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

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

Keywords: gender; medical reasoning; gynaecology; pelvic pain; Switzerland.

Interpretationen und Argumentationsweisen von Gynäkolog_Innen zu einer Unterbauchschmerz-Vignette: Was erfahren wir darin über Empowerment?

Zusammenfassung: Die Studie untersucht, wie Gynäkolog_innen über die Betreuung von Bauchbeschwerden nachdenken und was aus ihren Argumentationsweisen über Empowerment von Patientinnen erfahren werden kann. Sie basiert auf 11 halbstrukturierten qualitativen Interviews mit Ärzt_innen aus 6 verschiedenen gynäkologischen Betreuungs-Settings im Raum Basel, Schweiz. Die Analyse mittels konstruktiv-interpretativer Grounded Theory nach Charmaz konnte bezüglich Empowerment drei Perspektiven identifizieren. Diese zeigen, wie eine komplexe Sozialisierung von Männern und Frauen im gynäkologischen Arbeitskontext sich darin niederschlägt, was sie sich unter einer guten gynäkologischen Betreuung vorstellen. Gewisse Perspektiven erschweren ein Empowerment, andere sind dafür hilfreich. Es wird empfohlen, in die ärztlichen Curricula Module zu Selbstreflexion einzubauen, um Kliniker_innen dabei zu unterstützen, bei Patientinnen mit chronischen Bauchbeschwerden über eine biomedizinische Sichtweise hinauszugehen und ein Patientinnen-Empowerment zu ermöglichen.

Schlagwörter: Gender; medizinische Argumentationsweise; Gynäkologie; Unterbauchschmerz; Schweiz.

Background

Although chronic pelvic pain poses a high burden of disease on women (Latthe/Latthe/Say 2006: 2; McGowan/Escott/Luker 2010: 1), there exists no uniform definition due to the complexity of its clinical picture and to the wide range of possible physical and/or psychosocial causes (Deutsche Gesellschaft für

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Gynäkologie und Geburtshilfe 2009: 4-5). The diagnosis is often made by exclusion, that is when pain persists for 3 months or more and no underlying pathology is identified by ultrasound or laparoscopy (Allison/Lev-Toaff 2010: 211-218; Deutsche Gesellschaft für Gynäkologie und Geburtshilfe 2009: 24-31). In the absence of an identifiable organic pathology, pelvic pain is labelled functional or somatoform (Deutsche Gesellschaft für Gynäkologie und Geburtshilfe 2009: 5; Karnath/Breitkopf 2007: 41; Matheis/Martens/Kruse 2007: 3446).

Many patients therefore do not receive a medical explanation for their pain. This may not alleviate their fears and they may re-enter in a cycle of investigations (McGowan/Escott/Luker 2010: 1; Price/Farmer/Harris 2006: 449-450). The few studies which have explored women's perspectives on medical consultations for chronic pelvic pain (MacBride-Stewart/Grace 2007; McGowan/Luker/Creed 2007; Price/Farmer/Harris 2006), have shown that they often feel ignored, rejected, dismissed, devalued, and without help to better manage their condition: "I am not sure if anything can help…, a cure would be good or some recognition that this condition does exist… we… would like to have better things to do than be dismissed and left at limbo…" (McGowan/Luker/Creed 2007: 270); "I felt like it was going on and on… and there was no answer… that was the hardest part." (Price/Farmer/Harris 2006: 450).

This has led to calls that physicians should take on a more empowering attitude, recognising patients' concerns and supporting them in developing coping mechanism (Malterud 2000: 605-607, 609; McGowan/Luker/Creed 2007: 272; Price/Farmer/Harris 2006: 451-452; Vincent 2011: 147). However, there are ambiguities as to what an empowering attitude might indeed consist in. Price et al. (Price/Farmer/Harris 2006: 451) have advised 'effective reassurance', but within a biomedical understanding of the condition. In contrast, authors like McGowan and colleagues (McGowan/Escott/Luker 2010: 7-8, McGowan/Luker/Creed 2007: 272) state that going beyond the biomedical would be the only way to include patients' subjective experiences and for helping them in formulating self-management options. Alternatively, the group of Kristi Malterud (Malterud 2000: 609; Werner/Steihaug/Malterud 2003: 502-505) presents a more pronounced empowering strategy by emphasising, particularly when dealing with medically unexplained conditions, power inequalities involved in medical consultations. According to them, physicians need to be aware of their role in diagnostic processes to share power and knowledge with patients so that joint symptom interpretations might open new explanatory perspectives. This 'strong empowerment' approach has its roots in the 1970s, when the feminist women's health movement propagated a shift of power and information to women in order to enable them to own their health and body (The Boston Women's Health Collective 1973). Yet, 'patient empowerment' has over time changed its meanings. Former emancipatory aspects have been replaced by educational elements to support patients in making 'informed decisions' (Aujoulat/D'Hoore/Deccache 2007: 13-14, 18-19; Holmström/Röing 2010: 168; Malterud 2010: 140; Malterud 2000: 609; Piper 2010: 174).

Physicians confronted with chronic pelvic pain patients however often find themselves uncomfortable, struggling to realise an empowering strategy. They

prefer to diagnose irritable bowel syndrome instead of chronic pelvic pain (McGowan/Escott/Luker 2010: 107) and often feel unprepared to treat pain without an organic cause or to manage this condition effectively. This in turn may challenge their professional competences (Malterud 2000: 2; McGowan/Escott/Luker 2010: 2) and lead them to reinforce their expert position by putting blame on patients (Malterud 2000: 603). Hence, knowing more about clinicians' reasoning on pelvic pain management may help to elucidate professional perspectives which may empower women and allow giving directions to improve care for pelvic pain patients.

While a number of studies have addressed the perspectives of chronic pain patients (MacBride-Stewart/Grace 2007; McGowan/Luker/Creed 2007; Price/Farmer/Harris 2006), physicians' attitudes have remained understudied (McGowan/Escott/Luker 2010), and the need for more research on care providers has been identified (Hall 2003: 11). A qualitative approach serves best to investigate physicians' medical reasoning which is understood as a complex interpretative process of evidence construction (Burnum 1993: 941-942; Leder 1990: 11; Malterud 1999: 282-283, 2000: 604; Nessa 1996: 371-375), allowing insights into what is – or is not – interpreted as a relevant sign for diagnosis and management (Puustinen 1999: 276). It may also reveal variations in beliefs about what kind of position towards patients physicians might favour and how these may relate to empowering doctor-patient relationships (Malterud 1999: 283, 2000: 606; Undeland/Malterud 2008: 226).

The few studies which have applied an interpretative perspective towards diagnostic and management processes concentrate on unexplained medical symptoms, but not specifically chronic pelvic pain (Malterud/Candib/Code 2004; Malterud 1999, 2000; Undeland/Malterud 2008). So far, studies on pelvic pain management were conducted in general practices (McGowan/Excott/Luker 2010, McGowan/Luker/Creed 2007; Wileman/May/Chew-Graham 2002; Zondervan/Yudkin/Vessey 1999). Although gynaecological outpatient practices have the highest prevalence of medically unexplained conditions of any speciality (Nimnuan/Hotopf/Wessely 2001: 1), little is known on how chronic pelvic pain is managed in gynaecology (Abercrombie/Learman 2012).

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

Methods

This paper reports on the qualitative investigation of a mixed methods project called "Women and Gynaecology in Evaluation", funded by the Swiss National Science Foundation (SNF No. 32003B-121358). The qualitative part served to characterise gynaecologists' working approaches in selected outpatient settings in which quantitative patient data was collected. Both study parts are to be

integrated to explore reciprocities. Six different gynaecological outpatient settings in the Basel area (Switzerland) were selected by maximum variety sampling prior data collection. This strategy served to maximise the representation of diversity in gynaecological working approaches, enabling us to trace their similarities and differences (Teddlie/Yu 2007: 81). Settings included: (a) the outpatient department of the university's women's clinic; (b) four privately run gynaecological practices with varying sub-specialisations; and (c) one women's health centre (WHC).

2.2. Ethical Considerations

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

Conceptual framework

The study was led by an interest in medical care concepts influential for current gynaecology such as patient-centeredness (de Haes 2006; Mead/Bower 2000; Rademakers/Delnoij/Nijman 2012), gender research (Bertakis 2009; van den Brink-Muinen 1998; Carnes 2010; Christen/Alder/Bitzer 2008; Davies 2003; Eriksson 2003; Riska 2001), feminist care approaches related to women's health care (Bean-Mayberry/Yano/Caffrey 2007; van den Brink-Muinen 1998; van Den Brink-Muinen 1997; Zobrist 2005) and various decision-making models (van den Brink-Muinen 1998; Charles/Gafni/Whelan 1997; Elwyn/Edwards/Kinnersley 1999; Entwistle 2009; Mast 2004; Wensing/Elwyn/Edwards 2002). They served as 'sensitizing concepts' (Bowen 2006: 2-3; Charmaz 2006: 16) which, according to constructionist grounded theory, are understood as providing ideas regarding what to pursue during research. Thus, they helped us designing data collection tools. Empowerment emerged as a cross-cutting yet poorly defined theme which is considered as vital for current health care, putting emphasis on physician-patient relationships (Aujoulat/D'Hoore/Deccache 2007; Feste/Anderson 1995; Holmström/Röing 2010; Malterud 1993; Piper 2010). The importance of relational aspects is likewise recognised by symbolic interactionism which informed the constructionist grounded theory followed herein (Charmaz 2006: 7).

Sampling and participants

Purposive sampling was used to select physicians across the six selected outpatient gynaecological care settings (see table 1), which differ in services offered, organisational aspects, and gender of practicing gynaecologists.

Table 1: Characteristics of gynaecological care settings and number of interviewed clinicians

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

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

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

Interview design and data collection

Interviews followed a semi-structured interview guide with open-ended questions. Gynaecologists were encouraged to express themselves freely, while being guided to talk about the following themes: gynaecologists' specialisation, women's concerns, working approaches, significant influences on the latter, and 4 clinical vignettes. The vignettes served to compare gynaecologists' explicitly expressed working approach with their implicit attitudes presented regarding a given situation. It is with this aim that qualitative research regularly applies vignettes to gain a more balanced understanding of a topic (Hughes 1998). We kept vignettes brief to allow gynaecologists room for interpretation when being asked to outline what they would do. The vignettes, addressing menopause, vaginal mycosis, metrorrhagia and pelvic pain, were constructed with gynaecologists involved to assure their practice relevance. This paper presents findings regarding the pelvic pain vignette:

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

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

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

Data analysis

All data was imported into Atlas.ti (6.2). Analysis followed constructionist grounded theory (Charmaz/Belgrave 2012; Charmaz 2006) which applies an inductive approach and uses contrasting principles to investigate similarities and differences emerging from the data to come up with a new theory. The interviews were analysed by reviewing line-by-line and applying initial, open coding, while writing memos on ideas arising. This led to the emergence of focused codes (Charmaz 2006: 57-59). 4 study group members (BS, KG, NW, EZ) with different professional backgrounds (medicine, epidemiology, social science, sociology, medical anthropology) and experience in qualitative research read interviews individually. During group meetings each interview was jointly interpreted and contrasted with other interviews within/across settings to realise a comprehensive analysis. The group members met weekly, at least two were present throughout all meetings and served as member-checks for ensuring the findings' validity. Final categories were established by consensus. Data saturation was achieved with the initial sample as evinced by the re-occurrence of the identified variations within the emergent categories, such as proximity/distance in physician-patient relationships, women-centred strategies regarding examination, physician-patient conversations, decision-making processes and therapies. If we had not achieved saturation with the initial sample, we would have conducted more interviews.

Ensuring rigor

To ensure rigor, numerous measures were taken. A self-reflective journal was kept, which ensured a better understanding of interviews during analysis (Morrow 2005: 255). While interviewing, BS reframed questions and paraphrased participants' responses which served as on-spot member-checks to enhance the study's validity (Krefting 1991: 217). Study researchers had different disciplinary backgrounds and are experienced qualitative researchers. This enabled them to conceptualise the large volumes of qualitative data and apply a multidisciplinary approach (Krefting 1991: 219). Findings were presented to gynaecologists in April 2013 who confirmed these reflected their approaches.

Results

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

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

This position is represented by narratives about the relevance of standardised diagnostics aiming at excluding health risk to make patients feel safe. It was mainly followed by men who were board-certified gynaecologists and led their own practices, but also by one female medical doctor (see table 2). Although they differed in their (sub)specialisations (feto-maternal to psychosomatic medicine), their accounts portrayed them as science-oriented gynaecologists. They read pain as the key sign for initiating standardised diagnostics. These were depicted as means for excluding health risks, as reflected 1. by the interpretation of a male gynaecologist trained in psychosomatic medicine (l1) and 2. by the perspective of the female assistant doctor (l2):

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

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

All physicians presented sustained diagnostic procedures. By doing so they generated a picture of controlling knowledge production. This approach seemingly allowed them to present certainty on physical normality. Within physicians' interpretations, women only became addressees when being reassured, although clinicians were unable to provide an explanation. Psychosocial signs such as stress were not mentioned as relevant for diagnosis and management. Gynaecologists expressed neither including women's understandings of the condition nor

Table 2: Perspectives and characteristics of sampled gynaecologists/expert women across care settings

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

creating room for conversations. Instead, in their narratives, their controlling and powerful position as experts was reinforced, as was presented by another male gynaecologist who emphasised the strength of diagnostics to identify the "real reason" behind pain, whereas women would often wrongly associate the pain with the ovaries:

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

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

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

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

"There is room to talk…" – Advocating meaningful care

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

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

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

Gynaecologists and expert women displayed themselves as offering meaningful care by combining the biomedical view with women's concerns. Instead of exclusively offering reassurance, they displayed an enabling attitude: they described themselves as offering room for conversation to build a relationship without pressuring women to accept this. They explicitly acknowledged a societal influence on women's health, thereby turning the individual experience into a common one, and allowing women to attribute meaning to the pain. This is depicted in the interpretation by the physician trained in gynaecology:

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

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

> … such a woman has to get back into her body. She is better off with a compress, requiring lying down... (I8)

"There is no single answer" – Tailoring individual support

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

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

Communication and understanding appeared as tools for an enabling relationship built on partnership and trust. They portrayed both sides as navigating towards a joint management strategy. Apparently, diverse outcomes were possible, whereby medical expertise was exposed as convening with women's concerns, as was expressed by the female gynaecologists already quoted before:

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

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

> … there is no such patient… where you know she is stressed – another manager with pain...I need to look at the whole… perhaps she is happy with her career and enjoys the ringing phone… there are people who like it and who are absolutely not stressed (I10)

Discussion

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

Main results

Our findings suggest that variations in medical reasoning are rooted in interactions between gynaecologists' work environments, their (sub-)specialisations and gender: Female gynaecologists socialised in group practices presented a greater interest in psychosomatics, clearly tended to support the inclusion of women's perspectives, and went beyond a biomedical interpretation of pelvic pain, thus facilitating empowering processes. Male gynaecologists, affiliated to or working

in hospital settings with science-based evidence orientation, displayed a greater interest in technical and biomedical aspects, declared to apply standardised diagnostic procedures to exclude physical risks, and understood functional pelvic pain as a sign of psychosocial distress.

Reflections on empowering perspectives

In our study, female gynaecologists expressed that they generate, together with their patients, a comprehensive interpretation of pelvic pain, resonating with what Kristi Malterud has designated as empowering practices (Malterud/Code/Candib 2004: 15; Malterud, 1993: 367, 2000: 609). Malterud has emphasised the responsibility of physicians to share power with patients, as a precondition for giving patients space to voice their perspectives and experiences. This may allow a new understanding of complex symptoms which remain unexplained by a sole biomedical approach. This strategy has also been perceived as valuable to validate the suffering of chronic pelvic pain patients and to help them to find management strategies (McGowan/Luker/Creed 2007: 272).

Although some emergent perspectives of gynaecologists seemed more apt to realise an empowering approach, each stance towards symptom interpretation may have to deal with some sort of pitfall (Malterud 2000: 607). For example, female gynaecologists from the group practices favoured an individualised stance towards symptom interpretation and management, whereas those from the WHC proposed a social contextualisation. Whereas an individualised stance may allow learning more about a specific woman, it might reinforce that the pain is perceived as a personal failure. In contrast, a social contextualisation may empower women to understand their pain at the crossroads of individual and collective experiences, giving them the opportunity to alleviate feelings of isolation (McGowan/Luker/Creed 2007: 270-272; Price/Farmer/Harris 2006: 451). On the other hand, by interpreting stress as the almost single cause of pelvic pain, WHC's physicians might be prone to allocate diverse patients into a uniform group instead of reading symptoms as a result of multiple, complex and interactive causes. Such a 'universalistic trap' (Malterud 2000: 608) was also observed in the reasoning largely presented by male gynaecologists, who interpreted pelvic pain as virtually being evoked by an underlying psychosocial illness. However, according to a meta-analysis this attribution seems not to be adequate (McGowan/Clark-Carter/Pitts 1998): No matter whether women suffered from organic or non-organic pelvic pain, they showed no significant differences regarding psychosocial characteristics. Thus, male gynaecologists' stance may result in getting caught in a 'psychosocial trap' (Malterud 2000: 608).

We agree that gynaecologists' self-reflectivity about their role in knowledge production during medical encounters is a necessity for a 'strong empowering approach' (Aujoulat/D'Hoore/Deccache 2007: 18; Baarts/Tulinius/Reventlow 2000: 430-434; Malterud 2010: 140; Malterud 2000: 609). It may facilitate to become a qualified reader of patients' suffering, to recognise psychosocial conditions and to challenge biomedical exclusivity (Aujoulat/D'Hoore/Deccache 2007:

18; Malterud 2010: 140; Malterud 2000: 609). Moreover, solely an inclusive, empowering approach may retrieve information on sexuality, which is relevant in the case of pelvic pain, because it may indicate a history of sexual abuse (MacBride-Stewart/Grace 2007: 62; Malterud 2000: 609; Werner/Steihaug/Malterud 2003: 506). Surprisingly, the relation between intimate partner violence or sexual abuse and pelvic pain was almost absent in the reasoning of the interviewed gynaecologists, although this association is well established (Hilden/Sidenius/Langhoff 2003; Lampe/Doering/Rumpold 2003; Poleshuck/Dworkin/Howard 2005; Randolp/Reddy 2006; Siedentopf 2009).

Gender and gynaecologists' socialisations

Previous studies have acknowledged the effect of gender on gynaecologists' communication with patients (Christen/Alder/Bitzer 2008; Hall/Roter 2002; Janssen/Lagro-Janssen 2012; Kerssens/Bensing/Andela 1997; Van Dulmen/Bensing 2000), and a recent systematic review has concluded that female gynaecologists show a more patient-centred communication style and are more willing to include patients' perspectives than their male counterparts (Janssen/Lagro-Janssen 2012: 223, 225). A Dutch study has reported – similarly to our study – that female physicians across all their included care settings were more alike and inclined to include patients personal/social situations than their male colleagues (van den Brink-Muinen 1998: 123-127). All the above studies have largely relied on video recordings of medical consultations and thus analysed observed material. However, clinical relationships and the construction of diagnostic evidence include a subjective dimension arising from physicians' attitudes and emotions. Therefore, a switch from a descriptive to a more explanatory mode of understanding may be warranted (Hall 2003: 10-11). While our findings resonate with the findings of the above studies on gender and communication in gynaecology, it goes beyond in showing that medical reasoning of gynaecologists relates to their socialisations, producing a complex interaction of gender and professional socialisation.

Joan Acker (Acker 1990) had thematised that the organisational structure of work commonly maintains gender segregation and permeates into (organisational) thinking and work relations. A number of studies have explored interactions between gender and work within the medical profession (Cassell 1998; Davies 2003; Eriksson 2003; Hinze 1999; Risberg 2004; Riska 2001; Riska/Wegar 1993), particularly since the influx of women into medicine – into gynaecology in particular – has, at least numerically, 'feminised' the medical profession (Bertakis 2009; Buddeberg-Fischer/Klaghofer/Abel 2006; Chang/Odrobina/McIntyre 2010; Schnuth/Vasilenko/Mavis 2003; Thomas 2000). However, women are not evenly spread across the sub-specialisations of gynaecology (Buddeberg-Fischer 2003: 231). Female gynaecologists currently concentrate more on patient-focused areas, while male gynaecologists rather specialise in surgical and science-oriented areas. Our study mirrors such a gender-stratified social environment within gynaecology, but also suggests that this may re-affect gynaecologists' reasoning

and attitudes towards patients. Whereas De Jong (De Jong 2008: 171, 181) has acutally shown that work environments form normative communities which may result in the harmonisation of general practitioners' behaviours, she has not found any evidence that gender might explain such behavioural similarities.

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

Limitations and strengths

While the objective of qualitative research is not representativeness, we acknowledge the relatively small sample size. Due to this and the Swiss context, we caution to extend conclusions to other settings. The mixed methods approach of the project did not allow for theoretical sampling of gynaecological settings in the qualitative part, because we needed to identify these prior to collect the quantitative health data of respective patients. This trade-off is intrinsic to mixed methods approaches (Creswell 2003: 21-22; Teddlie/Yu 2007: 86-87). However, maximum variety sampling served the project purpose well, as it allowed identifying a diverse mix of gynaecological settings.

Limitations are offset by several strengths. Rigor was assured through acknowledged measures. We are able to stress a high internal validity of data, as analysis exposed great consistency. The generation of included gynaecologists is most appropriate for research on differences in current gynaecological care, because they have been exposed to the range of care approaches practiced between 1985 and 2000 (Whelan 2009: 1489).

Conclusion

Our study's findings show how the complex socialisations of gynaecologists (through sub-specialisations, work environments, gender) influence their medical reasoning. While primarily female gynaecologists, socialised in group practices, revealed more pronounced empowerment strategies than male gynaecologists, their approaches differed between taking an individual stance and linking the individual experience to the social circumstances of women with chronic pelvic pain. Whereas empowering approaches have not been clearly defined but considered crucial for women with chronic pelvic pain to alleviate suffering and to find ways to live with the condition, physicians' self-reflexivity is viewed as a precondition for their implementation. While the integration of psychosomatic training in the curriculum for training in gynaecology/obstetrics in 2002 in Switzerland marks a step in this direction (Tschudin/Kaplan/Alder 2013: 108), it might not be sufficient to consolidate self-reflective approaches. Thus, advanced postgraduate training courses in self-reflective, empowering approaches are recommended.

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