The Implications of a Sexist Culture

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ABSTRACT/RESUME

Cette communication met l'accent sur certaines des dimensions morales inhérentes aux relations médecin-patient, en décrivant comment des attitudes imprégnées de sexisme peuvent affecter ces relations. Deux questions morales y sont examinées: (1) comment les patients sont traités (e.g. respectivement à leur autonomie tel que dictée par la théorie morale) et (2) les effets des comportements sexistes sur les résultats de cette interaction. Le problème du paternalisme en médecine est traité au point 1. Au point 2 nous traiterons de l'effet du sexisme sur la confiance et l'empathie pour connaître de quelle façon la guérison est affectée par ces attitudes.

The relationship between patient and physician is significant from medical, social, political and moral points of view. It is the moral dimensions of the patient-physician relationship that I wish to focus attention upon; and, in particular, I want to investigate the effect of pervading sexist attitudes on such relationships and consider the moral significance of their influence.

The moral dimensions of the patient-physician relationship take two different forms, reflecting the two major sorts of ethical theories. Formalist theories concern themselves with how persons are to be treated, and this question must be applied to the way patients are treated by their physicians. Secondly, examining the patient-physician relationship from a utilitarian perspective, we must worry

on the Doctor-Patient Relationship

about the best ways of maximizing well-being and minimizing suffering. Any way in which the nature of the patient-physician relationship influences the effectiveness of medical care and the health of patients must, therefore, have moral significance. More specifically, I am concerned with considering how the sexist attitudes often existing between physicians and their female patients affect both of these morally significant aspects of the physician-patient relationship and hence are of particular significance in the moral analysis of that relationship.

Looking first to the analysis of how persons are to be treated, the central principle is that our primary moral duty is to treat persons with

respect and dignity; in other words, we are to recognize the status of mature competent persons as autonomous moral agents capable of, and responsible for, making decisions in matters primarily affecting themselves. Virtually all moral theorists see this attitude of respect as an important ethical duty; many see it as the fundamental duty.

Such a view makes paternalistic behaviour wrong in most circumstances. (Paternalism is making decisions about matters which primarily affect another individual according to one's own judgment of that person's interests but without her/his consent.) Since paternalism interferes with the individual's autonomy and reflects a lack of respect for the person concerned, it is generally wrong even though it is behaviour done out of benevolent motives. Paternalism is only justifiable if the individual affected is incapable of responsible decision-making under the current circumstances--hence parents are justified in making important decisions for their young children, relatives are justified in signing consent forms for comatose patients, etc. But if the individual concerned <u>is</u> capable of acting responsibly in the circumstances, paternalism is generally wrong.

As is well known, physicians often behave paternalistically towards their patients. They frequently consider themselves better judges of their patients' interests than the patients themselves. Of course, they often do know best what means are most effective for achieving health-related goals once those goals have been selected but that is not the same problem as choosing what goals are within the patients' interests and values. The moral question at issue is whether paternalism within the patient-physician relationship is a case of justifiable paternalism.

The difficulty in medical contexts is that patients, when ill, are dependent to varying degrees upon health professionals, especially doctors. Many physicians cite evidence that illness makes patients so anxious and incapacitated as to be barely capable of reasoned decision-making at all.

For instance,Eric J. Cassell describes it as follows:

> So pervasive is the helplessness that distress, pain and weakness may appear to be the only realities. Understanding fails and sustained thought seems too difficult to achieve. All control of the world is gone. . . The patient is dependent on all around him (p. 25). It is very important for us to understand that thought patterns change in the sick (p. 35) The sick have much in common with the infant (p. 45).(1)

Physicians commonly believe that illness is the sort of circumstance that justifies paternalistic action because the sick individual is incapable of rational decision-making. No doubt this is often true. However, physicians see patients in all sorts of degrees of illness, including "perfect health." Patients seek medical attention in times of severe crisis and also for minor, transitory ailments like the flu, for treatment of a broken or sprained limb, for weight control, for preventative check-ups, for psychological discomforts, for contraception, for pre and post-natal care, and so on. Surely it is stretching matters to suggest that patients (or clients) are always in need of paternalistic decision-making from physicians. Nonetheless, many physicians do say exactly that: some claim that illness and the threat of death is so frightening to human beings that any visit to the doctor, no matter how routine, is bound to produce much anxiety in the patient, making rational decision-making very unlikely. I find such a view very hard to believe, especially so since, although I have heard this claim made numerous times by doctors, I have yet to hear any offer compelling proof of it.

It seems, then, that paternalism is generally used too readily by physicians with their patients, and that is morally objectionable because it limits individual autonomy. The reason for this moral mistake seems to be that physicians believe patients are not fully rational, but rather are dependent and childlike.

What do you suppose happens when the patient is female? Doctors, like most of the population, tend to view women as weak, illogical, dependent and not fully rational. When the doctors are male, as the vast majority of Canadian doctors are, the grounds for misunderstanding surely widen. Evidence is that, on the average, physicians have even less respect for their women patients than for their male patients: viz., J.K. Broverman et al. showed in the well-known study "Sex-Role Stereotypes and Clinical Judgements of Mental Health"(2) that most psychotherapists view even healthy women as weak, dependent, submissive, easily confused, subjective and emotional, whereas healthy adults are thought to be strong, independent, logical and objective. In an article in The New England Journal of Medicine entitled "What Medical Schools Teach About Women,"(3), Mary C. Howell reveals a pervasive demonstration of hostile attitudes towards women. She claims "it is widely taught, both explicitly and implicitly, that women patients (when they receive notice at all) have uninteresting illnesses, are unreliable historians, and are beset by such emotionality that their symptoms are unlikely to reveal 'real disease.'" The teaching of such attitudes surely results in reinforced bias in students, soon to be physicians,

against the responsibility and autonomy of their female patients.

Such bias is not compatible with a patient-physician relationship in which the patient is treated with the respect demanded by moral considerations. It is bound to be detrimental to the legitimate autonomy the patient is entitled to exercise in decisions primarily affecting herself (her personal health care). Hence, from the perspective of the moral question of how persons ought to be treated, there is something wrong with the paternalism often unjustifiably inherent in the patient-physician relationship; the situation seems to be even more severe when the patient is female, presumably because of the widespread sexual prejudice in our culture.

This problem is closely related to the other moral concern I have cited, namely, the obligation of ensuring medical roles which will maximize well-being and minimize suffering. The sexist bias has a further dangerous consequence in its effects on the patient-physician relationship in that it seems to result in bad medicine, for it means the care given and the healing effected is less than optimal. The tendency of physicians to be authoritarian to their female patients and to not view them as fully responsible persons seems to reduce the reliability of physicians' diagnostic and healing power for women patients.

In an article which appeared in The New England Journal of Medicine entitled "Alleged Psychogenic Disorders in Women--A Possible Manifestation of Sexual Prejudice," four conditions which uniquely affect women are examined.(4) All are commonly thought by the medical profession to be psychogenic in origin even though the evidence points to an organic cause for each. Patients presenting with any of these conditions and other complaints, are likely not to receive much relief. Suitable treatment is not pursued when the origin of the disease is misperceived and, in fact, many physicians are contemptuous of such "psychogenic" conditions and may feel the patient does not merit any help at all.

There is a deeper level of error which may also arise from this lack of respect for female patients. We are directed towards this further difficulty by some arguments made by Sandra Harding in "Knowledge, Technology, and Social Relations."(5) In reviewing Stanley Joel Reiser's book Medicine and the Reign of Technology, Harding argues that prevailing social relations are not only affected by technological development in medicine as elsewhere but also that the development of technology and knowledge is itself limited and shaped by social forces. In other words, social values and attitudes largely influence the development of medical knowledge and technology. It seems that the physiological theories and diagnostic tech-

niques which evolved in the nineteenth century actually tended to decrease the physician's understanding of what illness personally means to the patient and hence decreased the reliability of the physician's diagnosis and therapy. More accurate diagnosis and greater success at healing often results from intelligent discussion with the patient than from diagnostic techniques limited to quantifiable evidence. If effective healing requires empathetic recognition and understanding of the patient's experience of illness, then sexist prejudice and scorn for female patients must be a great hindrance to their care.

Most significant for our discussion here is Harding's final claims about the "horrible truths" of science and politics:

> . . . that technological "progress" in an inegalitarian society increases the inequality in the society, since the benefits of innovative technologies tend to be made available in disproportionate amount to the already privileged amd are used by them to keep those worse off from improving their lot relative to the already privileged.
> . . . medical diagnostic technologies systematically have been used to keep women the sickly sex.
> . . . social inequality in a society increases the inaccuracy and the unreliability of the accounts of nature produced in that society.(6)

In other words if the patient-physician relationship tends to reflect other social inequalities, and if patients tend to be seen by their physicians and themselves as significantly different from their physicians in important respects, then we can expect some poor medical results. Knowledge of their illnesses will be limited and development of effective treatment will be hindered. Cassell echoes this theme in his book The Healer's Art. Like many contemporary physicians, he speaks of the importance of empathy and sympathy in effective healing. He insists that successful healing depends upon patients' possessing deep trust in their physicians and the knowledge that they are being "cared for" in the full sense. Surely that state is made especially difficult to achieve when the patient-physician relationship must bear the biases, prejudices and suspicions of broader social attidues on sex, class, race and age.

Moreover, physicians with little respect for the intelligence and responsibility of their patients are unlikely to offer patients the information they need for effective self-care. There is a breakdown in essential health communication flowing in both directions.

Because of general cultural prejudices

about women and other general cultural prejudices about physicians health care is likely to be much less effective at reducing suffering and increasing well-being than it would likely be if the patient-physician relationship were not tainted by such attitudes. That is a moral problem as well as a social and political one, for morality is concerned with benevolence, with reducing suffering and increasing well-being.

Is there any practical way of improving the medical situation? Presumably so. The preferable course would be to eliminate sexist attitudes from society, which obviously would have the advantage of righting a much broader set of social wrongs than the patient-physician relationship. Short of that, some other steps can be taken. Amongst other things, medical schools should be pressured to stop teaching specific disrespect for women as patients. They should also be encouraged to accept even larger numbers of women students, since the roles in the patient-physician relationship are bound to be altered by increasing the number of women serving as physicians. Further, the entire nature of the patient-physician relationship can be made less charged by adopting more realistic and less individualistic perceptions of the nature of health care structures in society: it should be stressed that health care is provided not by a single physician but by a whole complex organization of health professionals with various intertwining obligations and loyalties to patients involved in complex social and societal roles, hence, perhaps the significance of the entire patient-physician relationship should be downplayed. Moreover, it seems likely that the current consumer approach to health care, with its emphasis on patient education and legal protection against physicians' infringement on liberties, is bound to reduce the power of authoritarian paternalistic attitudes of doctors.

One other kind of innovation which holds promise of attacking the problem of sexist prejudice against female patients directly is a new program adopted at Harvard Medical School reported in the Journal of Medical Education.(5) In that program, pelvic examinations were taught to medical students by a group of women instructors and patient-models who were themselves trained at a self-help community women's health center. The same women simultaneously played the roles of patients and instructors for the medical students, dispelling rigid role casting in their minds. In this way they were able to foster more respectful attitudes toward women patients as competent intelligent agents with medically useful information to offer.

They could guide students in the sort of information patients need to receive and make explicit some of the

"insidious bias of medical knowledge." By redefining roles of patient, student, instructor and physician, the program seems to be a valuable technique towards reducing both sexist prejudice and its effect on the patient-physician relationship.

It is important that these and other imaginative solutions to the problem of sexism pervading and shaping the patient-physician relationship be implemented because the problem is serious from medical, social and moral points of view.

NOTES

1. Eric J. Cassell, The Healer's Art: A New Approach to the Doctor-Patient Relationship (Philadelphia: J.B. Lippincott Company, 1976), pp. 25, 35, 45.

2. J.K. Broverman, "Sex-Role Stereotypes and Clinical Judgements of Mental Health," Journal of Consulting and Clinical Psychology, Vol. 34 (1970), pp. 1-7.

3. Mary C. Howell, "What Medical Schools Teach About Women," The New England Journal of Medicine, Vol. 291, No. 6 (August 8, 1974), pp. 304-7.

4. K. Jean Lennane and R. John Lennane, "Alleged Psychogenic Disorders in Women," The New England Journal of Medicine, Vol. 288, No. 6 (February 8, 1973), pp. 288-92.

5. Sandra Harding, "Knowledge, Technology, and Social Relations," The Journal of Medicine and Philosophy, 3:4 (December, 1978).

6. Ibid., pp. 356-7.