodies with ovaries and uteruses. Frustration about this bias is illuminated in the anonymous story, in which the participant’s hesitancy to seek gynecologic care is based partly in her worry that she will be presented, as the only option for her problem, a medication that she does not want to take as the only option for their problem. Research on the female reproductive system and on effective treatments for gynecologic conditions has been notoriously underfunded (Mirin). Even when data and awareness are possible, that does not mean that all providers are competent in understanding this information. Claire’s tale of the radiologist who mistook her IUD (intra-*uterine* device) for a tampon (which goes in the vagina, not the uterus) serves as a clear example of this.

Even outside of reproductive science, these fears of lack of research on women seem to be realized in Claire’s experiences with seeking care for her concussions, as she states that even physicians have conceded that there simply is not much research on traumatic brain injuries (TBIs) in women’s brains. This is clearly recognized as an issue in the medical community, as the National Institute of Neurological Disorders and Stroke arranged for a workshop in 2019 to address this gap in TBI research (“Understanding”).

## **8.5 Shame is inherent in female sexuality and in conditions associated with it, including pregnancy**

Misogynistic clinical and research practices may be linked to the association of shame and stigma with female sexual health and sexuality in general in the United States. Though seventy years have passed since the original Kinsey reports, stigma surrounding sexual activity and sexuality is still present, especially in women. Though no patients reported feeling shamed for their sexual activity by a provider in a healthcare setting, this stigma around sexuality seems to be internalized in patients. Jessie discusses this extensively in her narrative, stating that reproductive healthcare is for her more private than other forms of healthcare, specifically due to its association to sexuality.

An interesting area for further study may be investigating whether these attitudes are consistent in countries where beliefs around sex and nudity differ from the United States. While the privacy aspect that Jessie mentions serves to cause discomfort in the idea of receiving gynecologic care from a cisgender male physician, it also initiates trust in female physicians. Her emphasis on shared experiences and a shared understanding of pain serves to form and strengthen the physician-patient relationship.

## **8.6 Race and other marginalizing identities greatly affect how an individual is treated in the medical context.**

However, this confidence in shared experience based on gender may be further complicated by the race of the individual obtaining care and the race of their provider. Though none of my participants were able to comment on this, nor on how other aspects of their identity such as sexual orientation affected their experience obtaining care, I find it necessary to include this theme in this thesis. The intersection of multiple identities plays a large part in many individuals' experiences obtaining healthcare, and to ignore it simply because it was not addressed directly by my participants would do a disservice to the people for whom race and other marginalizing identities transform the way their gender is viewed in both medical and non-medical settings. Future research done with a larger and more racially diverse population of participants with more racial diversity may be able to further illuminate this aspect of identity and how it transforms the ways that gender affects medical care.

## **8.7 Other Themes**

Though it was not specifically addressed in the historical literature, one theme which was present across all narratives was the emphasis on the necessity of open communication between physician and patient. When asked what made them comfortable in a healthcare setting, nearly all participants expressed a need to be capable of communicating with their physician on a human level. They stated that medical visits should be more like conversations: make jokes, leave space for questions. Even when patients received appropriate medical care, they described experiences negatively when a provider's interpersonal skills were lacking.

Another aspect discussed thoroughly in two narratives but not analyzed in the historical literature was mental health. While this was briefly mentioned in relation to hysteria, my

preliminary analyses of these texts such as Freud's writings and Maines' analysis of hysteria focused on the sociological attitudes that they represented rather than how they served as a precursor to contemporary mental health care. Narratives such as Sarah's which discuss feeling dismissed in the emergency room due to a history with mental health diagnoses could be used to reinforce these connections between hysteria and mental health care. Future research informed by these narratives may approach analyses of historical literature more thoroughly through the lens of mental health.

Overall, I intend for this project to be the first step in my pursuing similar, more expanded research in the future. In future iterations of this work, I will take care to recruit a larger, more racially and regionally diverse participant population in order to examine how these connecting themes between history, literature, and womanhood at large affect different groups of women differently.

## 9.0 Limitations

While the original intent of this study was to recruit a participant pool with diverse backgrounds and identities, all four of the participants in this study were white women under the age of thirty who have resided in Pennsylvania. This may be due to issues with recruitment, as most participants were self-selected from my community and had either a personal or professional connection to me in some form. Future research might make use of more extensive attempts at recruitment and be more aggressive in actively seeking out participants, particularly from a variety of backgrounds and ages. However, I, myself, am a white woman from Pennsylvania under the age of thirty. As Jessie's narrative explored, perceived similarities and familiarity between individuals can sometimes allow for increased trust and candor. The similarities between myself and my participants may have allowed them to be more comfortable and open in our interviews.

It is also important to note that those with negative experiences may be more proactive in participating in studies such as this one. Claire, herself, notes that while she has had many positive medical experiences, it is the negative ones which came more readily to the forefront of her mind when she was asked to share her experiences. I attempted to counter this by specifically asking participants about both positive and negative healthcare experiences, as well as asking what makes them feel comfortable in a medical setting.

There is also the factor of the number of interviews. Limiting the number of narratives to four allowed me to more thoroughly explore these women's experiences in this thesis, which was the objective of this qualitative study. Even with a larger sample size, it would be difficult to accurately quantify and predict how often each of the themes explored are present in an individual woman's life and in what forms they are present. These women's stories and the examination of

how their experiences of gender and medicine connect through time and connect to one another serve as an example of the value of narrative and the power of an individual's experience.

Future research may have a more extensive participant pool and may therefore be able to further analyze and stratify these themes and understandings as they apply to women of different ethnic, racial, religious, and socioeconomic backgrounds. Future research may also explore the economic impact of the American healthcare system on the ways that women seek and receive medical care<sup>9</sup>. Overall, I consider this research to be the first step in a long-term commitment to understanding the way that gender interacts with medical care and individual experiences.

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<sup>9</sup> My thanks to Dr. Kaliae Ung for presenting me with this question and sparking a possible future area of study to add further depth to this research.

## Appendix A Interview Questions

1. What is your age?
2. What is your race?
3. Where did you grow up?
4. Can you tell me more about your childhood and your family?
5. Where did you attend school?
6. What are some of your favorite hobbies?
7. What is your profession?
8. Where do you live now?
9. Who do you live with?
10. Have you ever undergone any medical procedures that you would consider to have had a large impact on your life? Can you tell me about it?
11. Is there a provider that you would consider to have had a large impact on your life, positive or negative? Can you tell me about them?
12. What makes you feel comfortable in your interactions with a healthcare provider?
13. Have you ever had an experience where you felt invalidated by or not listened to by a healthcare provider? Can you tell me about this experience?
14. Have you ever felt that your gender played a significant part in your treatment by a healthcare provider?
15. Have you ever felt that your race played a significant part in your treatment by a healthcare provider?

16. Have you ever felt that your sexuality played a significant part in your treatment by a healthcare provider?
17. Can you elaborate more on a previous topic?
18. You mentioned x experience, how did that make you feel?
19. Tell me about the experience of being diagnosed. Did you have trouble reaching a diagnosis for your symptoms?
20. Did you receive any treatments for your condition? Did you feel as though your course of treatment was determined primarily by you, by your provider, by your family, or through a collaboration between several actors?

This list of questions is provided as a baseline to guide the conversation with a participant, and actual questions may vary based on the experiences shared by the participant. All questions asked will be related to the overall purpose of the study.



## Works Cited

Aristotle. *On the Generation of Animals*. *The Electronic Scholarly Publishing Project*,  
[www.esp.org/books/aristotle/generation-of-animals/](http://www.esp.org/books/aristotle/generation-of-animals/).

Avicenna, and O. Cameron Gruner. *A Treatise on the Canon of Medicine of Avicenna: Incorporating a Translation of the First Book*. Birmingham, Classics of Medicine Library, 1984.

"Brachial Plexus Palsy." *Seattle Children's*, Seattle Children's Hospital,  
[www.seattlechildrens.org/conditions/brachial-plexus-palsy/](http://www.seattlechildrens.org/conditions/brachial-plexus-palsy/).

Cooper Owens, Deirdre. *Medical Bondage: Race, Gender, and the Origins of American Gynecology*. Athens, U of Georgia P, 2017.

Crenshaw, Kimberle. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." *University of Chicago Legal Forum*, vol. 1989, no. 1, [chicagounbound.uchicago.edu/uclf/vol1989/iss1/8](http://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8).

*Diversity in Medicine: Facts and Figures 2019*. 2019. American Association of Medical Colleges,  
[www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019](http://www.aamc.org/data-reports/workforce/report/diversity-medicine-facts-and-figures-2019).

Dobbeleir, Julie M L C L et al. "Aesthetic surgery of the female genitalia." *Seminars in plastic surgery* vol. 25,2 (2011): 130-41. doi:10.1055/s-0031-1281482

Feder, Shira. "A Woman Was Told She Needed Her Husband's Permission to Get Her Tubes Tied. Her Story Went Viral, but It's Not Uncommon." *Insider*, 25 Feb. 2020, [www.insider.com/a-woman-needed-husbands-consent-to-get-her-tubes-tied-2020-2](http://www.insider.com/a-woman-needed-husbands-consent-to-get-her-tubes-tied-2020-2).

Garrison, Laurie. "'She Read on More Eagerly, Almost Breathlessly': Mary Elizabeth Braddon's Challenge to Medical Depictions of Female Masturbation in *The Doctor's Wife*." *The Female Body in Medicine and Literature*, edited by Andrew Mangham and Greta Depledge, Liverpool University Press, 2011, pp. 148-68.

Green, Monica. "Women's Medical Practice and Health Care in Medieval Europe." *Signs*, vol. 14, no. 2, University of Chicago Press, 1989, pp. 434–73, <http://www.jstor.org/stable/3174557>.

Green, Monica H., editor. *The Trotula: A Medieval Compendium of Women's Medicine*. Philadelphia, U of Pennsylvania P, 2013.

Hippocrates, et al. *Hippocratic Writings*. New ed., Harmondsworth, Penguin, 1978.

Hite, Shere. *The Hite Report: A Nationwide Study on Female Sexuality*. New York City, Macmillan Publishing, 1976.

Kinsey, Alfred C., et al. *Sexual Behavior in the Human Female*. Philadelphia and London, W.B. Saunders Company, 1953.

"Lupus Facts and Statistics." *Lupus Foundation of America*, 6 Oct. 2016, [www.lupus.org/resources/lupus-facts-and-statistics#:~:text=On%20average%2C%20it%20takes%20nearly,first%20notice%20their%20lupus%20symptoms](http://www.lupus.org/resources/lupus-facts-and-statistics#:~:text=On%20average%2C%20it%20takes%20nearly,first%20notice%20their%20lupus%20symptoms). Accessed 20 Feb. 2022.

Maines, Rachel. *The Technology of Orgasm: "hysteria," the Vibrator, and Women's Sexual Satisfaction*. E-book, Baltimore, Md.: Johns Hopkins University Press, 1999, <https://hdl-handle-net.pitt.idm.oclc.org/2027/heb.00062>.

Mangham, Andrew, and Greta Depledge, editors. *The Female Body in Medicine and Literature*. Liverpool, Liverpool UP, 2012. *ProQuest Ebook Central*, [ebookcentral.proquest.com/lib/pitt-ebooks/detail.action?docID=688330](http://ebookcentral.proquest.com/lib/pitt-ebooks/detail.action?docID=688330).

McManimen, Stephanie et al. "Dismissing chronic illness: A qualitative analysis of negative health care experiences." *Health care for women international* vol. 40,3 (2019): 241-258. doi:10.1080/07399332.2018.1521811

Metzler, Irina. "Disabled Children: Birth Defects, Causality and Guilt." *Medicine, Religion and Gender in Medieval Culture*, edited by Naoë Kukita Yoshikawa, Boydell & Brewer, pp. 161-80.

Mirin, Arthur A. "Gender Disparity in the Funding of Diseases by the U.S. National Institutes of Health." *Journal of women's health (2002)* vol. 30,7 (2021): 956-963. doi:10.1089/jwh.2020.8682

Orcutt, James D., and Diane L. Mennella. "Gender and Perceptions of Interruption as Intrusive Talk: An Experimental Analysis and Reply to Criticism." *Symbolic Interaction*, vol. 18, no. 1, [Wiley, Society for the Study of Symbolic Interaction], 1995, pp. 59–72, <https://doi.org/10.1525/si.1995.18.1.59>.

- Quinn, Patricia O, and Manisha Madhoo. "A review of attention-deficit/hyperactivity disorder in women and girls: uncovering this hidden diagnosis." *The primary care companion for CNS disorders* vol. 16,3 (2014): PCC.13r01596. doi:10.4088/PCC.13r01596
- Roberts, Dorothy. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. 2nd ed., New York City, Vintage, 2017.
- Sommers, Sheena. "Transcending the Sexed Body: Reason, Sympathy, and 'Thinking Machines' in the Debates over Male Midwifery." *The Female Body in Medicine and Literature*, edited by Andrew Mangham and Greta Depledge, Liverpool University Press, 2011, pp. 89-106.
- Sterilization of Women: Ethical Issues and Considerations*. Apr. 2017. *The American College of Obstetricians and Gynecologists*, [www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/sterilization-of-women-ethical-issues-and-considerations](http://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/04/sterilization-of-women-ethical-issues-and-considerations).
- Stewart, Ada. "Women Have Closed Med School Enrollment Gap; Others Remain." *American Academy of Family Physicians Leader Voices Blog*, American Academy of Family Physicians, [www.aafp.org/news/blogs/leadervoices/entry/20200228lv-diversity.html](http://www.aafp.org/news/blogs/leadervoices/entry/20200228lv-diversity.html).
- "Understanding Traumatic Brain Injury in Women Workshop." *National Institute of Neurological Disorders and Stroke*, 28 June 2019, [www.ninds.nih.gov/News-Events/Events-Proceedings/Events/Understanding-Traumatic-Brain-Injury-Women-Workshop](http://www.ninds.nih.gov/News-Events/Events-Proceedings/Events/Understanding-Traumatic-Brain-Injury-Women-Workshop).
- Watt, Diane. "Mary the Physician: Women, Religion and Medicine in the Middle Ages." *Medicine, Religion and Gender in Medieval Culture*, edited by Naoë Kukita Yoshikawa, Boydell & Brewer, pp. 27-44.

"Working Together to Reduce Black Maternal Mortality." *Centers for Disease Control and Prevention*, U.S. Department of Health and Human Services, 9 Apr. 2021, [www.cdc.gov/healthequity/features/maternal-mortality/index.html](http://www.cdc.gov/healthequity/features/maternal-mortality/index.html).

Yoshikawa, Naoë Kukita, editor. *Medicine, Religion and Gender in Medieval Culture*. NED-New edition, Boydell & Brewer, 2015, <http://www.jstor.org/stable/10.7722/j.ctt13wwzh3>.