Athena's Journey: medicine and the feminine

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TABLE OF CONTENTS

List of Tables

List of Charts

Declaration of Originality

This is to certify that:

(a) the thesis comprises only my original work towards the PhD;

(b) due acknowledgment has been made in the text to all other material used;

(c) to the best of my knowledge, the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis

(d) the thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other institution.

Signed

Joanne Wainer 30th October 2004

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Many doctors have given me the gift of their stories and insights into their profession. I thank them for their trust. Dr Lexia Bryant has been a key informant and guide through the whole project of identifying the feminine in medicine and I have relied on her to ground me in the reality of the lives of doctors. Dr Deb Colville has invited me into the world of medical colleges and women doctors and provided encouragement and insight on the journey. Other members of my PhD group have been an inspiration and a source of much practical and theoretical advice. Thankyou to Jan, Deb, Elizabeth, Lyn and Ruth.

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I dedicate this thesis to my daughter, Zoe, and all the other young women training to be doctors. I hope it is of use to you.

Abstract

Athena's journey: medicine and the feminine

This thesis is a study of the relationship between medical culture and women doctors. It seeks to answer the question 'What do women do with their feminine when they become doctors'. The question is important to women doctors, to patients, to workforce planners and to all those who intersect with or are involved in the medical profession. Over the past 30-40 years women have joined the profession in increasing numbers in Australia and other countries with similar cultures such as Canada, the UK and the USA, and now comprise approximately half the medical school cohort and nearly a third of the medical workforce. Introducing women into the previously masculine culture of medicine has a substantial impact on the women, and also on medicine. The research detailed in this thesis identifies some of that impact in ways that will be useful to both women doctors and medical students, and to workforce planners.

The study is also an exploration of research methods that are effective in uncovering the comparatively silenced voice of women in medicine. It identifies what can be found by applying the lens of feminist epistemology to medical culture. It explores the knowledges brought forth by three approaches to research, each building on the other, each valid in its own right, and each assisting in identifying what is missing from the other approaches. It uses both quantitative and qualitative method to study the research question. Working with a post-modern feminist epistemology I use triangulation to refine the essence of the findings. The three methods comprise 1) qualitative data from interviews with nine female doctors that focused on their lived relationship between their female selves and their profession, and qualitative data from a national survey of rural doctors focussing on how women express their femaleness in their professional practice; 2) quantitative data from the national survey of rural doctors; and 3) a study of mythology of the feminine and its relation to the history of the construction of medical knowledge in the European tradition on which Australian medical culture draws. In the data chapters findings are analysed wherever possible using all three knowledge sources.

Thus the methodology used for this study is actually methodologies. I have used my skills as an historian to locate the story of women in medicine, quantitative survey research to transform anecdote to data, and qualitative interview research as an heuristic device to discover what is really going on, what is possible, and to provide the thematic framework for the data analysis. The unifying theme behind this multi-disciplinary approach is feminist theorising about women, the feminine, power, medicine, authority and knowledge within occidental culture.

The theoretical challenge is to bring these disparate ways of creating knowledges to a coherent and defensible conclusion. That is a challenge appropriate for this study, for I am concentrating on uncovering how medical knowledge is created, in whose image is it created, and identifying the consequences of excluding women as co-creators of this knowledge, as experienced by women doctors. The broader question, of the impact of the exclusion of women from the creation of medical knowledge on that knowledge itself, and consequently on patient care, is part of work I do as an academic in the Faculty of Medicine, Nursing and Health Sciences at Monash University.

This study then, is researching an important question.

The thesis has four Sections, each of which comprises between two to three chapters. Section One has three chapters. Chapter One introduces the study, describes the research approach and contains some information about me, the researcher, that provides context for the research approach taken. Chapter Two considers current feminist challenges to the construction of scientific knowledge and a description of the epistemology, methodology and method used in gathering and interpreting the data for the research. Chapter Three explores myths and archetypes about the feminine, considers what these tell us about the process of wresting the keys of the kingdom from women, discusses the witch-burnings and their impact on women and medical knowledge, and ends with a brief history of women in medicine.

Each Section is introduced with a Chapeau that reflects on the data to be considered. Section Two comprises two chapters that describe the impact of the culture of medicine on women doctors, using data from the myths, the interviews, and the national survey. Section Three comprises three chapters that consider the impact women are having on medicine, including the strategies women use to resist some of the adverse effects of medical culture on their female selves, and identifying what women are doing to change that culture. Section Four examines the relationship between women doctors and healing, and the thesis concludes with a consideration of the impact of women on medical culture and practice.

Section 1
KEYS TO THE KINGDOM

Chapeau 1

Occidental allopathic medicine reflects the culture in which it is embedded. Australian culture, like that of Canada, the United States, the United Kingdom and to a lesser extent European nations, has strong processes of gender identity that form the frame for internal thoughts, feelings and possibilities for women and men. These possibilities are more or less strictly patrolled in different eras, and individuals who deviate from them are severely punished. For most of the 20th Century women and men were required to do sex-specific work in largely single-sex environments. Some fracturing of the strictness of this requirement occurred in the latter half of the century and resulted in women taking on roles and behaviours that previously had been the sole province of men. Nevertheless Australia continues to have the most sex-specific occupational structure of any country of similar culture, with quite narrow definitions of appropriate male and female behaviour, particularly in rural environments. The established sexual order privileges the masculine and embeds a requirement that women give their energy in service to this regime of the fathers.

Over the past forty or so years some women have been challenging the established sexual order, seeking to find ways in which they can be all that it is possible for them to be, and to gain for themselves some of the privileges previously reserved for men. Among them are women who become doctors, who join that most honourable and respected of professions, medicine. This apparently recent phenomenon poses unique challenges for women. Where will they find the thought structures and internal dialogue that allows them to hold inner authority in their own lives, and outer authority in the lives of their patients – a necessary requirement to practice medicine ? How do individual women hold authority in the public sphere if women in general are seen to have none ?

These difficult questions are explored in Section One by searching through the collective unconscious – as represented in myths and archetypes - and the historical record to find the feminine as she has been and might still be, before women's lives became so circumscribed. She is not easy to know yet a thesis about women doctors will be richer for the search. Even if only a little of her potential is uncovered, the result might be a deeper understanding of how things got to be how they are, how women lost the keys to the kingdom and how, if they want to, they might get them back again.

So Section One guides the reader through the labyrinth of myth and history in search of what is possible. Being a thesis, of course, it starts by discussing methodology and method, demonstrating mastery of academic concepts appropriate to the genre in order to generate faith in the skills of the researcher before leading the reader off into less familiar territory. I invite you to join me on the journey.

1

Introduction

"Dr James Miranda Barry, the medical officer and inspector-general of the British Army hospitals between 1813 and 1865, was the first English-speaking woman doctor. She dressed, behaved, and lived as a man and was found to have been a woman only after her death. She disguised her sex and obscured her real self throughout her highly praised medical career in order to obtain, in her words "the privileges of manhood, the greatest of which was a doctor of medicine degree" (Lovejoy 1957 p 280)

1. The study

This thesis is a study of the relationship between medical culture and women doctors. It seeks to answer the question 'What do women do with their feminine when they become doctors'. The question is important to women doctors, to patients, to workforce planners and to all those who intersect with or are involved in the medical profession. Medicine developed as a profession at a time when women were not included. Over the past 30-40 years women have joined the profession in increasing numbers in Australia and other countries with similar cultures, and now comprise approximately half the medical school cohort and nearly a third of the medical workforce. Introducing women into the previously masculine culture of medicine has a substantial impact on the women, and also on medicine. The research detailed in this thesis identifies some of that impact in ways that will be useful to both women doctors and medical students, and to workforce planners. I intend, through this study, to create knowledge that, in the terms of Stanford Professor of nNeurology, Frances Conley, means that medical women 'now watch the entire landscape with increased acuity.' (Conley 1998 p 244).

The study is also an exploration of research methods that are effective in uncovering the comparatively silenced voice of women in medicine. It identifies what can be found by applying the lens of feminist epistemology to medical culture. It explores the knowledges brought forth by three approaches to research, each building on the other, each valid in its own right, and each assisting in identifying what is missing from the other approaches. It uses both quantitative and qualitative method to study the research question. Working with a post-modern feminist epistemology I use triangulation to refine the essence of the answer. The three methods comprise 1) qualitative data from interviews with nine female doctors that focused on their lived relationship between their female selves and their profession, and qualitative data from a national survey of rural doctors focussing on how women express their femaleness in their professional practice; 2) quantitative data from the national survey, from male as well as female doctors, and 3) a study of mythology of the feminine and its relation to the history of the construction of medical knowledge in the European tradition on which Australian medical culture draws. In the data chapters findings are analysed wherever possible using all three knowledge sources.

Thus the methodology used for this study is actually methodologies. I have used my skills as an historian to locate the story of women in medicine, quantitative survey research to transform anecdote to data, and qualitative interview research as an heuristic device to discover what is really going on, what is possible, and to provide the thematic framework for the data analysis. The unifying theme behind this multi-disciplinary approach is feminist theorising about women, the feminine, power, medicine, authority and knowledge within occidental culture.

The theoretical challenge is to bring these disparate ways of creating knowledges to a coherent and defensible conclusion. That is a challenge appropriate for this study, for I am concentrating on uncovering how medical knowledge is created, in whose image is it created, and identifying the consequences of excluding women as co-creators of this knowledge, as experienced by women doctors. The broader question, of the impact of the exclusion of women from the creation of medical knowledge on that knowledge itself, and consequently on patient care, is part of work I do as an academic in the Faculty of Medicine, Nursing and Health Sciences at Monash University, and will be the focus of my new position as incoming Director of the Centre for Gender and Medicine.

There is an emerging understanding that the presence of women as doctors has reached a critical mass and that medicine is being/will be changed by that (AMWAC 1998). Just what those changes will be is not clear, but more competent workforce planning requires a better understanding of the implications of half the medical graduates being women. Up until now the assumption has been that women can be added to medicine and they will adapt themselves to the existing requirements of the profession. Sociologist Rosemary Pringle provided strong evidence that something unforeseen was happening, in her study of women in medicine. She concluded that:

> 'The presence of growing numbers of women doctors has contributed subtly to .. changes, interrupting the smooth flows of medical power, creating the possibility of greater movement around the field, and even sharing the field with other practitioners. Women did not self-consciously or as a unified group set out to transform medicine but their presence is producing changes beyond what any but a tiny minority may have ever visualised.'(Pringle 1998 p 222).

In the United States the National Institutes of Health have been grappling with the implications for medicine of the insistence that women be included in the project. Their work began with a focus on women's health, moved on to require the inclusion of women in scientific trials, and is now moving to examine how women are changing medicine http://www.nlm.nih.gov/changingthefaceofmedicine/ .

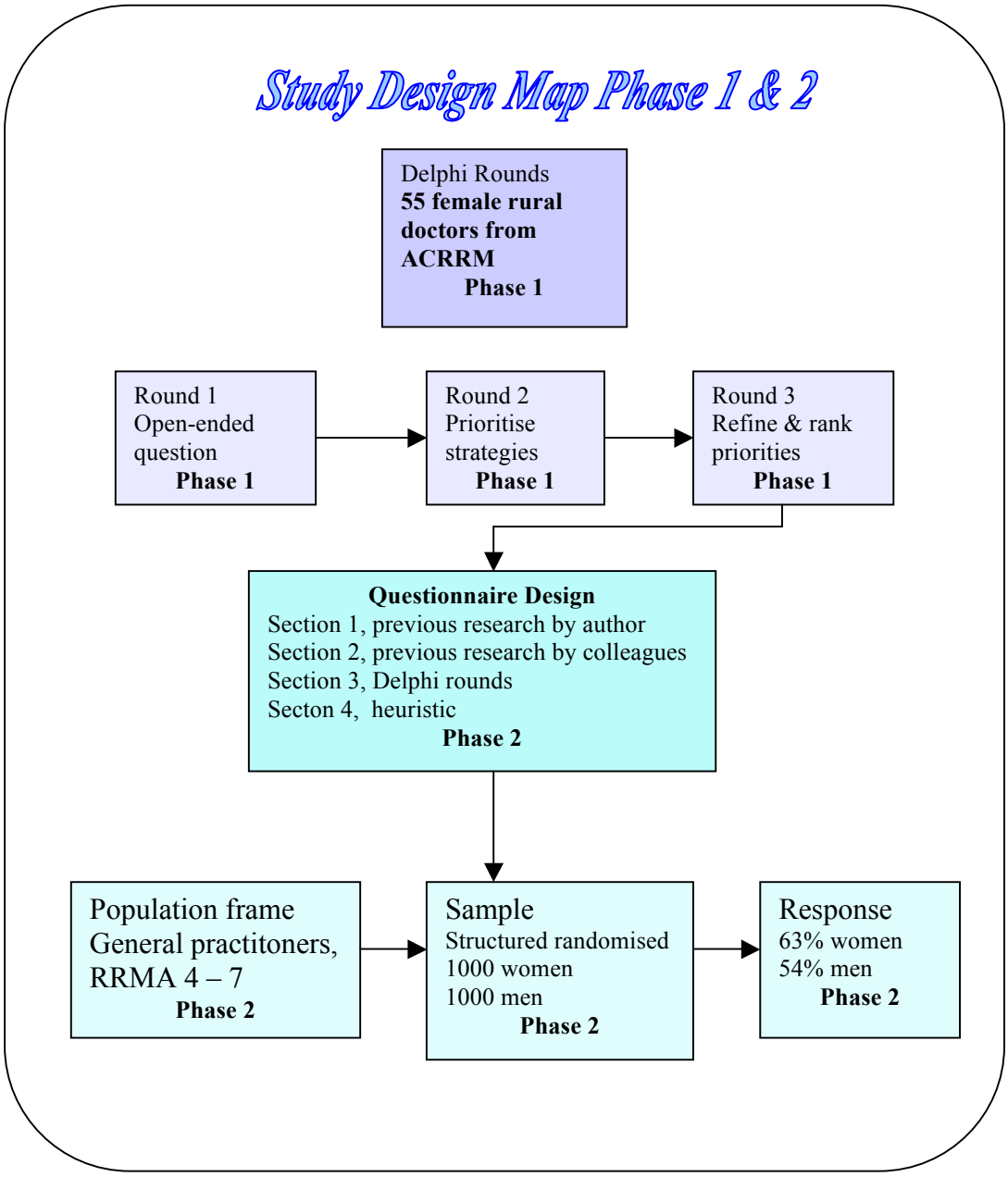
This study then, is researching an important question.

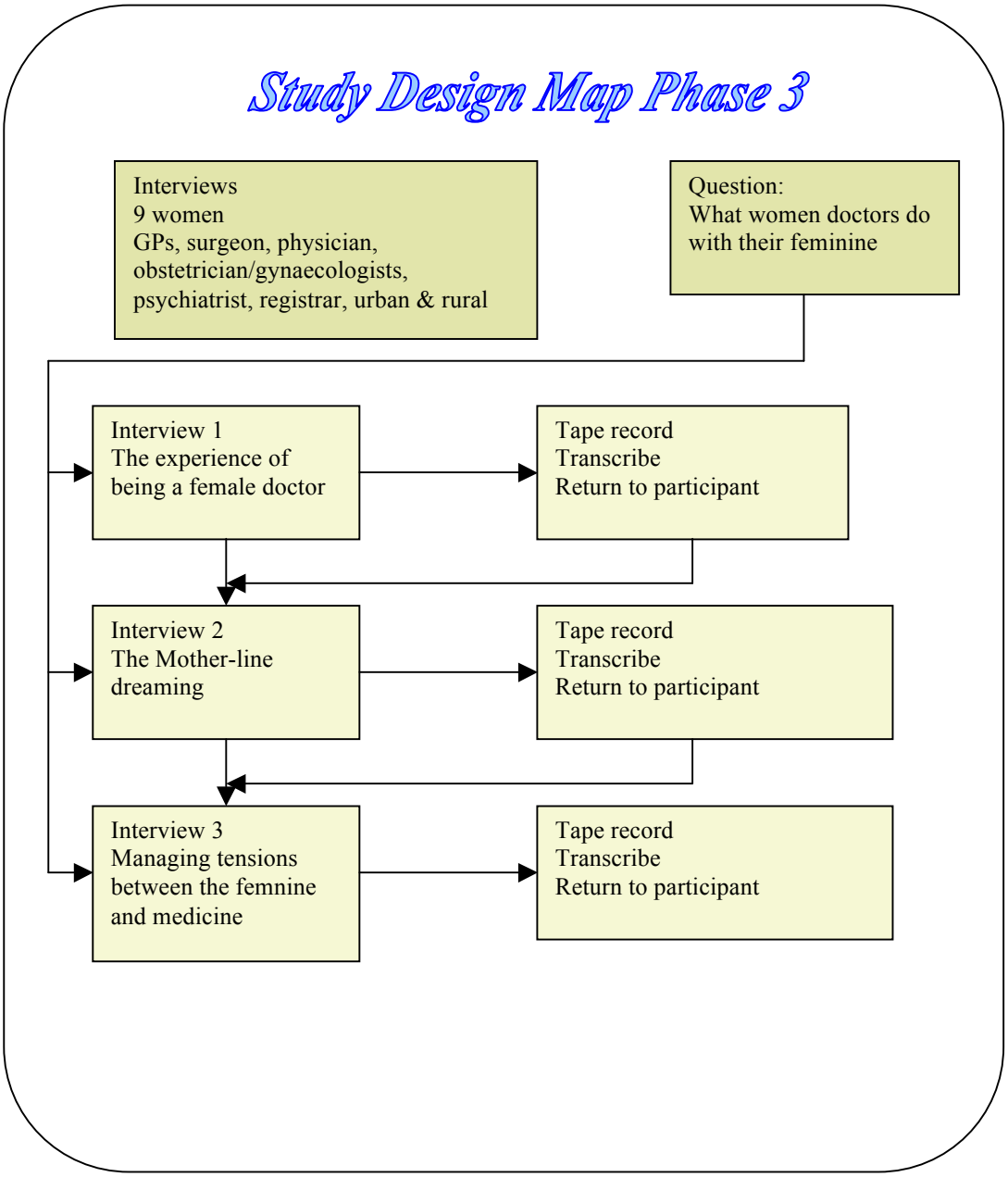
The thesis has four Sections, each of which comprises between two to three chapters. Each section begins with a Chapeau that introduces the concepts to be explored in the that part of the thesis. Section One has three chapters. Chapter One introduces the study, describes the research approach and contains some information about me, the researcher, that provides context for the research approach taken. Chapter Two documents how medical knowledge was developed in Europe and considers current feminist challenges to the construction of scientific knowledge and concludes with a description of the epistemology, methodology and method used in gathering and interpreting the data for the research. Chapter Three explores myths and archetypes about the feminine, considers what these tell us about the process of wresting the keys of the kingdom from women, discusses the

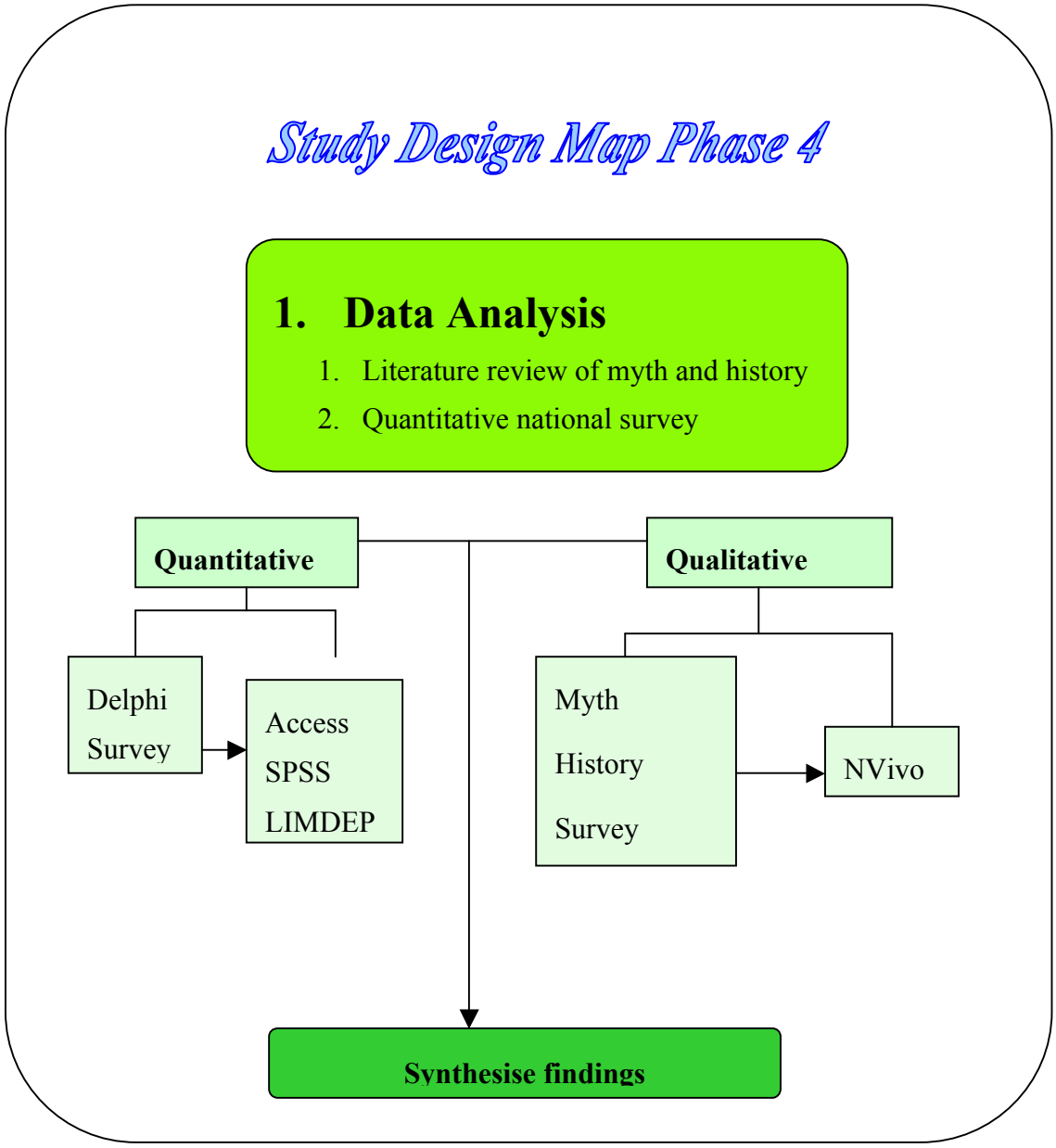
witch-burnings and their impact on women and medical knowledge, and ends with a brief history of women in medicine. These are background chapters that provide critical context for understanding the experience of female doctors in Australia.

Section Two comprises two chapters that describe the impact of the culture of medicine on women doctors, using data from the myths, the interviews, and the national survey. Section Three considers the impact women are having on medicine, including the strategies women use to resist some of the adverse effects of medical culture on their female selves, and identifying what women are doing to change that culture. Section Four examines the relationship between women doctors and healing, and the thesis concludes with a consideration of the impact of women on medical culture and practice.

To follow are three maps that picture the conduct of the study and the triangulated approach to data analysis.




Study Design Map Phase 3
Interviews
9 women
GPs, surgeon, physician, obstetrician/gynaecologists, psychiatrist, registrar, urban & rural
Question:
What women doctors do with their feminine
Interview 1
The experience of being a female doctor
Tape record
Transcribe
Return to participant
Interview 2
The Mother-line dreaming
Tape record
Transcribe
Return to participant
Interview 3
Managing tensions between the femnine and medicine
Tape record
Transcribe
Return to participant


Study Design Map Phase 4
1. Data Analysis
1. Literature review of myth and history
2. Quantitative national survey
Quantitative
Qualitative
Delphi Survey
Access
SPSS
LIMDEP
Myth
History
Survey
NVivo
Synthesise findings

The first map, of Phase 1 and 2 of the research, outlines the conduct of the national survey. This began with work with an Expert Panel of 35 female rural and remote doctors to identify strategies they had used to make rural practice work for them. The outcome of the Delphi Rounds with this Expert Panel comprised the central section of the questionnaire that was sent to the rural doctors. Details of the conduct of the survey are described in Chapter 2 and an Executive Summary of the Full Report into the findings is appended to the back cover of this thesis.

The second map outlines Phase 3 of the research, involving multiple interviews with nine doctors, while Phase 4 describes the integration of research findings in the analysis of the data.

This approach allows me to triangulate data and apply the firm foundation to the findings of my research of that most stable of structures, the three legged stool.

2. Ethics

Ethical issues raised by the study relate primarily to two aspects. The first is that of confidentiality and the second the possibility of distress for the doctors in identifying aspects of their encounters with medicine that had been wounding. Doctors who took part in the interviews and the survey were assured of confidentiality. Identifying features have been removed from descriptions of doctors who took part, particularly in the interviews, and their comments modified if necessary to eliminate identifying statements. Two of the doctors hold or have held nationally prominent positions and I have negotiated with them as to how to report their contribution in ways they are happy with. We are both aware of the potential for adverse political consequences, although there is some protection provided by reporting this work within the framework of a supervised academic thesis, as part of an authorised knowledge creation process.

Contact details were provided for access to doctor support telephone contact for the participants in the survey, and for access to an identified and trained medical supervisor for women who took part in the interviews.

Feedback has been provided to all participants, describing some of the outcomes of the study, and the results of the survey have been presented to rural doctor conferences, the Commonwealth and State governments, and to the General Practice Summit on behalf of the Rural Doctors Association of Australia, in 2004. Two articles have been published in rural health journals describing findings from the study, and a five page article featuring the findings was published in the news magazine directed to general practice, Australian Doctor. These publications demonstrate to the doctors that the information they have provided is being treated with respect and used in ways that may lead to improvements in their practice environments.

Ethics approval for the interviews, and a separate ethics approval for the national survey, were granted by Monash University.[1]

3. Women

I acknowledge from the outset that talking about 'women' as a discrete group is both necessary and problematic, as Quadrio's has pointed out (Quadrio 2001 p 55). Necessary because, as the half of humanity that has been excluded from the development of medicine, women, as a group, have something to say. And problematic because the underlying assumption that women are either homogeneous as a group or have common experiences because they are born female[2] has worried feminist theoreticians for decades. Women are clearly heterogeneous in temperament, embodiment, empowerment and sense of agency, and divided by class, race and wealth. Cohen has noted how important it is to consider how this diversity impacts on women and their health (Cohen 1998). However, only women mother, and women's bodies and life-cycle rhythms have commonalities that mark them as women (Quadrio 2001 p 79).

I deal with this dilemma by concentrating on making spaces for women to speak and representing their experiences with their own words wherever I can. I generally avoid comparing women with men, except when discussing the impact of gender on rural practice, in part because I am unhappy with the proposition that there are two sexes. Judith Butler has demonstrated eloquently the range of possible sex and gender identities that people can live their lives through, the highly political purpose of confining sex and gender to two, and the horrendous adverse consequences for people whose lives do not readily confirm to standard definitions of female and male (Butler 1999). I do not want to be part of the politics of binary gender.

4. Metaphor

Throughout this study I work with the metaphor of Athena, the Greek goddess of learning, as the archetype of the medical woman. The myth tells us that Athena was born fully armoured from her father's head. She carries a shield carved with figures representing ancient feminine wisdom, an owl as her familiar, and a book representing learning. She is a 'father's daughter', denying her mother and using her intellectual skills and warrior's determination to make her way in the imagination of the people of her time.

There are several key elements of this myth that inform my research. One is the takeover by the masculine of women's creativity and unique ways of being, symbolised through the experience of giving birth, and turning it into a male mystery. The myth also symbolises the time of the takeover in the pre-Christian era of the goddess by the gods and the beginning of the establishment of the patriarchy.

Another element is the sacrifice Athena had to make in being born without a mother and to act as a mouthpiece for her father in order to survive the new regime. I intend to use the

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[1] This is discussed more fully in Chapter 2, Methodology and Method.

[2] The 'essentialism' argument.

mythic representation of the goddess, born of no woman, to examine the ways in which this mythological figure functions as a guide to understanding women doctors.

The third element of the Athena myth is her role in helping kill off the last of the original female gods. Athena may have been required to do this in order to be allowed to survive. There are elements of this story that help explain some aspects of the relationship between women and medicine.

A fourth aspect of the story of Athena, and the one that holds the greatest possibility of surprises, is to see if together the female doctors and I can uncover what her mother whispered to Athena before she was born, what feminine wisdom did Athena, the last of the old female gods, keep hidden deep and safe within her, passed on to her by her original, unacknowledged mother.

Aspects of the story of Athena have been introduced here as part of the explanatory framework of this thesis. Further details of the myth of Athena and other relevant myths are explored in Chapter Three.

The other research tool I use, in addition to numbers, words, myths and history, is myself, the researcher. Like all researchers I bring a unique constellation of qualities and curiosities to this research and rather than pretend this is not so, I will, in the tradition of 'strong objectivity' identified by Sandra Harding, declare what I know of them so that the reader can draw their own conclusions about how this interacts with the research (Harding 1996).

5. The researcher as research instrument

Post-modern theorising denies the existence of absolute truth and foregrounds the impact of the researcher on constituting the research question and defining the appropriate epistemology for investigation. Swiss psychoanalyst Carl Jung, for example, was aware that the personhood of the scientist 'influences the choice and perception of data', and he, like me, identifies himself as the primary research instrument (Wehr 1988 p 97).

So I begin this task by situating myself as a learner, a knower and an actor in medical knowledge-making for the purposes described by West:

> Michelle Fine (Fine 1992) argues… for the reflexive and self-reflexive potential of experience, in which the knower is part of the matrix of what is known, and where the researcher needs to ask her/himself in what way has s/he grown in, and shaped the process of research. Such an aspiration assumes no monopoly of knowing but attempts, through collaboration and mutuality, to name more of what is difficult to say or articulate, and to think about its meaning collaboratively. This is a process that strives to surface power relationships, discomforts, dead ends and uncertainties. Rather than an absence of rigour, or truth, such auto/biographical methods ask much of the researcher, in terms of self-awareness, social and emotional intelligence, sensitivity, integrity, courage and openness (West 2000:5)

Or, as Silverblatt puts it 'The starting point of theorizing can be no other than our position in this world – with all its possibilities, blinding limits, and potentials for critical transcendence.' (Silverblatt 1991 p 160).

I belong to the dominant culture in Australia, that of the white European intellectual tradition. I am thus well-versed in valorising the intellect and structuring argument and data through rational thought. This is helpful because it parallels the construction of allopathic medical knowledge and gives me privileged access to such knowledge. I have been trained how to think within the same tradition doctors are trained in, the traditions of a Western university. This has required mastery of concepts of evidence, proof, theory, method, logic and argument, all masculine ways of thinking which women in universities learn well.

I have examined the fit and misfit between this constructed knowledge that reifies the intellect and rational thought, and my own experience of the world, and I have found it wanting in its hegemonic claim to define the believable. My inner world is not satisfied with rational thought and my spirit rebels at the nonsensical requirement to abjure feeling, emotion, intuition, cyclicity, connectedness. I resent the imposition of cold rational thought on hot blooded experience, the sanctification of the former and the ridicule of the latter as knowledge forms. I am not alone in this. James McWhinney has identified the challenge General Practice is making to medical knowledge based on 'abstract axioms'. He suggests that 'some of our discomfort in the medical school is due to our different valuation of knowledge' (McWhinney 1996). West has come across this in his study of doctors in London:

> Part of the problem may be a profound split between personhood and medical practice, science from subjectivity… the split is the consequence of a culture, which distrusts the idea of personal truth. If the academy, including medicine, claims multiple ways of knowing a world, the objective way – taking us into "the real world" and "out of ourselves" – remains a hegemonic value. The self within the culture is not a resource to be used but "a danger to be suppressed, not a potential to be fulfilled but an obstacle to be overcome." (West 2000:8)

I, and many others, refuse to be 'an obstacle to be overcome' and instead have learned through the wisdom of reflective experience to value the self as a knower, experience as a teacher, and the body/mind as a less masked and fanciful way of constructing the world than the fantasy of 'objective truth' or 'rational scientific method'. This makes me, in my whiteness, my middle classness, my tertiary educated membership of the dominant culture, an 'insider/outsider' in the construction of academic knowledge. I am inside the thought structures that underlie rational medical science, yet I see and experience a wider vision than that, and challenge it as the whole of what is to be known.

I have learnt to read, and thus also to be an author of text that includes my world.

I am also an 'insider/outsider' to medicine, in that I have spent a life-time enculturated in medical practice, yet have not studied medicine. My discipline is social science and I have informally and formally studied doctors rather than medicine. My late husband was a doctor, my daughter is a medical student, and I have spent my professional life working in medical service provision, theorising, advocacy and research. This makes me privy to the culture of the profession, but free of the forces that bind the medical student and young doctor to the tree of medical knowledge. With this freedom I will reflect back the medical gaze identified by Michael Foucault to illuminate the silenced voice of women in medicine (Foucault 1994). For I am wholly a woman. And unlike the women who inform my study, I am no longer required to make that invisible in my professional work.

As a young woman I too learned to speak with the tongue of the dominant culture, to keep my thoughts to myself and to query my sanity rather than the system when what I was being taught was patently partial. I refuse to continue to do that. In my middle years I spent a decade studying the feminine in many of her forms, travelling to women's sacred sites, gathering the symbolic objects and names and frames in which she speaks in order to find another way to see and speak that reflected more wholly the whole of who I am. And thus informed now I stand my ground and speak as a woman, even within the intellectual tradition that demands that I disallow those knowledges. So I am bi-sexual, referring not to sexual preference in intimate relationships, but to patterns of thought. I can use the tools of masculine thought, yet think like a woman, and in this thesis I will do both.

It was only after years of training that I could begin to see what was missing in the stories about the feminine that had been told to me as a young woman. What was missing were representations of the feminine in action, woman as actor, independent and self-referencing. I began then to search for representations of the autonomous feminine. They are hard to find and require expert knowledge and guidance. For example I spent a day at the Victoria and Albert museum in London, searching for the symbolic language of the feminine and positive representations of women. In six large rooms with sculpture and art representing the intellectual and religious tradition of an empire, the feminine and women are invisible. This was a shocking discovery, deeply wounding, to be so excluded and invisible in my own culture. I have since located an image of Lilith at the base of the Madonna and Child which is kept there[3] (Koltuv 1986). Confirming the absence of symbols of the feminine in modern religion, feminist theologian Rosemary Radford Reuther suggests that 'Few topics are as likely to arouse such passionate feelings in contemporary Christianity as the question of the exclusively male image of God' and notes 'phobic' reactions to the possibility of speaking of God as "She" (Ruether 1993 p 47).

I also situate myself as a knower in the cycle of life that includes menopause. It is a time to pause, reflect, deepen, moving from knowing to understanding, burning off the dross of daily trivia and mining for the gold of wisdom. Thus a thesis written at this time of the researcher's life will be qualitatively different from one written by a researcher in their twenties. As a menopausal women I am moving into my own authority. I can afford to be wilful and playful, to believe that my own life is as valid as those of valorised heroes, and to be beyond silencing. I bring to this research a life-time of experience, search and

[3] Lilith enters the story in Chapter Two

reflection. This rich mother-lode of wisdom informs my research method, the topic, the way I engage with the subject matter and the subjects, and particularly the depth and intensity of my interactions with the women who inform this work, and to whom I am indebted. I have lived my life in such a way that I have demonstrated I can be trusted with women's truths and my gift in exchange (Hyde 1983) is 'a good listening to' that is possible only because I bring to that listening a life-time's study of the feminine in medicine.

I brought this knowledge with me when I joined the medical faculty at Monash University. Knowing what the feminine looked like, I became acutely aware that she is nearly absent from the content and structures of medicine and the medical curriculum, and I began to enquire why, and after the why came the what. What are the effects on women and men today, both as members of the profession, and as patients.

And finally, I position myself as a feminist. Dame Rebecca West said of feminism in 1913 "I myself have never been able to find out precisely what feminism is: I simply know that people call me a feminist whenever I express sentiments that differentiate me from a doormat or a prostitute." (West and Leonard 1982). A feminist is a person intent on naming and claiming that women's lived experience is as valid as men's in creating the public order and culture in which we live. In Silverblatt's words 'today's feminists have contributed to a re-examination of our humanness: to the cultural and political boundedness of our knowledge claims, and to the ethical and political imperatives of our intellectual activities. Although feminists do not speak in one voice, they share a hope and a commitment to a world free of dominations' (Silverblatt 1991 p 165).

Feminism, then, is an appropriate theoretical approach to support the work I have done to bring forward women's voice and experience, so that it too may inform the foundations of the profession of medicine.

This thesis explores in detail what is going on beneath the surface of medicine. It examines both what medicine is doing to women, and what women are doing to medicine, through the eyes of women doctors.

In Chapter 2 I establish my academic credentials and position the study within existing and developing knowledge traditions, detailing my theory, methodology and method.

2

Methodology, Method and the Construction of Scientific Knowledge

'scientific knowledge cannot be fully understood apart from its deployments in particular material, intellectual, and social contexts' (Longino 2002 p 9)

'there exists a historically wrought clash between the cultures of science and women' (Schiebinger 1999 p 14).

"Since feminism seeks to understand and to subvert the forces which maintain women's disadvantage in society it was chosen as the appropriate theoretical approach."(Quadrio 2000 p ix)

'Feminist objectivity makes room for surprises and ironies at the heart of all knowledge production; we are not in charge of the world. We just live here and try to strike up non-innocent conversations' (Haraway 1996 p 260)

1. Making trouble in the archives[4]

This chapter describes the theoretical position I take as a researcher, and the theory, methodology and method I use to establish and analyse the data that forms the heart of the thesis. It explores the notion that 'truth' is authorised knowledge by sanctioned knowledge-makers, and that many knowledges and knowers are excluded or silenced from 'truth-making'. I examine some of the theoretic contributions women philosophers and scientists have made to theorising the impact of sex and gender on science, and I then describe the theoretical and practical methodology and methods used to conduct this study.

[4] Quoted from Pollock, G. (2001). Looking back to the future: essays on art, life and death. Amsterdam, G+B Arts International.

This chapter provides the foundations on which the my work is based and demonstrate its connectedness to the chain of knowledge creation that precedes it.

Science, including medical science, is masculine. This has been noticed, and theorists are now systematically challenging the canons of Western science and philosophy, those received and authorised versions of the story of the development of objective, rational universal science (Easlea 1981; Irigaray 1985; Bordo 1987; Haraway 1991; Foucault 1994; Harding 1996; Keller and Longino 1996; Haraway 1997; Maynard 1997; Wertheim 1997; Butler 1999; Oakley 2000; West 2000; Pollock 2001; Quadrio 2001; Longino 2002). Scientific observation, they argue, is never innocent but 'always and inevitably influenced by theoretical commitments' that derive from the social place from which the observation occurs (Keller and Longino 1996 p 1).

Ann Oakley, for example, has surveyed the development of knowledge in occidental cultures and introduces her book as a

> 'discussion of how the definition of ways of knowing has constantly been interlaced with who is doing the defining, and about how the patterning of all of this has followed certain fundamental divisions existing in the wider culture. One of the implications of this argument is that some ways of knowing have traditionally occupied spaces at the edge of the dominant vision, the same kinds of spaces as are filled by the lives and experiences of the socially marginalized, including women. Thus, neither methods nor methodology can be understood *except* in the context of gendered social relations. Understanding this involves a mapping of how gender, women, nature and knowledge have been constructed both inside and outside all forms of science' (Oakley 2000 p 4).

My thesis has been written to contribute to the mapping project she describes.

2. Ontology

Ontology describes beliefs about how the world is, about what is the nature of reality (Denzin and Lincoln 1994 p 13). Simplistically this can be typified into beliefs that the world is knowable, leading scientific endeavour to emphasise precise research methods; or that the world is infinitely diverse, resulting in a perspective that the position of the researcher is as important as the subject being researched and denial of the notion of 'absolute truth'. I take the latter position, known as post-modern.

Modern scientific thought

The modern era of scientific certainty began in the late 18th century and placed man at the centre of knowledge creation. It coincided with the development of capitalism and widespread education (Danaher, Schirato et al. 2000). In modernism, knowledge is created systematically and logically through experimental observation, with one piece of knowledge rooted in and layered on those that went before. It is a cumulative process of rational enquiry based on the premise that the world is knowable and the chief challenge is to establish correct procedures for locating the truth. Universal rules were established and privileged as to what counts as scientific practice. Implicit in this positivist/empiricist model is a teleological belief that the rules of nature are orderly and discoverable and that each discovery will lead to the next in an unbroken chain (Barnes 1985).

Four key components of the natural sciences have been identified. These are: only directly observable phenomena are legitimate subjects for research; scientific knowledge is produced by an accumulation of verified facts; scientific theories underpin empirical research; and the researcher must be objective, devoid of values and feeling (Maynard 1997 p 4).

Thomas Kuhn provided a major critique of this belief system when he described how science really happens, and how paradigmatic shifts come about, bringing in new ways of looking at the world and working within it. These shifts occur when anomalies cannot be explained by the existing regime of truth and counterclaims for knowledge creation arise. Data and observations are theory led, not the other way around, and in the actual practice of science, theory or paradigm choice depends on normative consensus within the scientific community rather than being a universal truth (Kuhn 1970). In 'normal' science, paradigms are used in research by agreement. They are not themselves to be tested, but rather they are the basis for judgement (Barnes 1985).

Michel Foucault also undermines the accepted story that modern science tells itself about the orderly progression of knowledge, in a radical critique of the relationship between power and knowledge that decentred the human subject and led to the post-modern world view (Philip 1985).

Postmodern science

Postmodernism is a late-20th century challenge to modernism, and can be considered a paradigm shift in the Kuhnian sense. . It challenges the notion of an ordered universe, dispassionate observer and single locatable truth, and argues that there is not one truth, but many voices, and that all research is a product of cultural practices (Coffey, Holbrook et al. 1996; Usher 1997; Oakley 2000; Quadrio 2001 p 12). Knowledge is seen as being full of contradictions and truth is just the experience of the dominant culture (Danaher, Schirato et al. 2000). So that rather than epistemology – how we know what we know – being the process by which we understand the world, ontology – the nature of how the world is – has to be decided first; 'in other words, in the postmodern, ontology precedes epistemology' (Usher 1997 p 204).

Postmodernism is not a research theory or methodology, it is a world view that informs both theory and practice. It is a world view that stands outside the accepted scientific tradition within medicine, and its authenticity lies in uncovering hidden voices in the knowledge traditions of medicine. It brings to the foreground the power relationships embedded in positivist scientific research, the 'taken-for grantedness' that medical research is objective, scientific and valid. It makes problematic notions of objectivity, science and validity and places context, language, affect and the researcher at the centre of the research process. Post-modern is 'incredulous', it is always asking questions such as 'is it really that simple ? The question becomes 'who speaks' rather than 'what is spoken'

One of the most disruptive of the postmodern shifts is to unmask the power dynamics behind the proposition that there can be an unbiased, value-neutral, atheoretical and context-free scientific subject who is located outside their culture and outside the cultural codes of language. This is the subject of Descartes and Bacon, the 'man of reason' on whose shoulders has rested the task of building the construct of modern science. This 'man of reason', however, is a cultural product, using language that is culturally constrained and above all, he is a product of the exercise of power in determining what is

knowable and who is allowed to know it. Usher, Bryant and Johnston point out that knowledge is:

> 'always partial and perspectival, always shaped by language.. always situated within specific cultures which provide meaning and significance… All epistemological paradigms and research traditions are coded by language and discourse in terms of binary oppositions eg., masculine/feminine, subject/object, rational/irrational – oppositions that constitute identity through powerful and oppressive hierarchies which are their consequences' (Usher 1997 p 205).

There is great power in these binary oppositions to relegate women and the feminine to the 'other', the' not male' to whom is attached all the characteristics that masculinity and men want to separate from themselves. This has been a dangerous activity for women, and an ontology that sees the world another way is potentially a much safer practice for women.

The second most important interruption to the epistemological hegemony of modern science is the capacity for postmodernism to decentre the scientist, the 'knowing subject' attributed with universal human characteristics who occupies an Archimedean point outside the research field, the 'stance from nowhere' or the 'god trick' that transcends subjectivity (Haraway 1996) This stance from nowhere, the disembodied rational mind, is the basis for the claim to objectivity that underpins occidental science. The characteristics of this 'knower' are those of white middle-class men of European origin and this homogeneity underpins the public verifiability of scientific knowledge (Usher 1997).

Postmodernism challenges the notion that an international group of like-minded people trained in rigorous and exclusionary method can create the scientific world for the rest of humanity, and insists that scientific knowers too have culture, gender, race and class that position them in relation to their research, and most importantly, determine what questions are asked. Scientists are as enmeshed in language and culture as everyone else and it takes reflexivity rather than objectivity to understand the impact on their science. Postmodernism uncovers 'complexity, uncertainty, heterogeneity and difference' and challenges foundational systems of thought which secure, legitimate and privilege objective ways of knowing the world (Usher 1997 p 206).

The third destabilising challenge to come from postmodernism is bringing power into the picture. Foucault has articulated with compelling logic the interrelationship between power and knowledge, and the understanding that power creates knowledge (Foucault 1980). Those with cultural power determine where resources for research are allocated, what questions are asked and what answers will be heard. Power is present in any attempt to know; there is a politics of research (Usher 1997).

A postmodern approach to research then, is 'an injunction to be constantly vigilant', to take nothing for granted, to understand research as a sort of 'storytelling' (Usher 1997 p 208). It encourages the researcher to reflect on questions of voice and power, what is said and what is not allowed to be said, and to look for what is missing. This is an approach that fits well with the purpose of my research, which is to locate a hidden voice in medicine, that of women, and bring it to the foreground. Postmodernism is an appropriate ontology for a quest to understand how women engage in a profession that was established in part to separate its knowledge and practice from the feminine.

A shattered mirror is a useful metaphor to describe the relationship between positivist and post-modern research paradigms. Positivists believe they can reassemble the mirror to a

perfect whole once they understand the mechanism behind its creation, while post-modernists understand that many techniques will be used to collect the pieces – sweep with a broom, pick up the bigger pieces, vacuum the dust – and that the reassembled whole will at best resemble only perspectives on the original.

3. Epistemology

Epistemology speaks to how we know the world is as it is. In Western thought the primary approaches to knowledge creation have been thought of as 'positivism', the notion that the world is knowable and it can be known through detailed, careful and objective exploration; and 'relativism', the position that how we know the world depends on how we are situated in it. I draw on the work of science philosophers discussed in Chapter 2 to provide the theoretical underpinning for the epistemological stance I take in this study, that of relativism, within a feminist framework.

There is a lively debate in the literature reporting on the philosophy of knowledge about how we can know things, and what is to be known (Denzin and Lincoln 1994). The great complexity of this debate is summarised as the quantitative/qualitative divide, or in Oakley's terms the 'paradigm wars' (Oakley 2000).

Feminist epistemology

The project of feminism is to include women in the world of culture and knowledge as autonomous, self-referencing and fully human. Feminist scholars seek modes of understanding that do not reduce women to the position of voiceless objects, but treat them as subjects in their own right, entitled to their own voices. The very foundations of the feminist research process is concern with voice and authority, accounts and experience (Coffey, Holbrook et al. 1996). I use these foundational processes throughout my work, always keeping in mind that women are the authors of their own lives and what they know constitutes the knowledge I seek to work with.[5]

Feminist theory challenges the undifferentiated framework that assumes that there is one, universal sex[6] and brings to the fore the certainty that there is 'a womanly capacity that men do not possess' that in part is related to women's relationship with their bodies, and birthing (Pateman and Gross 1986 p 7; Cohen 1998). Throughout the study I search for this 'womanly capacity' and how it influences the experience of medicine, and medical practice as women practice it.

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[5] One of feminisms' gifts is its attention to concrete ways of being in the world. This results in not merely knowing differently and acting differently on and with that knowledge (praxis), but this seeing and knowing differently 'pushes us to be differently at our very core, who and how we choose to be daily in all our circles of relationships. And therein lies the ontological challenge.' Maguire, P. (1996). Proposing a more feminist participatory research:
knowing and being embraced openly". Participatory Research in Health. K. d. K. a. M. Martin. London, Zed Books**:** 27 - 39. Throughout this research I meet this challenge by conscious attention to questions of voice and authority; by undertaking research that is potentially useful for the participants; and by developing structures in which women who take part in this research are able to do so through research paradigms and instruments that include them. I consider this to be the basis of ethical research.

[6] Cohen describes how medicine has regarded women as 'a special case – a deviation from the norm presented by the male' Cohen, M. (1998). "Towards a framework for women's health." Patient Education and Counseling 33: 187 - 196.

Feminist epistemology of science

According to science philosopher Helen Longino, 'faced with traditions in philosophy and science that are deeply hostile to women (women) have had to invent new and more appropriate ways of knowing the world' (Longino 1996 p 264). This chapter traces how that tradition was developed in science and considers its consequences for women in medicine.

The mind/body split, objective reason, overcoming nature, the standpoint from nowhere that define modern scientific method present problems for women, who are constituted as profoundly embodied and thus 'materially conditioned', associated with nature, and devoid of privilege and thus the capacity for objectivity. How then are women to be who they are and also be constituted as knowers?

Women and femininity are complex issues, a potential disturbance, that which transgresses what man defines as humanity and challenges the notion of one standard, one truth. This is seen most clearly in the slippage from 'man' to 'human', the assumption that what scientific man knows is without culture, when it is actually the world as understood by the winners in a savage battle to establish who determines reality.[7] The feminine is a disturbing 'psychic space, a space of dreams and imagination, symbols and meanings' (Pollock 2001 p 25). Such a space has the potential to absorb and reshape the narrow version of reality constructed by masculine thought.

One of the leading feminist theorists about science is Donna Haraway and she defines the importance of revisioning science through a feminist lens as follows:

> 'Feminism is about a critical vision consequent upon a critical positioning in homogeneous gendered social space. Translation is always interpretive, critical, and partial. Here is a ground for conversation, rationality, and objectivity – which is power-sensitive'… Rational knowledge is a process of ongoing critical interpretation among 'fields' of interpreters and decoders. Rational knowledge is power-sensitive conversation.' (Haraway 1996 p 258).

Feminist scholarship has challenged the foundations of science (Wertheim). Now might be the time for medicine too to engage in power-sensitive conversation to better reflect its purpose of bringing succour to the whole of human kind. As Silverblatt puts it 'Now that "others" are in our view, scholars are asking how they could have been "disappeared" so long from historical record' (Silverblatt 1991 p 162) and, I would argue, with Cohen, from the science and clinical research on which medicine is based (Cohen 1998). The disappearing of women from science is discussed in Chapter 2.

Women restructuring science

Current thinking has begun to understand scientific thought as a 'cultural artefact' made, rather than discovered, by the conditions of knowledge and practice of their time and place, rather than some absolute, context-free truth. Understanding science requires understanding the context in which it is produced. An unchallenged and continuing assumption has been that definitions of what constituted knowledge and science belonged with men. Women were systematically and thoroughly excluded from the process. So

[7] This battle is described in Chapter 3

thoroughly that the fact of the exclusion is not considered problematic. The absence of women will have narrowed the possibilities inherent in the emerging philosophy of science, and it also left women untrained and unpractised in articulating their own natural philosophy. This leaves medical women with no choice but to work within the linguistic and philosophical frameworks established by men.

Feminist scholarship began by exploring the experiences of women that were ignored in the development of bodies of knowledge, and then extended its insights into an analysis of how all knowledge is constructed, on the understanding that politics and knowledge are innately intertwined, and for that reason knowledge must be reconstructed to include women (Leonardo 1991; Coffey, Holbrook et al. 1996). As Longino notes:

> 'data are dumb, requiring .. assumptions in order to function as evidence. The frameworks belong to ways of seeing and being in the world that assign different degrees of reality and value to male and female activities' (Longino 1990 p 111).

She uses the case of debates about human evolution to illustrate the unarticulated power of assumptions to determine what is seen. The general acceptance of the transition from primate to early hominid was based on the story of 'man the hunter'. It took female scientists to re-evaluate the data and posit the theory of 'woman the gatherer' as the primary developer of the use of tools, encouraging the advantage of enlarged brains for problem-solving and bipedal gait.

Women scientists have reworked some areas, such as primatology, and rewritten sex and gender as no longer binary events patterned on the patriarchal family, but as aspects of fluid agency(Butler 1999). With this new vision has come new discoveries of what counts as sex.

> 'The *body,* the object of biological discourse, becomes a most engaging being. Claims of biological determinism can never be the same again. When female 'sex' has been so thoroughly retheorized and revisualized that it emerges as practically indistinguishable from 'mind', something basic has happened to the categories of biology. The biological female peopling current biological behavioural accounts has almost no passive properties left. She is structuring and active in every respect; the 'body' is an agent, not a resource. Difference is theorized *biologically* as situational, not intrinsic, at every level from gene to foraging pattern, thereby fundamentally changing the biological politics of the body. The relationship between sex and gender need to be categorically reworked within these frames of knowledge.' (Haraway 1996 p 261).

Women are demonstrating that sex and gender affect the epistemology, the identification of what is important in natural processes, the findings, and the purpose to which the findings are put as well as who is advantaged by scientific knowledge, and who is either ignored or conquered by it. As Longino puts it 'what has been labelled as scientific method does not succeed as a means to the attainment of unconditioned subjectivity on the part of individual knowers' (Longino 1996 p 271). So the task becomes one of acknowledging the situatedness of the knower and her/his essential embodiedness and using these as research tools to see hypothesis, data and findings through multiple lenses, including the lens of women's ways of knowing.

Women can bring what Belenky and her colleagues have identified as connected knowledge, contextual thinking and collaborative discourses into science (Belenky, Clinchy et al. 1997).

The inclusion of multiple perspectives, including those of women, will help protect the scientific endeavour from the unreflective acceptance of its own assumptions, but only if the participants have not had to absorb those same assumptions in order to be recognised as capable of creating truth. This process of being identified as part of the scientific community, a process that requires absorption and reflecting back of agreed norms and values as well as technical skills (Kuhn 1970), is part of what makes medicine problematic for women when those agreed norms and values do not include norms and values that women may hold differently. Women must either give up their particular perspectives or risk being excluded from the scientific project.

One of the rules that has been challenged by feminist theorists is the notion of 'objectivity', the idealised 'view from nowhere' which assumes that it is possible, and desirable, to create knowledge that is free of context and culture. An alternative view is a philosophy of science that is embodied, 'socially and temporally and spatially situated knowledge' (Keller and Longino 1996 p 9) that makes manifest the perspective that informs it. This perspective acknowledges science as 'immutably grounded, embodied, and partial; that its goals are subject to contestation; and that the dream of absolute, universal, and comprehensive truth' is a fantasy (Keller and Longino 1996 p 12).

In conventional empiricist epistemology the subject, the knower, is invisible, disembodied, without culture. This standpoint from everywhere and nowhere, what Haraway calls the 'god trick', supposes that knowledge is consistent and coherent (Haraway 1996 p. 256). In order to achieve this 'the subject of knowledge must be homogeneous, unitary, and coherent; it cannot be heterogeneous, multiple and conflicted.' (Harding 1996 p 243). When women insist on being knowers too they disturb the homogeneity of the elite, and if they are powerful enough, cause confusion and conflict.

Harding introduces the idea of 'strong objectivity', objectivity which includes the subject of knowing, the scientist, in the same critical framework as the object the scientist studies (Harding 1996). Only this way can the unspoken values and beliefs that lie within the culture of scientific enquiry be made explicit and taken into account. She argues that it is the homogeneity of the culture of science that leads to its blindness to its own bias and that 'strong objectivity' will result from the inclusion in the scientific endeavour of non-elite actors, including women, who could identify the social values and interests encoded in science that are invisible to the elite because they are shared among them, what Harding calls 'the cyclopean, self-satiated eye of the master subject' (Harding 1996 p 256).

The ideal of the scientific 'knower from nowhere' has been challenged by those who are more likely to be the objects than the subjects of knowledge creation, including women, on the grounds that only the most privileged in a society could believe that it was possible to exist in a place without culture or body. They want to 'change the subject' so that the fantasy of the disembodied mind is replaced by epistemologies in which body, culture, history and values are made transparent rather than made to disappear. The task of objectivity, then, becomes one of understanding the effects of location on cognition and taking that into account in constructing knowledge.

This feminist epistemology of relational knowledge is one that I rely on to inform my study. The particular theory I work with is standpoint theory.

Standpoint theory

Standpoint theory began with the understanding that there are sections of the population whose culture, or world-view, is dominant (e.g. men; upper classes; dominant ethnic groups, European and North American). There are others (e.g. women; lower classes; suppressed minorities) who are 'muted' in that they are deprived of their own culturally legitimated means of expression. Muted groups are seen - and must often see themselves - through the categories of the dominant. They are visible and audible only through the eyes or voices of the dominating groups. As a consequence, they cease to be the subjects of their own experiences and actions (Coffey, Holbrook et al. 1996). It is part of the project I am engaged in to support medical women in their subversive endeavour to become 'subjects of their own experiences'.

Sandra Harding is one of the theorists who has developed standpoint theory and applied it to science. She argues persuasively that the view from underneath, the view of the disempowered, gives a surer gaze that gets closer to the structure of truth than the eye of the elite. This theory begins with the understanding that one's place in the hierarchy of societies stratified by gender, race, class or other categories both enables and sets limits on what can be known. In particular, the critically unexamined dominant position is more limited than others in its ability to question received beliefs (Harding 1996). Understanding the political nature of knowledge is the core project of standpoint theory, in order to strengthen scientific objectivity by making manifest the cultural values of the knowers as well as the subjects of research. She maintains that:

> 'Conventional epistemological and scientific questions have excluded values and interests arising from women's lives' and this has distorted and made nonsense of science's claims to universal truths (Harding 1996 p 243).

Standpoint theory poses the possibility that the experience of marginalised groups, including women, is the most effective entry-point to scientific truths, and that women scientists (and I would say, doctors too) have to learn to bring their 'perspective from the margin' into their science. It is acknowledged that this is very difficult to do, held as women scientists are within the crush of the dominant scientific perspective.

Harding uses standpoint theory 'to bring into clearer focus new questions.. (to generate) wider discussion of crucial issues that were either invisible, considered unimportant, or delegitimated'. This wider view is intended to advance scientific knowledge by making visible those things that are invisible to dominant cultures and practices (Harding 1998 p 18) .

The theory proposes that multiple standpoints from the margin will provide interpretations of reality that are 'less false' than others (Tanesini 1999 p 152). Researchers and knowledge producers who agree that their perspective is partial can also agree to share their perspectives, on the understanding that each of their knowledges is incomplete and will be strengthened by the multiple perspectives of others. This will avoid the false universalism that arises when the scientist considers only his experience of reality, investing it with the label of 'knowledge'. Thus 'objectivity can be achieved from partial perspectives' (Tanesini 1999 p 157). A standpoint, according to science philosopher Donna Haraway, is 'a cognitive, psychological and political tool for more adequate knowledge.. of strong objectivity… a practical technology rooted in yearning (Haraway 1997 p 198-199).

These counter hegemonic standpoints are also sites of resistance, drawing on Foucault's understanding of power as being a force that permeates all levels of relationships and which creates opportunities as well as restricting options (Tanesini 1999 p 154). Insider/outsiders and people on the margins of the mainstream also exercise power, and use it to resist the consequences of being imposed upon or ignored.

After all, if the scientific project is to 'disclose relations not otherwise apparent' (Oakley 2000 p 293) then standpoint theory, with its view from underneath and multiple perspectives of otherwise hidden relationships, is likely to be the most effective theoretical approach. It is the theory I use throughout this work.

4. Methodology

Methodology in the classic sense is the study of method, of the epistemological assumptions implicit in specific research methods (Tuchman 1994). As a researcher I am situated within a medical faculty in which experimental method is so entrenched it does not even know it is a method (Kuhn 1970). It is just the way research is done. As Harding puts it 'the sciences hold … suppressed or unconscious epistemologies' (Harding 1991 p 308). I have demonstrated above that outside medicine and science, experimental method and even the whole project of positivist, quantitative research has been deemed problematic from many perspectives.

Working in a cross-disciplinary environment poses a challenge for me. There is little point in bringing to my intended audience (doctors) the rarefied language and concepts within which dwell the most advanced feminist and qualitative thinking. The language is exclusionary and this would not serve my purpose. However I am also unable to leave aside some of the insights such thinkers present, some of which have been discussed above. I resolve this by working with multiple methodologies in order to reach multiple audiences, and to bring diverse perspectives to focus on the central question, the relationship between women and medicine. As a writer and researcher it pleases me to be able to draw on hard-won skills in both quantitative and qualitative research, and findings from both research approaches are integrated in the write up of the data in Chapters 4 - 9. I am also trained as an historian and have added this research approach to establish the background to the research, and to contribute to understanding how things got to be the way they are, a type of modified 'genealogy' in Foucault's terms (Philip 1985). This historical context is crucial to the systems thinking that I intend to be an outcome of this research.

Quadrio has argued that 'traditional (research) models are androcentric and fail to account for the particularities of women's lives' (Quadrio 1998 p ix). The research reported here is unwavering in the intention, and meticulous in the practice, of paying attention to the 'particularities of women's lives'. This is my response to the gendered nature of the paradigm wars. Oakley describes how the 'quantitative/qualitative' dichotomy functions chiefly as a gendered description of ways of knowing' and concludes that in this role these paradigms are destined to be opposed to each other. However in practice many researchers use a mix of methods and I include myself among them (Oakley 2000 p 44).

Quantitative survey

The first part of the data collection for this study was a national survey of rural doctors, based on many years of prior work. The purpose was to put the authority of numbers and statistics at the service of the experiences of rural practice that had been identified by doctors in previous workshops, presentations, interviews and state-based studies. I, and a handful of other researchers, have been tracking the story of female rural doctors since the mid 1990's and it was time to call in the authority of the dominant research paradigm, quantitative research, to make the transition from theory, story and anecdote, to data. Number and statistics is a language readily understood by policy makers and medical workforce planners as well as doctors, and as they are the intended audience it was important to be able to communicate through a methodology that has value for them. Haraway agrees that 'statistics is a basic technology for crafting objectivity and stabilizing facts …Credible statistical representation is one aspect of building connection and coalition' and I will use them for that purpose, to stabilize facts (Haraway 1997 p 199).

Survey research has a long and rigorous tradition in social science and the methodology is well established. My study introduced into this tradition the intention of creating female-defined knowledge generated through quantitative data collection and statistical analysis. This intention is counter to much feminist work, begun in the 1960s, that identified a conflation between quantitative research and masculine perspectives that excluded or distorted women and women's knowledge (Oakley 2000 p 33). I have endeavoured, as Oakley suggests is possible (Oakley 2000 p 134), to compensate for some of the deficiencies of survey research by beginning with women's voice, and holding fast to the discipline of speaking with that voice through the whole research process. Details of how I have done this are in the section titled Surveying women in practice.

Qualitative interviews

Letter to Freud[8]

What does a woman want
Sigmund
it's simple
what a funny question
well speaking for myself
to be loved
same as everyone else I know
yes
by the man who I want to love me
and by the greengrocer
the chemist
the postmistress
my children
- I take it my friends will anyway
and I want to be left alone
no-one saying sit down
stand up
come here
I run away then
no
it may surprise you but I'd really rather not
have a penis thanks all the same
I suppose it's hard for you to believe that
I'd like a few laughs
rolling round a bed laughing my head off
and all the normal human things
clean water shelter
fresh food
that most never see
in their whole male or female lives
and not to want anything
Sigmund
most of all that
or does that only come like a ticket
with death ?

This study is about what is going on between women and medicine, so I decided to ask some female doctors. Unlike Freud, I believe the answer to his famous question, 'what do women want ?' is readily to be found. Ask, and if you listen carefully and respectfully women will tell you, and so the second part of data collection for this study this involved between 1 – 4 interviews with nine women.[9]

Conducting interviews to generate scientifically valid findings is quite problematic. For many years interview technique tried to mimic the natural sciences and striving for

[8] Source unknown and I include it despite this difficulty because of the precision of purpose.
[9] One woman was interviewed only once. This was the initial pilot interview. Her data are included in this thesis because in qualitative research, everything is data.

repeatability. This required closed questions, trained interviewers who were instructed to not engage with the interviewee, and strategies for diverting respondents who asked questions or strayed off the topic. Phenomenologists and feminists, however, challenged the bias built into these techniques, and particularly the inequality in the relationship between interviewer and interviewed (Fontana and Frey 1994). Anne Oakley found that the technique did not work for her when she was interviewing women – they kept asking questions and getting side-tracked - and decided the problem lay with the technique rather than the women (Oakley 1981). Others agree with her. Feminist theory places woman and her experience at the centre of knowing, and if classical theory or research method does not work with women, 'then the problem lies with the theory, not with women' (Pateman 1986 p 3).

Interviewing has a long tradition as a knowledge source in qualitative research methodologies (Fontana and Frey 1994). Interviewing as a biographical resource has also been used with great effect. West says auto/biographical research

> "derives from the belief that the complex stories of individuals are essential to understanding the dialectics of structure and agency in particular lives…. Auto/biographical research challenges conventional genre distinctions between self and other, memory and present, researcher and researched in interpreting lives and composing texts about them." (West 2000 p 13).

I used a similar technique in my study, and as a result have been able to 'compose texts' from anecdotes the participants told me about how they, as women doctors, relate to medicine.

Phenomenologist van Manen identifies the value of anecdotes as powerful accounts of experiences. He stresses that the important feature of experiential anecdote is that it draws the reader in, then prompts them to reflect because:

> anecdotes possess a certain pragmatic thrust. They force us to search out the relation between living and thinking, between situation and reflection. Anecdote makes it possible to involve us pre-reflectively in the lived quality of concrete experience while paradoxically inviting us into a reflective stance vis-à-vis the meanings embedded in the experience (van Manen 1990 p 121).

In the 1990's interview techniques were adapted to better suit post-modern theories and the needs of researchers who wanted to understand what was going on in the lives of their respondents. Researchers, it seemed, needed to 'interview them at length and in depth in an unstructured way.' (Fontana and Frey 1994 p 373). Interviews that involve give and take, that involve a real conversation instead of a staged one, are 'more honest, morally sound and reliable' (Fontana and Frey 1994 p 371). Interviewers are now advised to adapt to the world of the individuals studied to create a common space for conversation.

I chose an approach to the interviews that was interactive, semi-structured and exploratory, balancing the requirement that I explore the same questions with each of the women interviewed, with the uniqueness of their experiences and responses.

Interviewing was the ideal method for getting to the heart of things for the purposes of this study. Interviews produce stories and anecdotes that bring life to the data and create a sense of immediacy and recognition in the reader, and I used the response of women

doctors to my handling of the data as a test of the validity of the findings, so immediacy and recognition have been critical to the success of the project.[10]

Oakley's description of her experiences interviewing women, and her subsequent journey to discover how things got to be the way they were, provided the theoretical foundation for the interview process used in this study (Oakley 1981; Oakley 2000).

All the doctors undertook all the interviews I requested of them, demonstrating that I was successful in establishing sufficient involvement for the doctors to stay connected to the project. They were generous in setting aside the time, in digging through memories of sometimes painful experiences, and in responding to questions that took them out of their usual conversational space, and in trusting me with intimate stories of their professional lives. The validity of the findings depends on that trust.

Historical social science and imagining

There is a perspective in social science that includes the theoretical use of historical information in order to locate social phenomena in context (Tuchman 1994). I have found it necessary to travel back to the time when myths and archetypes included the feminine in a positive light in order to make sense of how the feminine became demonised and women lost the keys to the kingdom. This study is not classic history, although my primary training is as an historian. I have depended on secondary sources written by historians and other explorers of occidental culture. Nevertheless I have been able to uncover a coherent discourse, one which deepens the understanding of the phenomenon under study, that of the uneasy relationship between women, knowledge, and medicine.

I have drawn on myth and archetype to understand the feminine when she was still valued in European consciousness. This perspective enables an 'unnaturalising' of the undervalourised feminine within which women live their lives today. If the feminine has not always been devalued and decentred from her own culture, then it is possible that it is not the natural order of things for women to be invisible in public life and culture.. As Tuchman says about the canons of social science 'historical knowledge is essential to the interpretation of the argument' (Tuchman 1994 p 307). I have found historical knowledge to be essential in understanding how things came to be the way they are because it illuminates the process by which current perspectives are created and provides essential context for understanding the experiences of women doctors, even if they do not know this history themselves. The past continues to speak to the present (Tuchman 1994 p 310).

Tuchman argues that quantitative data yields meaningful patterns more readily than qualitative data but that without historical context quantitative patterns are reduced in meaning (Tuchman 1994 p 312). Conversely, with an historical context, the patterns of meaning will be richer and it is this richness that I am searching for when using history to inform the quantitative and qualitative data assembled for this thesis, and this richness I have found.

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[10] I have written several thousand words describing the detail of methods used to collect data for this thesis. They are not included here because of the limitation on the number of words allowed. I described the method in detail to demonstrate my knowledge of the research traditions on which I draw, and thus my academic competence. Forced to choose between words describing how I know what I know, and words describing the data, I have preferenced the data in the belief the findings will demonstrate my competence.

McLaren found in her work with artists experiencing menopause that women writers, artists and feminist scholars are looking into the mirror of mythology to help them redefine their relationship to themselves and to the world. 'By restoring that which has been devalued, forbidden or silenced, they are re-interpreting the meanings of mythical narratives. (McLaren 1999 p 82). I bring a similar perspective to my work, weaving the explanatory power of myth with data through the interviews and the survey.

Rigour

Qualitative research is no different from quantitative research in that it involves a creative, imaginative 'leap from observed data to synthesis, hypothesis and findings' (Oakley 2000 p 54). The key to determining the reliability and validity of the 'leap' lies in the transparency with which it is reported.

Validity is about the truth. It is a function of how well the data collection process measures what it purports to measure. It comprises face validity, in which the survey or questionnaire has the appearance of doing what it says it will do; content validity, which requires that the data collected be all the relevant data for that subject; construct validity, which refers to the way in which the data collection fits within the conceptual framework of the research and discriminates between each topic; and criterion validity, which refers to the fit with accepted standards. I have addressed each of these components of validity throughout the research. The most problematic for this study is criterion validity, because it is part of the purpose of this study to challenge the way medical knowledge-making is constructed. I have dealt with this problem by locating the study within a philosophy of science that recognises and supports this purpose.

Garman has identified that a major theme emerging in qualitative research is the need to 'create spaces for the here-to-for unheard voices and positions in human inquiry' (Garman 1996). Criterion validity requires new processes for assuring reliability and validity that reflect emerging research approaches, and researchers wishing to create spaces for unheard voices must give careful consideration to what constitutes the quality of good research that has that as its purpose. McLaren draws on Garmen's discussion of a number of criteria for assessing the validity of such a project and in the footnote I have answered each question, which is italicised, as it is reflected through my work (McLaren 1999 pp 90-91).[11]

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[11] *Verite Does the work ring true ?* I have tested this through presentations to doctors, conversations with doctors, returning transcripts to the interview participants, and presentations to Psychiatric Grand Rounds and the School of Rural Health.
Integrity Is the work structurally sound ? The conduct of the research is detailed so that the reader may assess the integrity of the work.
Rigour Is there sufficient depth of intellectual, rather than superficial or simplistic reasoning ? This is not for me to judge, however the work is a result of wide reading, years of inquiry, and builds on critical appraisal of existing knowledge-making, requiring an understanding of how scientific knowledge is created.
Utility Is the work useful and professionally relevant ? Does it have a sense of vibrancy, intensity, excitement of discovery ? Do metaphors, images, communicate powerfully ? The work has proved to be professionally useful for female rural doctors and has contributed to national and international policy for them Wainer, J. and B. Doty (2003). Wonca Policy for Female Rural Family Physicians, World Organisation of Family Doctors. Women doctors who have read the draft have provided feedback that the metaphors and images are meaningful for them.
Aesthetics Is it enriching, pleasing to anticipate and experience ? Does it give me insight into some universal part of my educational self ? Does it touch my spirit in some way ? This is its intention, to be useful for female doctors. The responses of doctors who were interviewed, and some comments from doctors

One way of pursuing validity in interviews is to engage the respondents in this task of drawing out meaning (Oakley 2000). This was done for the interview group in this study by returning their interviews to them for verification and reflection, which was sought in the subsequent interviews. In addition the task of drawing out meaning was the principle work of the Delphi Expert Panel who were prime informants in developing the innovative section of the questionnaire that provided the data-gathering instrument for the national survey of rural doctors.

Triangulating data

Triangulating data is an established method within the social sciences for enhancing validity, reliability and generalisability (Oakley 2000). Validity can be established by cross-checking information, using a mix of methods and speaking with different groups of informants. This approach assists in establishing internal validity (Jick 1979).

Triangulation of data is the key research approach for this study. Data were collected in three forms: from the national survey of rural doctors, from the interviews, and from myths and history. The findings of the research, reported in Chapters 4 - 9, are consistently supported with data from all three data sources.

5. Method

This section details how the data were collected for the study. I first discuss my philosophical approach, working within the gift economy, to maximize the chance that taking part in the research was of benefit to the participants as well as to me. I then detail how I conducted the national survey of rural doctors, and how I identified the participants and carried out the interviews.

Gift economy

My interactions with respondents to both the questionnaire and the interviews were situated within what Hyde has identified as a 'gift economy'. A gift, he says is not something we can obtain by our own efforts, it is ' bestowed upon us…a gift revives the soul.' (Hyde 1983 p xii). Gift economies have 3 obligations: to give, to receive and to reciprocate, and it is a key property of a gift that 'whatever we have been given is supposed to be given away again'. If not literally, then another item is given, for gifts must move on (Hyde 1983 p 4). Working within a gift economy was part of the ethics of my research approach.

In the interview process I drew on many years of conversation with medical women to establish conversational space and topic outline, the participants shared their experiences, together we reflected, and I contributed learning about the feminine I had received from other women. We conversed to create new knowledge that can be given away, in articles,

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who completed the survey, indicate that taking part in the research gave them insight into their relationship with medicine and the feminine.

Verisimilitude Does the work represent human experiences with sufficient detail so that the portrayals can be recognizable as 'truly conceivable experience ?' The findings of my research are richly adorned with quotes from doctors describing their own 'conceivable experience'.Garman, N. (1996). Qualitative Inquiry: Meaning and menace for educational researchers. Qualitative Research in Practice in Adult Education. P. Willis and B. Neville. Melbourne, David Lovell Publishing.

policies, strategies, actions, conversations, networks. The wider the circle the gift travels the less it can be commodified. Hyde makes the point that the gift economy is appropriate to preserve natural increase, 'gift exchange is the commerce of choice, for it is a commerce that harmonizes with, or participates in, the process of that increase." (Hyde 1983 p 27). The essence of the gift is in its increase, which it gains from being passed on to a third party.

Surveying women in practice – crunching the numbers

I undertook a national survey of rural doctors to identify innovative strategies that doctors use to make rural practice work for them. The survey was designed to uncover what women were doing as rural doctors, and the findings contribute to the thesis as examples of women doctors working with the feminine in practice.

The research question that unpins the study, what women do with their feminine when they become doctors, has been approached in two ways in the conduct of the survey. The first is to identify the ways in which women enact their femaleness in their professional practice. This part of the study involved an iterative process in collaboration with 35 female rural and remote doctors, the Delphi Expert Panel (see para 4.1.4), to identify language, experience and behaviours that reflect their practice. This data formed the basis of a section of a questionnaire that was sent to 2000 doctors. The remaining 3 sections of the questionnaire were drawn from my previous research with female rural doctors (Wainer, Bryant et al. 1998; Wainer, Bryant et al. 1999; Wainer, Carson et al. 2000; Wainer 2001; Wainer 2002; Wainer and Doty 2003).

Oakley points out 'The best way to derive unwarranted conclusions about one sex (or about human beings in general) is to omit the other' (Oakley 2000 p 50) so in this part of the study men were recruited as well as women so I could examine the effect of gender. However the purpose of this thesis is to identify what is going on between women and medicine. I am not looking for 'difference'; I am looking for women's experience. So in this thesis I will report the analysis of difference that is found in the data only where relevant.

The survey instrument was explicitly developed from the experience of women, and with women's language. The text of the survey was modified slightly for the men, to de-emphasise the origin and connection with women. The expectation was that men would adopt the fall-back position of universalising the male experience. Correspondence with male doctors was designed to appeal to their chivalry. It is one of only two instances of research on rural doctors in Australia where men have been asked to respond to female designed research, although the reverse position is very common. This part of the study focussed on rural general practitioners as a case study of women in action.

The process of creating a cooperative research environment with rural doctors has been described in a paper published in the International Journal of Rural and Remote Health (Wainer 2004). This paper can be found in Appendix 1.

The Sustainable Rural Practice Study[12] is an Explanatory Case Control Study involving a survey of rural and remote general practitioners (family doctors). The survey focussed on what works for rural doctors, and was designed to discover the strategies female and male doctors use to make rural practice work for them. The study tests the hypothesis that women have developed innovative strategies for sustainable rural practice and that some of these work for men too. It has an integrated gender perspective underlying the study. It draws on previous research by the author and others (Rourke, Rourke et al. 1996; Strasser, Kamien et al. 1997; Somers, Maxfield et al. 1999; Somers, Maxfield et al. 1999; Tolhurst, Mc Millan et al. 1999; Wainer, Bryant et al. 1999; McEwin 2001; Ozolins, Greenwood et al. 2001; Wainer 2001; White and Ferguson 2001; Roach 2002; Tolhurst and Lippert 2003; Wonca 2003)in identifying factors that might impact on four dependent variables.

Dependent Variables:

1. Satisfaction with rural practice
2. Contentment with life as a rural doctor
3. Intended length of stay in current practice
4. Intended length of stay in rural practice

Explanatory variables include hours of work, on call, family relationships, rurality, and hospital-based and emergency medicine.

More than half of young doctors training for rural general practice are female and women comprise more than 60% of the 2002 general practice rural registrar intake (Tolhurst and Lippert 2003). This has profound implications for rural medicine. Several authors (Bryant 1997; Strasser, Kamien et al. 1997; Thompson 1997; Carson and Stringer 1998; Wainer, Bryant et al. 1999) have identified an emerging cultural change among younger doctors within the rural medical workforce, led by women. This change makes it urgent that we develop a systematic understanding of how women are engaging in rural practice in Australia alongside their male colleagues. This study contributes substantially to that understanding.

Objectives

Integrating women into rural practice requires an understanding of the ways women work, and the similarities and differences with men. This study was undertaken to identify women's experience, and test how men's experience compared with that of women.

Background

Studies published by the Australian Medical Workforce Advisory Committee (AMWAC), Australian Institute of Health and Welfare, and the Department of

12 The Full Report of this study has been printed and is contained in the CD at the end of the thesis, including sample frame, non-response and response rates, statistical analysis and findings. It is referenced as Wainer, J., R. Strasser, et al. (2004). Sustainable Rural Practice: successful strategies from male and female doctors. Traralgon, Monash University School of Rural Health**:** 150.

Human Services and Health, have documented the increasing participation by women in the medical workforce, and their relative shortage in rural medicine (DHSH 1995; AMWAC and AIHW 1996; AMWAC 1998). A more recent study for the Australian Rural Workforce Agencies by Doyle has confirmed the trend, documenting that 28% of the rural general practitioner workforce is female (Doyle 2003 p 9). This figure reflects that of the Viable Models study, which recorded 27% of its study of rural general practitioners as female (Mildenhall and Humphreys 2003 p 92), although it lists women as 25% of the total rural general practitioner workforce. The changing sex ratio of rural doctors is having important effects on the rural medical workforce that are as yet poorly understood.

The study is a response to the need identified by policy bodies for a more accurate understanding of a gender perspective in rural medical practice, and a body of work that has begun to articulate that practice.

Purpose of the Study

The hypothesis being tested by the survey was "Women have implemented innovative forms of sustainable rural practice". Up until now rural doctors have been men (Strasser, Kamien et al. 1997), and women have been required to accommodate themselves as best they can to the practice structures established by the men who preceded them (Tolhurst, Bell et al. 1997). Studies of rural medical practice have uncovered the structures, needs and expectations held by the majority of doctors, and programs of support and recruitment have been based on these studies (McEwin 2001). The incoming cohort of young doctors comprises a much higher proportion of women, who may now be present in rural practice in sufficient numbers to enable their culture of practice to become visible. In the context of a male-defined field, the activities of women are outside the norm and are thus 'innovative'. The survey was designed to uncover these 'innovative' practices.

Delphi Technique

The Delphi technique involves repeated rounds of communication with an Expert Panel, starting with an open-ended question to enable a wide range of responses, and ending with consensus. It is a well-established research method designed to use the judgement of experts to provide scientific evidence in fields that have not yet developed to the point of establishing formal scientific laws (Adler and Ziglio 1996). It is a procedure for eliciting and refining group opinion and replaces direct debate with a carefully designed programme of sequential interrogations interspersed with information and opinion feedback. It is used within health research and is particularly suited to a widely dispersed group such as rural doctors.

The Expert Panel

The selection of the Expert Panel was done through cooperation with the Australian College of Rural and Remote Medicine (ACRRM). It comprised 35 women from rural and remote practice from all areas of Australia. Women were preferentially selected if working in small (1000 – 5000) rural and remote towns. They were co-researchers in the project.

Delphi Rounds

The purpose of the Delphi study was to identify the core strategies that contribute to successful rural practice for women. A full description of this aspect of the study was published in the Australian Journal of Rural Health in 2001 (Wainer, Bryant et al. 2001) and is available in Appendix 2. The question asked in the First Round was "What have you done to make practising rural medicine work for you ?". The open-ended question from the First Round generated 113 strategies. These responses were refined and prioritised in two further rounds, and eight general strategies and 32 specific strategies were identified.[13] These formed the basis for Section 3 of the national survey. So as we developed the Delphi rounds I gave the Expert Panel a question medical women had identified as being important, they gave me their responses, I returned this information so we could share strategies and then their distilled wisdom was passed on to participants in the survey, who responded by completing and returning the questionnaire. This is an example of the gift economy at work within this research. The questionnaire for the survey is in Appendix 4.

Developing the Survey

The innovative aspect of the survey was based on the experience of female rural and remote doctors. From the outset the project was committed to using the women's language as much as possible, and to directing the survey to them, in their own words. Examples of comments the Expert Panel had made when nominating the strategies were deliberately included. For example, for the specific strategy 'worked 3-4 days a week in 5 or more sessions and some on call' the quote "This gives continuity of care for patients, a great sense of ownership of work and also some acute care to keep on the ball" was included. The purpose behind including these quotes from the Expert Panel was three fold. Firstly it gave an immediacy and legitimacy to the specific strategy, locating it firmly in the experience of the researched group. Secondly it was reflecting back their own language to the Expert Panel, and demonstrating that this work was based on their input. And thirdly it was a gift to the doctors completing the questionnaire, who might not have thought of these ways of working in rural medicine. This approach was tested during the piloting process to see whether it caused an identifiable bias in response rates or responses. There were no identifiable differences in the responses during the pilot phase to those surveys with and without these additional comments.

Ethics clearance for survey

Ethics clearance to conduct the survey was obtained from the Monash University Steering Committee for Research on Humans. Field clearance to conduct the survey was obtained from the Statistical Clearing House of the Australian Bureau of Statistics. The research was supported by the Australian College of Rural and Remote Medicine (ACRRM), the Royal Australian College of General Practitioners

[13] This apparently simple process took nearly 13 months, and many hours of work communicating with women in remote areas of Australia with little access to modern communications, and lengthy delays in the mail, as well as severe shortages of time to engage with the research process.

(RACGP), the Australian Divisions of General Practice and the Australian Rural and Remote Workforce Agency Group. Both colleges awarded continuing medical education points for participation in the survey.

Defining rural Practice

The concept of 'rurality' is a contested field. Many definitions have been developed, and two have been adopted by governments and non-governmental agencies to underpin policy and programs supporting rural communities. The first is the Rural, Remote and Metropolitan Area classification, known as RRMA, and the second is the Accessibility/Remoteness Index of Australia, known as ARIA (DHAC 2001). RRMA is based on combined measures of population density, and distance to higher level urban centres that can be assumed to provide a wider range of health and other services.

RRMA 4 Small Rural centre, population 10,000 – 24,999

RRMA 5 Other rural area, population <10,000

RRMA 6 Remote centre, population >5,000

RRMA 7 Other remote area, population < 5000

The RRMA classification has been challenged for treating the terms 'remote', 'rural' and 'urban' as single categorical variables rather than a continuum, which would more accurately reflect the experience of people who live there; for grouping population centres with great diversity into single descriptors; and for its use of the Australian Bureau of Statistics Statistical Local Area (SLA) as the basis for classification. SLAs are heterogeneous, large and vary in size (DHAC 2001). However it is the classification used by the Commonwealth Government as the basis for rural health-related policy and programs, and was chosen as the appropriate definition for this study.

Sample

The database for constructing the survey sample is held by AMPCo, the publishing arm of the Australian Medical Association (AMPCo 2003). The survey was specifically directed to general practitioners. Using social exchange theory (Dilman 2000) it was anticipated that there would be a higher response rate by women, for whom the questionnaire is highly salient, compared with men, who are not accustomed to responding to female-designed knowledge instruments. The resources were not available to over sample the men to compensate for this.

The sample frame was a purposive stratified random sample based on sex (male and female) and rurality measured by RRMA. General practitioners in RRMA 4 – 7 were sampled. Sample sizes were calculated using the Statistical Clearing House calculator (SCH 2004). Minimum sample size for each RRMA by sex was calculated using 95% confidence level.

The initial sample frame comprised 993 women and a control group of a matched sample of 1000 men. The results of the survey are reported separately for women and men. It is not possible to combine the results and present data about 'rural

general practitioners' because of the way the sample was constructed. It is not a random sample of rural general practitioners, but a purposive sample in which women are deliberately over-sampled, and men included as a control group.

Table 1: Population and Sample Frame

RRMA category	Pop. %	Female GPs No. and %		**Sample**		Male GPs, No and %		**Sample**	
4	28%	414	25%	**342**	**34%**	883	34%	**340**	**34%**
5	60%	1096	67%	**556**	**56%**	1431	55%	**549**	**55%**
6	12%	42	8%	**43**	**10%**	145	11%	**57**	**11%**
7		52		**52**		141		**54**	
Total	100%	1604	100%	**993**	**100%**	2600	100%	**1000**	**100%**

Women in the survey are much younger than the whole population of general practitioners while the age profile of the male doctors more closely matches that of the whole population of general practitioners.

Response rate

The response rate for this survey was high, generated by careful attention to language and reciprocal process, and following the method described by Dilman (Dilman 2000). Sixty three percent of eligible women and 54% of eligible men returned usable questionnaires. Seven contacts with doctors were used to maximize response. In the final communication I sent all participating doctors a summary of the findings.

The responses were checked prior to the final mail out to test for non-response bias. Data were available for most doctors in the sample frame for age, sex, RRMA and full-time or part-time status.

There was no statistically significant difference between female respondents and non-respondents for RRMA ($p=0.254$) but there was a significant difference for the men, with male doctors from RRMA 5 over-represented and from RRMA 4 under-represented ($p=0.031$).

There was some difference in age for the women, with respondents being younger than non-respondents, although this was not statistically significant. There was no difference in age between male respondents and non-respondents.

Data on full-time or part-time work was available only for the women. There was a significant difference at the 1% level ($p=0.008$), with women working full-time under represented, and women working part-time over represented. Female respondents were less likely to work fulltime than non-respondents (64% compared with 74%).

The mode for the age of female respondents was 40-44, and for non-respondents it was 45-49. This data was not available for the men.

Data handling

Surveys were logged as they were returned, a thankyou card posted to the respondent, and surveys sent for data entry. Extensive data-cleaning was carried out, with random audits of surveys for data entry quality. All summary tables were checked to ensure that responses fitted within the described response categories. Alpha entries were checked by a medical student, and difficult technical passages were checked by a medical practitioner.

Data analysis

Data were entered into an Access database. Numeric data were exported to SPSS for statistical analysis (SPSS 2002). Data were first subject to univariate descriptive analysis, then linear regression modelling was applied to determine statistically significant relationships for the continuous dependent variables. Logistic regression was used to analyse the dependent categorical variables. Qualitative data were analysed using NVivo software(QSR 2002).

LIMDEP was used to estimate the Probit model (LIMDEP 1995). A binary Probit model was chosen to estimate the marginal effects of explanatory variables on the dependent variables (Greene 2000 p 812). This model helps uncover the unobserved or latent process that lies behind a binary outcome (Harris, Macquarie et al. 2000), and is appropriately used in medical and health sciences research (Bhargave 2003). The marginal effect is estimated by applying the mean to all variables except one explanatory variable at a time, thus keeping the data constant, and turning the nominated explanatory variable on and off. The model predicts the relationship between the dependent variable and the explanatory variables, in both the direction and the amount of marginal effect.[14]

Interviewing women

The second part of the data collection drew on multiple interviews with 9 female doctors. Ethics approval was granted by the Standing Committee on Ethics in Research on Humans (SCERH) at Monash University. The research was directed by an epistemology of 'thinking from women's lives' (Harding 1991).

The position of 'friendly stranger' has value in the interview. It allows the women to exercise control over the relationship. It places the woman and her stories at the centre of the discourse and encourages a 'really good listening to' which may be of value in itself.

My status as an 'outside insider' was helpful in recruiting women to be interviewed, and in the conduct of the interviews. It meant that I have sufficient knowledge of the medical culture to be able to make sense of the experiences that are told to me, and yet have no power to impact on the standing of doctors in their profession. Thus I am able to see and

[14] I am indebted to Mr Alastair Boast, statistician at Monash University, for his assistance in developing and running the model. He did the data manipulation and ran the model. I did not learn the necessary software and statistics skills.

say things that doctors cannot allow themselves to see or say for fear of being regarded as disloyal to their profession and untrustworthy members of it. I am also now well-trained in the feminine and was able to offer this skill in exchange for stories about their experiences.

The interviews were based on a semi-structured interview schedule (see Appendix 3).

Constructing the interview sample

Recognising the embeddedness of gender in culture, this research restricts itself to an in-depth study of the culture in which I and the medical women who inform this study are situated, that of the Australian with Anglo-Celtic antecedents. To complement this restriction the women who were interviewed for this study share a common culture with me, a deliberate decision made to maximize the strengths of shared language and understanding in order to enquire further and deeper into 'what is going on', rather than seek the insights that are provided by a cross-cultural perspective. There is one exception. One of the doctors who took part has an Asian background. I readily concede that 'whiteness' and 'Anglo-Celtic' are not homogeneous categories, however I am enquiring into what is possible for doctors to do and think in relation to the feminine, rather than how cultural diversity is expressed in medicine, so I acknowledge the influence of culture and do not explore it further.

The interview group have in common only that they are known to the researcher or have been suggested to her, that they are female doctors, and that they are willing to take part in the study. This willingness was a critical factor, both because of the time commitment and the exploratory nature of the interviews.

I chose as participants women who have an awakening or fully fledged consciousness of gender construction in themselves and within medicine. This allowed us to go further and deeper than if I were working with women who were not interested in exploring this possibility. I acknowledge that a majority of medical women may not have such an interest. The purpose of the interviews is to explore what is possible, rather than to demonstrate the generalisability of the findings, and no attempt was made to find a 'representative' sample of doctors.

The following table (Table 1) provides some information about where participants sit within the profession of medicine. Throughout the study I refer to these women as participants in the research, and I use the title of P1, P2 and so on, representing Participant 1, Participant 2, to identify their contributions to the findings.

Table 2 Doctors Interviewed

Discipline	Urban/rural	Age group	Partner	Children
P1 General practitioner	Urban	44-49	Doctor	3
P2 Paediatrician	Urban	50-54	No	2
P3 Obstetrician & Gynaecologist	Urban with rural outreach	40-44	Yes	3
P4 Obstetrician & Gynaecologist	RRMA 4	34-39	Doctor	1
P5 General Practitioner	RRMA 6	44-49	Yes	2
P6 Surgical registrar	RRMA 4	30-34	Yes	0
P7 Psychiatrist	Urban	34-39	Yes	2
P8 Surgeon	Urban	50-54	Yes	2
P9 General practitioner	Urban	44-49	No	1

The doctors are located in three different states although a majority are from the state of Victoria. RRMA is an indication of rurality.

There are ethical issues raised by interviewing people who are known to me in a professional context and I explored these in some depth with the participants before beginning the interviews. There could be a useful analogy made with the doctor/patient relationship. It is ethically acceptable to interview your friends, but more complex to make friends from your interviewees. I worked hard to avoid exploiting friendship which might pressure women to say too much about themselves. I dealt with this by clarifying the role we each took when I turned on the tape-recorder, and by making explicit that the information we exchanged will become part of the public record, albeit anonymous.

Constructing the Interviews

The opening question 'tell me about your journey into medicine' was designed to engage the participant, provide space for her to say as much or as little as she wanted to, and to speak about the things that mattered to her. It was anticipated that the response to this question would cover some or even many of the questions in the interview schedule and if so, those questions would not need to be asked. There was the potential for overlap among many of the questions and no attempt was made to seek the information in the order in which the questions were written if responses to later questions were provided along the way. This approach, the semi-structured part of the interview schedule, allowed for a conversational style that was interactive and to some extent driven by the participant.

There is a challenge for women to imagine new forms of language and linguistic structures to recount their stories in a way that is true to their experience, separated from man-made language. Part of the exchange during the interviews was to begin to create jointly these new possibilities for thinking and speaking for women doctors. I held the role as a medium for truth-telling by the women, using my training in the feminine and social theory to create a vocabulary and space through which participants could access and articulate some of their experiences which might have been hidden to them.

While the quantitative part of this study is deeply rooted in the literature and previous work of the author and others, the qualitative data collection is more heuristic. The purpose of the interviews was to hear women speak about their lives as doctors within a structure that I had developed from years of work. This work included uncovering the pre-modern feminine, understanding some aspects of the culture of medicine, understanding aspects of the culture of women, and years of discussion with women doctors. From this I determined that the next questions to be answered in piecing together the puzzle of integrating women with medicine were those that could identify the points of intersection between medicine and women, the points of difference, and some of the power dynamics in operation.

The fragments of stories we remember provide a structure for re-constructing our own stories and setting our inner lives in motion. Through story-telling we can find out who we are. Oliver Sacks points out that:

> We have, each of us, a life story, an inner narrative – whose continuity whose sense, is our lives. It might be said that each of us constructs and lives, a narrative, and that this narrative is us, is our identities (Sacks 1985 p 105)

This is why I open the interviews by asking the women to tell me the story of their journey into medicine.

The interview, then, was designed to be interactive, dynamic, explored experiences and feelings that I knew medical women are not generally given permission to articulate, and which I hoped we would both enjoy.

Conducting the interviews

Feminist researchers are conscious of the power dynamics between interviewer and interviewee and usually posit the researcher as having greater power and responsibility than the participants (Oakley 1981; Cotterill 1992). She is the learned knower, the researched are constituted as subjects of their own experience and co-collaborators in the research, but not as definers of knowledge, and without access to the whole project. This means they are unable to place themselves within the matrix of knowledge being constructed, which the researcher can do. The power dynamics between me and the individual female doctors was more fluid than that. As doctors each of these women occupies a more powerful social position with greater prestige than I have as an academic. However for the most part (one doctor was an exception) I have greater knowledge about an aspect of their professional selves – their gendered selves - than they do.

I also have greater knowledge about an aspect of their professional culture, its history of excluding women, and the implications for their profession, themselves and their patients. This constitutes me as an authority in an area in which they experience confusion and hurt.

My ultimate power is to define what is knowledge from the data collected. I decided the research question, determined how it is to be answered, and then selected from all the text and data that which is to be valued and included as well as that which is to be left out. And then I decided what it all means.

It was crucial to establish and nurture the motivation of the women to continue on their journey of discovery with me. That motivation came from the saliency of the experience for them and/or their hope that their stories would help other women find their way. In the end they took part in the interviews not for me, but for their own understanding and purposes, and that is the exchange we engaged in.

Each participant was interviewed between three times, with the exception of one who was interviewed once, two who were interviewed twice and one who was interviewed four times. Interviews were tape-recorded and transcribed, and returned to the participant for correction and reflection prior to the next interview, where possible. Interviews were conducted between one to two weeks apart where possible. Multiple interviews allowed a deepening of understanding by both the participant and the researcher, the development of trust, and a sense of adventure as we travelled on this journey of exploration. I gave my time, my reflections on the experience of women in medicine, and a chance to speak in a safe and attentive environment about issues that had high saliency and affect, and little opportunity for exploration during the development of their professional selves. In return the participants gave of their time, their stories, their truths, their dilemmas, their trust that I would handle the data carefully. At the end of the interview process I asked what the experience of being interviewed had been like.

Data analysis

Interview data were analysed using NVivo qualitative data analysis software(QSR 2002). This is a powerful programme, based on grounded theory, that supports thematic analysis and builds theory up from the data.

6. Summary

This research is located within a post-modern feminist epistemology, using standpoint theory and interactive research methodology. Data have been collected using quantitative and qualitative method, and as we shall see in the next chapter, are supported by historical research locating myths, archetypes and a brief history of the witch burnings and other aspects of the relationship between women and medicine. Thinking from women's lives underpins each approach, with the intention of paying attention to the particularities of women's experience.

In the next chapter I introduce myths and archetypes that describe both the feminine and her overthrow, including the story of Athena that runs through the whole thesis, to deepen our understanding of women doctors.

3

Identifying the Feminine

"as curses mostly are metaphors, they are stronger if they are feminine"(Rabinovitch 2000)

'The shift in dogmatism from witch belief to rationalism took place over a period in which many women were burned or hanged as witches… The mass killings of witches began when science began' (Green and Bigelow 1998 p 198 & 201).

Myth speaks of the neglected Life/Death/Life nature of the Feminine, the triple Goddess. It also speaks of the patriarchal/male fear of the power of the Feminine cycles. The challenge is to face Lady Death, her embrace and her life and death cycles. She cannot be appeased, she is not letting go, she is surfacing, for without Lady Death there can be no real knowledge of life, and without that knowing, there can be no real love or devotion, no faith. Love costs, it costs bravery and going the distance.

What dies? Illusion dies, expectations die, greed for having it all, for wanting to have all, be beautiful only, all this dies. When one is in the company of the great powers of the psyche, and one is naïve, then one is sure to get more than one was fishing for.

This is the entire elemental feminine nature, the neglected Life/Death/Life nature. It cannot be overlooked, for wherever new life begins, the Death Queen shows up, and when this occurs, people pay rapt and fearful attention. (Estes 1992 p 140 - 142)

1. Introduction

This chapter establishes the setting in which the research takes place that is reported in Chapters 4 - 9. Its purpose is to position the feminine, and women, as central to the enquiry, to introduce some of the history and mystery that valourises the feminine, and to trace the relationship between women and power, authority and healing in the Western tradition. Similar enquiries can be made in other cultures, as Leonard Schlein and Joseph Campbell have undertaken which demonstrate similarities across cultures and across continents (Campbell; Shlain 1998). Yet anthropologists reject historical and

universalising statements about gender and sex roles, masculine and feminine, noting that 'how women and men are thought to be like and unlike one another as human beings, what they can and cannot do, are rarely givens, but historically and culturally contingent.' (Leonardo 1991 p 29). When discussing women, then, it is necessary to deal with history and culture.

Throughout the thesis I make no attempt to define 'the feminine' even though it is a central concept for this work. My purpose is to avoid premature closure by putting limits on how the feminine might be imagined. Instead I draw on many sources to provide illustrations of how the feminine has been described, mythologised, overthrown, marginalised and valorised. I understand that positivist scientific paradigms require precise definition of the question to be researched and the terms used in that research, but that approach does not yield the outcome sought in this research, which is to explore what is possible, rather than define what is known.

The chapter begins with an exploration of the potential qualities of the feminine as expressed through myths, symbols and archetypes, in order to understand what is possible for individual women. As Shlain points out, 'The cosmology of any given culture is analogous to the psyche of an individual. Its myths and religion reveal how the group psyche arrives at its values concerning sex, power, wealth and gender roles.' (Shlain 1998 p 5). Carl Jung agrees, saying that 'What we are to our inward vision, and what man (sic) appears to be *sub specie aeternitatis,* can only be expressed by way of myth' (Jung 1961 p 3). Myths cannot be proved, their origin is a mystery, yet that does not reduce their utility. In Jung's terms 'There is.. a strong empirical reason why we should cultivate thoughts that can never be proved. It is that they are known to be useful.' (Jung 1961 p 76). Jung admits that to the scientific mind symbolic ideas are 'a nuisance because they cannot be formulated in a way that is satisfactory to intellect and logic.' and adds that 'Even a man of high intellect can go badly astray for lack of intuition and feeling.' because imagination and intuition are vital to understanding (Jung 1964 pp 80, 81).

Working with myths, symbols and archetypes is also a device to access the story of the reshaping of the relationship of the masculine and feminine principles, and the relationship of women and men both to each other, and to the creation and representation of the culture they inhabit. Mythology tells us that women were once co-creators of European culture, and then for thousands of years women disappeared into the silence of the private sphere. It is part of the purpose of this thesis to connect the present to the past, to unveil the process that has led to medical women working within a system of thought and practice that has excluded them up until now. The use of myth is a deliberate attempt to locate the feminine outside the restricted definitions that have been imposed on 'her' by thousands of years of patriarchy.

Patriarchy is a term used to describe the interwoven social, cultural, psychological, religious, educational, economic and political systems that situate men and masculinity as the norm and women and the feminine as other (Daly 1979 p 39), so that 'mankind' is taken to mean the human race when it really means mankind (Wehr 1988 p 130). Patriarchal mythology systematically devalues the female function 'not only in a symbolical cosmological sense, but also in a personal, psychological [*sic*]. Just as her role is cut down, or even out, in myths of the origin of the universe, so also in hero legends.' until the great and active female figures are reduced to the status of objects, or if still functioning as subjects, are demonised or depicted as allies of masculine will (Campbell 1976 p 158).

Patriarchy is a system that has resulted in the fundamentals of human connectedness (those of language and thought structures) reflecting men's life course, while women's lives remain hidden in the private sphere using a language that is rarely above a whisper in the public domain (Daly 1979; Spender 1980; Gilligan 1982; Irigaray 1985; Shlain 1998; Quadrio 2001). Patriarchal women are trained to not seek gratification of their own needs or even recognition of their desires. Psychology and religion have been drafted to this purpose, defining women's fulfillment in terms of their service to others, rather than as agents in their own lives (Wehr 1988; Ruether 1993). Reuther defines patriarchy as

> 'not only the subordination of females to males, but the whole structure of Father-ruled society; aristocracy over serfs, masters over slaves, king over subjects, racial overlord over colonized people' and notes that 'Religions that reinforce hierarchical stratification use the Divine as the apex of this system of privilege and control' (Ruether 1993 p 61).

I trace how the patriarchy came into being, using myths as well as history. The stories of a number of goddesses from the Greek pantheon are explored to tease out aspects of the feminine that have been hidden from women today. Carl Jung notes that the goddess can be both generous and cruel (a point I consider later in this chapter) and that understanding is more likely if we work with 'the sphere of ancient mythologies' (Jung 1964 p 36).

This exploration of the feminine is followed by the mythical telling of the takeover by the masculine principle, and the pushing aside and domesticating of the female gods by the heroic male. One female god is selected out as a possible archetype of women in medicine. Athena, the goddess of learning, is the last of the female gods to survive the takeover, and the first to put herself in service to the now dominant male gods, Zeus and Apollo. In this myth lie clues to understanding the experience of women in medicine as they do what is necessary to hold themselves as both woman and doctor.

The next step in the story is to understand the dynamics and implications of the European witch burnings. Over two centuries, from 1550 – 1750, an estimated 100,000 witches were tortured and killed in most of the countries of Europe. The best evidence about who these witches were establishes about 80% were women, and up to 20% were healers (Clark 1997). This was the time of the Reformation, the Early Modern Era that established the foundation of modern European culture. It was also the time that the teaching of medicine was confined to universities and women were formally excluded. It is an hypothesis of this research that the misogyny and gynocide of this time continues to play a part in the unconsciousness of women today, especially women who heal.

The chapter is completed with a brief look at the path of women into medicine so that we can better understand the ground on which today's medical woman stands.

2. Symbols, Myths and Archetypes

The power of symbolic language

The power of symbolic language is its capacity to connect directly with the unconscious, operating pre-verbally and by-passing rational thought. Carl Jung describes the symbolic as that which 'implies something more than its obvious and immediate meaning. It has a wider 'unconscious' aspect that is never precisely defined or completely explained' and notes that 'As the mind explores the symbol, it is led to ideas that lie beyond the grasp of

reason' and 'we constantly use symbolic terms to represent concepts that we cannot define or fully comprehend' (Jung 1964 p 4).

I am working with the symbolic language of myths involving the feminine as a way of accessing knowledges that are outside rational thought, 'beyond the grasp of reason', knowledges that have been hidden by millennia of structures and thought systems that have made the feminine into a caricature of what is possible. I am searching for her, for her full possibility and, along with Jung, believe that 'we shall certainly get closer to it in the sphere of ancient mythologies… than in the consciousness of modern man.' (Jung 1964 p 36).

Jung states that it is the role of religious symbols to give meaning to the life of 'man' (Jung 1964 p 76). Carol Christ agrees with him and summarises the power of religious symbols thus 'Symbols have both psychological and political effects, because they create the inner conditions .. that lead people to feel comfortable with or to accept social and political arrangements that correspond to the symbol system' (Christ and Plaskow 1979 p 274). The implications go further than that. What has not been made available within a culture by way of story, image or symbol cannot be thought.[15]

Jung insists that cultural symbols contain 'numinosity', with the power of a 'spell' and that they can 'evoke a deep emotional response in some individuals, and .. are important constituents of our mental make-up and vital forces in the building up of human society; and they cannot be eradicated without serious loss.' (Jung 1964 p 83). Women experienced this 'serious loss' when the feminine and women were expunged from history, religious iconography and the public realm (Miles 1989).

Medicine is also responsible for this 'serious loss'. At the Wellcome Institute of the History of Medicine and Related Sciences in London, the most complete collection of images of Western medicine in the world, I searched for images of women doctors. I found twelve among 7000 images in their collection. When young women walk into the medical faculty and the anatomy department and see portraits of men as their professors and distinguished leaders in the profession, when they walk the corridors of the Royal Australasian College of Surgeons and see portraits only of men, the knowledge that they are not meant to be there, in those roles as actors in their own profession, lodges deeply in the unconscious of some, and rules their feelings and behaviours.[16]

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[15] As an example, in mythology, dragons and serpents represent earth based feminine wisdom and this is represented in the universal symbol of allopathic medicine, the Caduceus, the winged staff of Mercury the messenger. According to Campbell the serpent represents 'the rhythmic, circling round of the lunar tides of time' Campbell, J. (1976). The Masks of the Gods: Occidental Mythology. New York, Penguin Books.which contrasts with the patriarchal, left brained and monotheistic religious tradition that time is linear and finite. The patriarchal story is that heroic males, such as St George, have to go around killing dragons to keep them from swallowing maidens. Another interpretation is that, mythologically, being swallowed by a dragon, or python, is being initiated into the feminine mysteries. Henderson describes the dragon as 'a symbolic image for the "devouring" aspect of .. attachment to .. mother Henderson, J. (1964). Ancient Myths and Modern Man. Man and his Symbols. C. Jung. London, Aldus Books. The rescue by St George is thus a metaphor for the rational masculine 'rescuing' modern humanity from the irrational, superstitious and devouring nature of the feminine principal, and he does this by destroying the beast that symbolises and informs the feminine.

16 The Royal Australasian College of Surgeons in Australia hung its first portrait of a woman councillor, Dr Deb Colville, in its gallery in 2003 and in the same year elected its first female president.

Archetypes

Symbolic language has great power in creating what is possible in the minds of people, particularly the unconscious mind. Jung believed the 'experienced investigator of the mind' had to be knowledgeable about symbolic language and 'mythology in its widest sense' in order to understand what was going on (Jung 1964 p 57). Symbols can be collective in their nature and origin and it is these symbols that he terms 'archetypes'. Archetypes, he says, have no identifiable origin in human thought, but rather are "collective representations" of archaic instincts, emanating from primeval dreams and creative fantasies.' (Jung 1964 p 42). He describes archetypes as instincts that reveal themselves through symbolic images and 'influence and characterize whole nations and epochs of history' (Jung 1964 pp 67-68). They contain both images and emotions, 'pieces of life itself- images that are integrally connected to the living individual by the bridge of the emotions.' (Jung 1964 p 87).

Jungian analyst Eric Whitmont uses the language of gods and goddesses in his work, noting that the modern mind might find these words archaic but that they are:

> 'archetypal and compelling ideals (and) these symbolic representations are real and powerful…. They arise as energetic configurations from very deep levels within us and can elicit tonifying responses not possible through mere abstract thought.' (Whitmont 1983 p x).

He describes archetypes as timeless images that 'provide patterns of behaviour, emotion, and perceptual experience that transcend personal history' and myths as 'the ever-recurring collective dreams of mankind' so that the 'integrity of an individual life, no less than of the collective life that is culture, depends upon the myths. Their archetypal themes give form and meaning.' (Whitmont 1983 pp 29-30).

One of the challenges of working with the archetypes represented in myths is that the legends we have inherited represent patriarchal consciousness. Victors write history, and European history as recorded in literature is exactly that, his story. Women are almost absent as autonomous subjects although they do appear as witches, mothers, whores and manipulators. Archetypes and myths, then, matter in the daily lives of all of us. We would do well to know what they are, for according to Jung, myths set the tone for a whole society.

Myths

Jung and Henderson both outline the universal myth of the heroic male who defeats evil manifested as dragons, serpents and other monsters[17] and who liberates his people from destruction and death.

I will demonstrate that the hero's journey has set the tone of society, to the detriment of women, because the hero's journey is not the heroine's journey. She must take her own path and for that she needs stories that speak to her unconscious and provide possibilities for transformation. Stories of the heroic feminine are largely denied to women in Western culture, who instead are fed a constant diet of sacrifice and subordination, of the virtue of

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[17] Without remarking that dragons and serpents are symbols of female wisdom.

handing over their creative life force in support of the male endeavour. Psychiatry has been a key player in defining self-sacrifice as 'normal' female behaviour and punishing women who transgress (Astbury 1996; Kulkarni; Quadrio 2001). Medicine is deeply implicated in this story of the reification of the masculine at the expense of women, and this makes the relationship between medicine and women, as doctors, deeply problematic.

It is a feature of the Greek heroic tales that the hero has a tutor, guide or mentor. Theseus had Poseidon the sea god, Perseus had Athena, and Archilles had Cheiron, the wounded healer and wise centaur, to guide them through the challenges of the journey (Henderson 1964 p 101). The absence of mythic mentors for women is paralleled by the struggle women in medicine have today to find mentors for their professional development.

Searching out the pre-patriarchal feminine

Many women and men who are puzzled by the absence of women from the construction of public and symbolic life have gone back to the archaeological evidence and myths to find representations of the feminine and of women that have not been corrupted by the prism of patriarchy, anticipating that myths and cults of goddesses might provide alternative resources for modern women's identity (Ehrenreich and English 1973; Campbell 1976; Daly 1979; Fiorenza 1983; Whitmont 1983; Christ 1987; Rowan 1987; Downing 1989; Miles 1989; Murdock 1990; Leonardo 1991; Ruether 1993; Pollack 1997; Shlain 1998; Gimbutas 2001).

Joseph Campbell provides a carefully researched guide to the value of myths in understanding the essence of the feminine and her overthrow in the pre-Christian era. I will quote him at length because he tells the story eloquently. He begins with the assertion that:

> "it is now perfectly clear that before the violent entry of the late Bronze and early Iron Age nomadic Aryan cattle-herders from the north and Semitic sheep-and-goat-herders from the south into the old cult sites of the ancient world, there had prevailed in that world an essentially organic, vegetal, non-heroic view of the nature and necessities of life that was completely repugnant to those lion hearts for whom not the patient toil of earth but the battle spear and its plunder were the source of both wealth and joy. In the older mother myths and rites the light and darker aspects of the mixed thing that is life had been honoured equally and together, whereas in the later, male-oriented, patriarchal myths, all that is good and noble was attributed to the new, heroic master gods, leaving to the native nature powers the character only of darkness – to which, also, a negative moral judgment now was added. For, as a great body of evidence shows, the social as well as mythic orders of the two contrasting ways of life were opposed. Where the goddess had been venerated as the giver and supporter of life as well as consumer of the dead, women as her representatives had been accorded a paramount position in society as well as in the cult. Such an order of female-dominated social and cultic custom is termed, in a broad and general way, the order of Mother Right. And opposed to such, without quarter, is the order of the Patriarchy, with an ardour of righteous eloquence and a fury of fire and sword.' (Campbell 1976 pp 21-22).

Joseph Campbell has much to say about myth. He claims ancient myths live subliminally within our unconscious. Myth and memory are inseparable. Where there is conscious thought being acted upon there will be myth (Campbell 1991). The invisibilisation of women from the history of medicine, the elimination of the memory of having been rightfully in the work of healing, is a deep wounding for women, and is the impetus for my

search among the myths and legends for the undomesticated feminine who can inform the subconscious of medical women today, if they have access to her.

3. The feminine

This research is about the feminine and the way that is reflected in the lives of doctors who are women.

The concept of 'the feminine' is itself problematic. There is both a difference and an overlap with 'woman'; and with the Jungian notion of anima as the feminine principle in men. Many feminists challenge the essentialising notion of female/women as a distinct and homogeneous group (Irigaray 1985; Bordo 1993; Butler 1999); psychology, psychiatry and psychoanalysis have deep theories about how female identity is established, and there is a symbolic language drawn from millennia of association between women and specific representational symbols, particularly the spiral, the moon and the serpent/snake/dragon.

In this study I will touch on each of these, concentrating on the symbolic and mythic language of the feminine on the understanding that it informs the unconscious of medical women in ways that are not usually brought to awareness, and yet in ways that matter.

Mythic feminine

An exploration of the mythic feminine is intended to provide the background to understanding the depth and power of some of the unconscious forces that operate among women in medicine today (Wehr 1988). It will be argued that the position of woman as 'other' (de Beauvoir 1953), her energies subordinated in service to the reified masculine and her voice all but silenced in the public domain, is not the natural order of things but rather the result of systematic processes that destroyed the goddess and installed a monotheistic male god over a 1500 year period some 3000 years ago. The major sources for the myths that will be discussed are Barbara Walker (Walker 1983), Eric Whitmont (Whitmont 1983), Joseph Campbell (Campbell 1976), Leonard Shlain (Shlain 1998), Robert Graves (Graves 1955), Rosemary Radford Reuther (Ruether 1993) and Maria Gimbutas (Gimbutas 2001).

The story that will be told of the feminine in myth, archetype and history is a version of events that works in the context of this research. It is a story that draws on the work of others in searching for the feminine in history, archaeology and theology. I make no attempt to undertake the historical research from primary sources myself in this thesis but rather have relied on secondary sources that have glimpsed a view of herstory within history in their search for answers to the same question I am asking "how and when did women lose the keys to the kingdom ?" The answer to this question is central to deconstructing the culture of Western medicine and I have placed the search for the answer as central to this thesis for two reasons.

The first is to locate the times in the European tradition when the feminine was valued differently from the way it has been valued during recorded history. This is important to those women today who are struggling to find their way into the public domain, to be heard, and to be co-creators of the knowledge they are learning and practising. If there were a time when women and men worked cooperatively in the public sphere and gods and goddesses shared the mythical space, then the patriarchy that has structured social relations

in modern times is just one form of human organisation, rather than the 'natural order' of things. As Mary Wakeman said 'To see patriarchy coming into existence is also to see it passing away' (quoted in Ruether 1993 p 41).

The second reason is to flush out the archetypes and myths that may be affecting the experience and behaviours of women doctors (Wehr 1988; Ruether 1993), and to work with the myth of Athena as an archetype for medical women. I am using the unconscious here in the Jungian sense, with the limitations of a lay person and aware that the 'unconscious' is itself the subject of considerable study in the disciplines of psychiatry and psychotherapy (Freud; Jung 1961; van der Post 1976; Wehr 1988). A detailed examination of such work is beyond the scope of this study.

These archetypes and myths will also shed light on the possible qualities of the feminine which reach beyond the narrow construction available to women today. The feminine has been devalued so completely in European culture, and for so long, that it takes years of research and practice to uncover her potential and hint at what is possible (Daly 1973; Daly 1979; Whitmont 1983; Daly 1984; Ruether 1993; Clement and Kristeva 2001). Women have been ignored in written history and invisabilised in the story of European development. The feminine is now being written back in to history (Miles 1989; Shlain 1998) and theology (Fiorenza 1983; Daly 1985; Osiek 1986; Christ 1987; Ruether 1993; Clement and Kristeva 2001). Feminist scholarship since the 1970s has provided rich sources for re-creating knowledge with women in mind (Daly 1979; Bordo 1987; Leonardo 1991; Bordo 1993; Weiner 1994; Astbury 1996; Kulkarni; Usher 1997; Wear 1997; Doyle 1998; Armour 1999; Oakley 2000; Quadrio 2000; Manderson 2003; Ubach, Scott et al. 2003).

The ancient myths that speak of the authority of the goddess and the potential of the feminine provide a lens through which to examine what is possible in the encounter between women and medicine described in this thesis.

Identifying the feminine

Once upon a time, a long time ago, women contributed to the definition of the public realm alongside men in Europe and the Middle East. Ancient mythology tells of the role of the goddess and of her incarnation, woman, in birthing the world and in birthing human life (Shlain 1998; Gimbutas 2001). A time that Campbell calls 'the great Age of the Goddess' (Campbell 1976 p 477). This was pre-patriarchy, when gods and goddesses shared the heavenly pantheon, when the Amazons roamed the steppes on horseback (Walker 1983) and in Crete there was a peaceful society without battlements where women and men ruled together and women too were healers and priests (Gimbutas 2001).

Archaeology and anthropology have documented pre-literate societies where the fertile female was the primary symbolic figure. For example Reuther begins her analysis of female and male images of the Divine with the assertion that "From Palaeolithic to Neolithic times and into the beginnings of ancient civilization, we find the widely diffused image of the Goddess without an accompanying male cult figure' (Ruether 1993 p 47). Reuther calls this principle the 'Goddess as Primal Matrix' and argues that this image has survived in the metaphor of the divine as 'Ground of Being', where the divine is not 'out there' as abstracted ego, but beneath and around, grounded and material, the source of life and renewal, and spirit and matter are not split hierarchically (Ruether 1993 p 49).

The archaeologist, Margaret Ehrenberg, undertook a detailed study in search of evidence that there were times and cultures pre-patriarchy when women had equal status with men. Her measured conclusion is that 'although the social status of women has long been inferior to that of men, it must also be remembered that the foraging societies of the Palaeolithic and Mesolithic spanned an immense period. So, throughout human history, the great majority of women who have ever lived had far more status than recently, and probably had equality with men.' (Ehrenberg 1995 p 173).

It was a time of deeply earthed instinct, of the honouring of cycles, of Mother Earth, of harmony with nature. It was pre-scientific and non-rational and instinctual. It was a time that was overthrown by the patriarchy when the goddesses withdrew and left the world to 3-4000 years of masculine dominance. The symbols and myths of this time are reappearing in Western consciousness now and can provide insight into what women are capable of thinking (Whitmont 1983; Ruether 1993).

According to Eric Whitmont the notion of male and female as different is 'an archetypally predetermined perception, patterned in the unconscious psyche' and the most basic of the dualisms (Whitmont 1983 p 128). Accompanied by Susan Bordo and Stuart Clark I will examine the impact of dualistic thinking a little further on in this thesis (Bordo 1987; Clark 1997).

The feminine principle in the West has the moon and Venus as its mythological, alchemical and astrological symbols. Whitmont describes the moon as embodying actualisation, the senses and sensuality, the soul and the body, 'a matrix for fantasy and dreams.. container and holder of the life energies' representing the collective in terms of inner consciousness that focuses on playfulness and imagination, open to the intangible and susceptible to the mystic, magical and psychic'. Venus is associated with 'joy, pleasure, artistic expression, and the appreciation of beauty and harmony' (Whitmont 1983 p 129). The feminine is associated with the right hemisphere of the brain, and on the whole women act out of the feminine, while containing within them an 'animus', or masculine potential (Whitmont 1983 p 142).

The masculine potential draws on the archetype of the masculine, represented by the sun, Mars and Saturn. According to Whitmont the solar principle stands for 'spirit, logos, creativity and self-conscious awareness, the striving for consciousness and separateness, purposefulness and authority' while Mars includes Eros, the god of sexual attraction and desire, as well as being a warrior god embodying courage, the active principal, aggression, determination, brutality and destructive hostility.[18]

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[18] Jung described the feminine thus:
"The goddess, in my thinking, is the movement of the spiral. Like so many things in nature (plants, the seasons, the moon) the goddess moves in the darkness as much as in the light.
She lives in the present and evaluates the moment. What is right today may be wrong tomorrow. She lives by the spirit, not by the law. She demands constant awareness and spontaneity.
She loves the potential in things: the possibilities in the growing plant, the growing child, the growing hopes and dreams. She trusts life: trusts change, trusts love and holds nothing static. She loves and lets go. She loves with her whole being, so that vulnerability becomes her greatest strength.
What, for those who do not love her, is a contradiction, for those who do love her becomes paradox."
Jung also notes that while nature and the goddess are beautiful and generous, in the shadow is 'the cruel goddess' Jung, C. (1964). Man and his Symbols. London, Aldus Books..

Whitmont continues his description of the archetypal forms of the feminine:

> "intuitional and impulse-dependent, unsystematic and given to fantasizing, dreaming and wishing. In spiritual or creative activity it is inspired rather than analytic. It is receptive toward what is felt, the impulse, or even invasion, by the spirit. That sense is stronger than the sense of self as originator. Insights have to mature, to be assimilated into a total organic feeling experience if they are to be real. The feminine experiencing is thus given over to, or interconnected with, the processes of growth and decay, the natural cycles of living, ripening and dying, and the rhythms and periods of nature, spirit and time. Thus, we designate it moon-attuned. Feminine consciousness experiences time as quality, not as an abstract measure of action. As a result, it is attuned to the mood, meaning, and favourable or unfavourable quality of the given moment…This outlook may be called meditative and oriented toward the existential and experiential mystery. It is less impressed by the analytic and by ready intellectual verbalization. Consequently the archetypal feminine attitude is more empathy-and involvement-oriented than the more abstract masculine attitude. It is part of an extended natural field, where all elements are interwoven in circular rather than linear fashion' (Whitmont 1983).

Intuition 'that faculty for seeing below the horizon of time and round the corners of life' (van der Post 1976 p 243) is a powerful tool for the clinician, although not validated as part of the science of medicine. It is often claimed as part of women's ways of knowing (Gilligan 1982 p 969; Belenky, Clinchy et al. 1997; Bever 2002).

Yet paradoxically the feminine, according to Whitmont, for this very reason, shares in the very impersonalness and playfulness of nature in its more ready acceptance of suffering, of cruel necessities, of severance and destruction and the necessity to inflict them. Whitmont also names a feminine urge to personalization and involvement that is active, transformative and unconcerned with relatedness. The feminine has also been depicted as the queen of heaven, life and fertility 'awakening life and setting it to rest she represents energies that cannot be contained or made certain or secure' and accepts life as an ever-changing process, just as women's biology involves continuous change (Whitmont 1983 pp 133-134).

Wehr critiques Jung's notion of the feminine, which is shorthand for 'the feminine principle', and especially his tendency to confound it with the masculine anima, which is described as organic, awesome and powerful. She describes how Jungian theory understands part of the reason why, as a group, men need to keep women under control and outside professional authority. She identifies the confusion between Jung's anima (the female principle in men) and real women, and in particular how men experience the anima as powerful, while women experience themselves as powerless in the world, and concludes:

> 'With an anima as powerful as this, it is not surprising that men have tried to depotentiate women in the social sphere. Since they tend to confuse their animus with real women, the combination of powerful animus and powerful women would overwhelm them. Thus men need to keep real women from gaining real power, authority, and respect in the 'outer' world (Wehr 1988 p 107).

Wehr argues that women's assumed closer association with the unconscious and its apparently 'magical' qualities is likely to be a result of their subordinate position, for

lacking power to control her outer circumstances, her very life may depend on finely tuned observation and reflection of the behaviour of the dominant group (Wehr 1988; Bever 2002). She has to 'get it' first, to see it coming, so she can get out of the way if she has to. It may be also that 'women's intuition' is a result of thousands of years of patriarchy that has silenced her, leaving her space for reflection and requiring exquisite attention.

So it is possible to find the original feminine, buried in myth and archetype, and I go on to describe some of the myths that describe her. However I acknowledge Butler's challenge to the dualism of the construction sex and gender itself, demonstrating that both sex and gender are continuums and that people move among them throughout their lives (Butler 1999). This radically destablising notion is acknowledged but does not form part of the explanatory paradigm of this thesis.

The untamed feminine

I have hinted that the feminine has a dark side, the untamed feminine that is so frightening it has been savagely repressed. This is the side which is kept in Pandora's box.

The story of Pandora's box (slang for vagina) is part of the story of the overthrow of the goddess approximately 1500-1200 BC by the Greek gods. Zeus was angry that Prometheus had given the gift of fire to mortals and avenged himself on the mortals by creating women as malevolent and irritating companions. He gave Pandora to a Titan[19], Epimetheus, as wife, and entrusted him with a box containing all the ills of the world. Pandora was instructed to not open it, but in her quest for knowledge, like Eve, she did, and released the evil spirits that have tormented the world since. This story, like that of Eve, denigrates women, demotes the goddess and provides justification for the subordination of women (Shlain 1998 pp 128 - 129).

This fear of the potentially disruptive and untrustworthy (according to the patriarchal order) nature of the feminine is one impetus for the determined, structured, multi-layered, unforgiving and relentless intention throughout the world to keep the feminine suppressed and in service (Irigaray 1985; Miles 1989 p 14).

Isis and Inanna/Ereshkigal

The mythic feminine is also an impersonal force that can devour, destroy, incubate and bring to birth with implacable pitilessness' (Whitmont 1983 p 135). She wields power and authority with imagery unavailable to women today. For example, Isis is a pre-patriarchal Egyptian god and she describes herself thus:

> 'I am she that is the natural mother of all things, mistress and governess of all the elements, the initial progeny of worlds, chief of the powers divine, queen of all that are in hell, the principal of them that dwell in heaven, manifested alone and under one form of all the gods and goddesses. At my will the planets of the sky, the wholesome winds of the seas, and the lamentable silences of hell are disposed; my name, my divinity is adored throughout the world, in divers manners, in variable customs, and by many names… the Egyptians, which are excellent in all kind of ancient doctrine, and by

[19] Half god, half human.

> their proper ceremonies accustomed to worship me, do call me by my true name, Queen Isis.' (Campbell 1976 p 41).

Whitmont draws on Sumerian poetry to describe the features of the goddess Inanna, a lion-goddess of war: 'all-devouring in power and angry heart.. ambitious, regal and powerful' (Whitmont 1983 p 134). Her untamed nature makes her fierce and independent, self-willed, the undomesticated aspect of the feminine. In her dark side, as Ereshkigal, she rules over everything that seems opposed to life, full of fury and rage, overseeing rot, decay, gestation like impersonal forces that devour, destroy, incubate and bring to birth with implacable pitilessness. Whitmont argues that brought to the light of consciousness these can become elements of creativity, but that for the emerging patriarchal ego this aspect of the goddess/feminine was 'utterly terrifying' and one which had to be tamed and controlled to avoid confrontation with the 'awesomely dissolving and destructive, yet also dangerously attractive, abyss of the dark side of the goddess' (Whitmont 1983 p 135).

He traces the subordination of women to fear of the threatening power of her 'dark moon' side, to the ego's fear of the transformative function of the goddess/woman 'their roles as priestess, seeress, prophetess and magic healer', and concludes 'In all of these manifestations they have been ruthlessly persecuted' (Whitmont 1983 p 139). The persecution of the 'magic healer' is traced in this thesis as part of the underlying dynamic with which women in medicine must engage today.

The untamed feminine also looks like Lilith, Medusa, and Metis. Athena is there too, problematically. There are others, but I will tell here only the myths that directly inform this research.

Lilith

Lilith was Adam's first wife, like him made from the earth as his equal. They never found peace together. She disagreed with him in many matters and refused to lie beneath him in sexual intercourse, claiming they had been created equal and she had no intention of taking a subordinate position (Koltuv 1986). Instead Lilith sneered at Adam's crude sexuality, cursed him and flew away to make her home by the Red Sea where she dwelt in a cave and engaged in unbridled promiscuity, consorted with lascivious demons and gave birth to hundreds of demonic babies. When Lilith left, Adam was afraid and sacrificed Lilith's totem, the Unicorn. Lilith then took the screech owl as her companion for it can move in the dark and is a creature of the moon. God sent angels to fetch Lilith back. The angels threatened her with the death of 100 of her children every day if she did not return but she cursed them and refused, so God created Eve, this time from Adam's rib, as a more docile replacement.

Lilith has disappeared from the story told in the Bible, replaced by the more compliant Eve, but her daughters have continued to haunt men for thousands of years (Whitmont 1983). The Greeks call them the daughters of Hecate, Christians call them succubai, or daughters of hell. These are lustful she demons who visit boys and men in their sleep and ride them, causing nocturnal emissions and accompanying guilt and confusion (Walker 1983). She visits women too, and in previous times people were warned not to sleep alone because Lilith would visit and bring with her erotic dreams and nocturnal orgasm.

Lilith arose from chaos, a counter force to God's goodness and maleness. In the Jewish story God is paired with Shekhina in the realm above, and Lilith is paired with Samael, the Devil, in the realm below. Lilith is represented by the moon, cast out of heaven, the neglected, rejected feminine quality, the transpersonal feminine shadow. She became the bride of the Devil, and men experience her as the seductive witch. During the witch burnings of the early Modern Era women were punished again and again because of anxiety that they may follow in her footsteps.

Lilith is the original untamed feminine, that quality in women that refuses to be bound in relationship. She wants not equality and sameness in the sense of identity or merging, but equal freedom to move, change, operate intuitively without compromise and be herself completely. She arouses great anxiety in both men and women and as a consequence has been ruthlessly suppressed (Koltuv 1986). Women today can draw on Lilith's qualities to move on from the effect of traditional forms of relating with the masculine, forms that require 'qualities of dependence and submissiveness (that) has the effect of weighing a woman down, binding her up, and preventing her from becoming herself' (Koltuv 1986 p 22). Lilith can unbind with her qualities of freedom, movement and instinctuality, drawing on creative powers that were once the prerogative of the goddess, for Lilith contains the neglected and rejected aspects of the Goddess.

Koltuv maintains that:

> 'The sense of being cast out into psychological development is familiar in feminine psychology. As in many myths of women's individuation, there are the elements of surprise and force. Persephone reaches for a flower and finds herself dragged kicking and screaming into Hades. Psyche, pregnant by Eros, seeks a glimpse of her baby's father, and finds herself adrift in the world facing all the difficult tasks of individuation. Women, unlike men, do not shoulder a knapsack and sword, mount a steed, and go forth to meet a heroic challenge. Rather more Lilith-like, they have no choice, they feel cast out and forced into consciousness' (Koltuv 1986 p 24).

This time in the wilderness, filled with furious, fiery energy, transforms Lilith-consciousness into the wisdom aspect of the feminine, kept company by Lilith's owls and the moon, so that the wisdom of the night gains ascendancy within the individual woman over the solar consciousness she adopted in order to practice in the world.

Koltuv notes that while on a personal level there is a primary psychological need for women to know and integrate Lilith as 'both personal and collective shadow' the primary means for dealing with her has been to suppress or cast her out (Koltuv 1986 p 91).

Lilith's story speaks to images of humiliation, diminishment, flight into the wilderness and desolation, followed by fiery rage and revenge as seductress and child killer. As I will show these are qualities that medical women experience today, humiliation during their training, diminishment when they find themselves as 'other' in their own profession, flight into forms of life and practice that separate them from the medical mainstream, creating for themselves what I am describing as

'microclimates', and for an unknown proportion of women, recognition of the rage that is aroused by being so disregarded. The story of how this is manifest in medical women today unfolds in Chapters 6 - 8.

4. Losing the keys to the kingdom

There are many stories of the takeover by the masculine principle, stories which indicate that women did not lose the keys to the kingdom, they were stolen from women by brute force. The story of the takeover of the Delphic Oracle is symbolic of the silencing of women that continues today.[20]

Pythia

There was in ancient times, in Delphi in Greece, an oracular priestess, the Pythia, who served the gods and prophesied the future. Her attendants were priestesses and she was guided by a python, to draw her knowledge through trance and vision from the bowels of mother earth. People came from all the civilised world to seek her guidance on matters of business, love and war, and to align themselves with the gods. Carl Jung gives the example of the Delphic oracle who advised King Croesus that if he crossed the Halys River he would destroy a great kingdom, which proved to be true, although the kingdom was his own (Jung 1964 p 36).

The oracle was overthrown by Apollo who came ashore at Delphi, forcibly took control of the Pythia, and killed her familiar, the python, (just as Adam killed Lilith's unicorn). Apollo placed priests as interpreters between the Pythia and the people and thus began the silencing of women, which continues until this day.[21]

Freud, of course, created a whole branch of knowledge based on the assertion that women did not know what had happened to them and their stories were fantasies (Irigaray 1985; Astbury 1996; Quadrio 2001). The Oedipus complex, in which he maintained that women who told him they were sexually abused as children were really fantasising and suffering from penis envy, is still deeply embedded in psychiatry, medicine and the law.

One survived

A pivotal point in the story of the demolition of the feminine lies with Athena and Medusa. They were the last of the independent female deities, the others having been systematically destroyed or subjugated by the male gods.

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[20] Cassandra also was an oracle. She received the gift of clairvoyance by sleeping in the temple of Apollo and allowing snakes to lick her ears. When Apollo tried to seduce her she rebuffed him and he punished her by declaring that no-one would pay attention to her forecasts. She prophesied the fall of Troy but no-one would listen to her – to their peril, just as no-one listens to women today.

[21] It is an interesting aspect of this story that Apollo was assisted in this by dolphins, feminine creatures of water, which is a feminine element. The dolphins brought him to shore from the watery depths, whereupon he climbed the hill to the Pythia's sacred place. Today many medical women are puzzled by women who undermine them, and appear to side with the dominant males, when they attempt to introduce changes to medical culture so they can feel fully included. Athena's story sheds more light on this process of women denying women.

Athena

Athena has many names and many legends in her name. I have chosen to call her Athena, unless one of her other names such as Athene, which is commonly used, is more appropriate. Athene/Athena originally came from North Africa. She was the Libyan Triple Goddess Neith, made up of Metis, Medusa, Anath, or Athe-enna. Metis/Medusa was the Destroyer aspect as well as the serpent goddess of female wisdom, symbolised by the female face surrounded by serpent-hair, which is an ancient symbol of divine female wisdom.

Athena was the daughter of Zeus and Metis. Zeus was the major god of classical Greece and mythically responsible for taming the goddesses of the Old European culture. Zeus wanted to steal the wisdom of Metis. Metis was pregnant with Athena when she turned herself into a fly to escape from Zeus, who promptly swallowed her. Metis thus gave birth to Athena inside Zeus. He began to suffer an excruciating headache and Hephaestus took a double sided axe (the labrys, feminine symbol from Crete) and cleaved his skull in two. Athena sprang out of Zeus's head as a full-grown woman, wearing flashing gold armour, holding a sharp spear in one hand and a shield in the other, and emitting a mighty war cry. Following this dramatic birth Athena associated herself with Zeus, acknowledging him as her sole parent. The goddess never acknowledged her mother, Metis. In fact, Athena gave the appearance of being ignorant of the fact that she had a mother (Walker 1983).

Athena was the beautiful warrior goddess who protected her Greek heroes in battle. She was the goddess of wisdom and crafts, a master strategist, diplomat, and weaver, and patroness of cities and civilization. She was a major contributor to many of the developments of civilisation, contributing to the crafts, inventing the flute, trumpet, pottery, metallurgy, spinning and weaving and was the major goddess of the city of Athens. She helped Jason and the Argonauts build their ship before setting out to capture the Golden Fleece and assisted the Greeks in bringing down Troy. (Johnson 1977; Walker 1983; Pollack 1997; Gimbutas 2001).

Athena in the Eumenides by Aeschylus declared that she sided with the father against the mother in all things except marriage – which she shunned. She avoided the company of women but nurtured heroes such as Odysseus, Theseus, Hercules, Perseus, and Erichthonius. Her virginity meant she could consort with men as an equal and engage in the masculine pursuit of war (Christ 1987). In another story of betrayal, of siding with the father, Athena is called upon to judge a conflict between Orestes, who murdered his mother, Clytemnestra, to avenge the murder of his father, Agamemnon, after the Trojan War, and the Furies, archaic female identities beyond the control of the male gods who were intent on punishing Orestes for matricide. Athena sides with Orestes, claiming that as she was not born of women respect for mothers is misplaced (Shlain 1998 p 151). In doing so she turns away from the independent aspect of the pre-patriarchal feminine and puts herself in the service of the new male gods.

However Athena's snake-haired shield was invested with power to turn men to stone. The Gorgon was Athena's Destroyer aspect. (Walker 1983 p 74).

Christ points out that Athena might be born from the head of Zeus, but her temple on the Delphi mountain and on the Parthenon hill, and her companions, the owl and the snake, remind us of her connection to the older, chthonic (pre-rational, instinctual, earth-based) Mountain Mother and the Lady of the Animals. Athena's roots in the prehistoric

goddesses were not fully obscured by her allegiance to Zeus. Her companion animal the owl (remember that Lilith also has an owl as her familiar), the snakes hiding behind her shield, and the olive tree that she caused to spring up on the Parthenon hill, suggest the autonomous feminine lies within (Christ 1987 p 172-3).

So Athena is a complex figure. She is the last surviving goddess, and survived the take-over by the patriarchy by aligning herself with it. She had no external mother or childhood. She is an intellectual construct, and she served her father well. She became a god of learning and of civilisation and of culture, she was also a healer who cured blindness, and the owl she had as her familiar is perhaps a secret sign that part of Lilith lies dormant within (Wynn 2000). She is a potent allegory for the competing allegiances medical women experience, as they seek to find and hold their authority, autonomy and voice as women while staying safe in service to the heroic masculine.

Athena and Medusa

Medusa was the serpent goddess of the Amazons and the Destroyer aspect of the Triple Goddess. None could lift her veil and look upon her lest they be turned to stone, to look at the face of death was to die (Walker 1983). She was the only mortal among the three Gorgon sisters, who were originally beautiful sea goddesses who lived on the edge of the world, guarding the golden apples of the Hesperides, the place of transition between this world and the next (Campbell 1976 p 153). Medusa was pursued by many lovers, and eventually lay with the sea god, Poseidon, in one of Athena's sanctuaries. In a fit of jealousy and rage Athena transformed the sisters into ugly hags, and then assisted Perseus, the son of Zeus, to kill Medusa. He brought her severed head to Athena, who then attached it to the front of her shield.

So Athena hides behind, and is perhaps protected by, the mask of the last of the powerful feminine images, disguised as a terrifying hag, perhaps to divert attention from what is really going on. Medusa had become pregnant from lying with Poseidon and from her severed neck sprang Pegasus, a winged horse which pulled the chariot of Zeus. The feminine principle in service to the masculine, yet with the power to covertly lead the way (Campbell 1976 p 25).

The story that has Medusa as one aspect of the Triple Goddess, who was Athena's mother, makes Athena's role in destroying Medusa matricide, the most psychologically devastating act of self-hatred for women. In the real world mothers are trained to tame their daughters through foot-binding, dressing in stiletto heels, cutting off the clitoris, confining them inside the house, teaching them to flatter young men and hide their intelligence, in order that they be acceptable to men and able to marry and find a place in society. Young women doctors who are drawn into disparaging conversations about older female doctors in order to be accepted by their colleagues, detailed in Chapter 5, may be unconsciously taking part in a similar process of matricide, unaware of the risk of self-hatred it generates.

It may be that helping Perseus strike down Medusa was necessary to allow Athena to survive the dark times until the feminine energy could rise again. Perhaps she agreed to be taken in and trained into the patriarchy and has at least survived when all the feminine forces who resisted were conquered or converted in service to the new male order. Perhaps Athena abets the slaying of Medusa partly as cover to ensure her protection by the masculine forces that had taken over. It is quite a common strategy for women in medicine to attempt to gain access to the inner circle by attacking other women and distancing

themselves from the feminine and in this way they are reflecting the story of Athena, forced to trade off the feminine aspect in return for survival in the patriarchy.

Athena may be a model for how women have found a way to work in medicine in relative safety. It is a model which requires them to valorise the intellect, distance themselves from their femaleness, and undermine other women.

According to Murdock an 'Athena woman' is a father's daughter; she deprecates her own mother and identifies with her father. She is bright and ambitious and gets things done. She has little value for emotional relationship; she lacks empathy and compassion for vulnerability. If she does not take the time to discover her mother's strengths and reclaim her deep connection to the maternal bond, she may never heal her separation from the feminine. Metis was not the last mother to be swallowed by male ego, and Athena was not the last daughter who discarded her mother in favour of dad (Murdock 1990 p 33-34).

Throughout this thesis I will refer to the myths relating to Athena to deepen our understanding of what is going on between women and medicine. At the symbolic level, it is the purpose of this research to track down what Metis might have said to Athena while still enwombed within Zeus, about how to sustain and protect the feminine, for she was the last of the independent goddesses. Athena's warlike disguise after all was designed for her by her mother. Metis dressed Athena in the cloak that would allow her to survive the dark ages ahead. Surely she had a purpose.

5. Defeat of the Feminine

Worship of the goddess was a significant feature of Mycenaean culture in the Bronze Age. Following a tidal wave that destroyed their coastal cities they were invaded and defeated around 1200 BC by a wave of Indo-European tribes people, fell into a Dark Age, and several centuries later Greek culture arose to replace the central role of the goddess with an emphasis on the heroic masculine and the relegation of the goddess to be the consort of the gods.

Males giving birth

As part of this process male gods took over birthing, although it required some convoluted story-telling to convert the great goddesses who were born of no-one, the original Great Mother, to minor gods born from a male body. Eve, we are told, was created from Adam's rib. Athena was born from Zeus's head so that the goddess of wisdom emerged from the brain of a male. Demeter, the great goddess of fertility and crops, had six offspring with Cronus. Told by an oracle that one of his children would murder him Cronus swallowed each of them as soon as they were born. Demeter fooled Cronus by substituting a rock when Zeus was born, and brought him up in secret. Zeus fulfilled the prophecy and killed Cronus, slitting him open to 'give birth' to Hera, Poseidon, Hephaestus, Pan and Hades, thus transferring the power to create life from the ascendant feminine to the male gods[22].

[22] Zeus subsequently gave birth to a child of his own when he rescued Dionysus, then a seven month foetus, and had him sewn into his groin and subsequently gave birth to him. In the myth of Orestes killing his mother, Clytemnestra, Apollo is said to defend him on the grounds that 'The mother is no parent of that which is called her child, but only nurse of the new-planted seed that grows. The parent is he who mounts.'

Aphrodite, for example, the goddess of love and sexual desire, was born fully formed from the ocean after her father was castrated and his genitals were flung into the sea (Shlain 1998 p 130). So these three aspects of the Great Mother, Hera, goddess of the hearth, Athena, goddess of wisdom, and Aphrodite, goddess of love have been birthed by males, and were motherless. In this way the central role in the mythic cosmos of the creator goddesses was subverted.

Strong goddesses continued to be included in the Greek pantheon but these revisions of the Old European gynocentric myths by the classical Greeks resulted in a radically diminished role for women, so that women came to be excluded from public life and scarcely participated in significant social, political or intellectual life (Gimbutas 2001).

Rise of male gods

In parallel with the changing role of women, the Greeks narrowed the scope of the feminine in mythology. The old goddesses remained, but were transformed to wives and in service to the male gods so that the Greek goddesses, while fulfilling roles similar to earlier Minoan-Mycenaean ones, now served male deities. In Gimbutas' analysis 'Rather than a central feminine force guiding the world, male powers dominated it' (Gimbutas 2001 p 153).

Henderson describes how Theseus represented the young patriarchal spirit of Athens. His heroic journey was to brave the terrors of the labyrinth and kill the Minotaur which he speculates 'symbolized the unhealthy decadence of matriarchal Crete' noting that 'In all culture, the labyrinth has the meaning of an entangling and confusing representation of the world of matriarchal consciousness' and concluding that 'Having overcome this danger, Theseus rescued Ariadne, a maiden in distress.' (Henderson 1964 p 117). Perhaps what was distressing Ariadne was the stealing of her birthright to autonomy and authority in her own right, in which Theseus was an active player.

There are aspects of the feminine which are ungovernable and chaotic, although not without natural laws of their own, and it is these aspects which were defeated in a titanic battle, and driven underground.

The conquering of the feminine lodges deep in antiquity. In Joseph Campbell's terms

> "It is the conquest of a local matriarchal order by invading patriarchal nomads, and their reshaping of the local lore of the productive earth to their own ends. It is an example of the employment of a priestly device of mythological defamation, which has been in constant use .. ever since." (Campbell 1976 p 80)
>
> This process turns the defeated people's gods into demons, and binds their rituals into new rituals for the new all-powerful god. It is a process which was implemented by Christianity in reconstructing the goddess into the servant Mary, and was repeated in Europe in the Middle Ages with the burning of the witches. Campbell says that the "battle was of two aspects of the human psyche at a critical moment of human history, when the light and rational, divisive functions, under the sign of the Heroic Male, overcame .. the fascination of the dark mystery of the deeper levels of the soul." (Campbell 1976 p 80).

Walker, B. G. (1983). The Woman's Encyclopedia of Myths and Secrets. San Francisco, HarperSanFrancisco. This was the Christian view even after the discovery of the ovum in 1827.

Table 3 summarises the relationship between eras, the myths that belonged to them, and the status of women.

Table 3 Timeline of the takeover

Time	Period	Myths	Women
	Minoan	Goddess rules	Women hold authority
C10-8th BC	Protogeometric & Geometric	Goddess rules	Women hold authority
C7th – 6th BC	Archaic	Goddess rules	Women hold authority
C5th – 2nd BC	Bronze age Mycenaean/Minoan	Gynocentric	Women hold authority
1200 – 500 BC	Dark Age		Overthrown
500 BC	Classical Greece	Heroic male	Lose social status, still involved in learning and medicine
0-2000 AD	Christian era/Piscean age	God the Father	Pushed into service
2012	Age of Aquarius	?	?

Barbara Walker says that the "most significant revolution in Greece was the transformation from matrilineal to patrilineal succession and the resulting destruction of clan loyalties" (Walker 1983 p 620). These processes began the world wide movement in which "Patriarchal religious authorities everywhere changed ancient systems of matrilineal inheritance to put property in the hands of men. This legal/ecclesiastical war on female property ownership went on century after century, until women were so hamstrung by the laws of God and man that they had almost nothing left that they could call their own."(Walker 1983 p 623).

Women, of course, resisted then and continue to resist now, and around the globe are working to change this reality, and women doctors are in the front line.

The alphabet

Shlain documents the concurrence of the invention of alphabet literacy with the defeat of the feminine (Shlain 1998). His conclusion is that 'It was not the Kurgan horsemen from the north who ended the reign of the Goddess, nor was it the creation of private property, nor surplus wealth… the central factor in the fall of the Goddess was a revolutionary development which occurred during the same period – literacy. First writing and then its more sophisticated refinement, the alphabet, tolled the death knell of feminine values both metaphorically and .. quite literally.' (Shlain 1998 p 39). Carl Jung dates the beginning of

'the civilized state' with the invention of script, which he dates as 4000BC (Jung 1964 p 6). French feminist philosopher, Luce Irigaray, has come to the same conclusion and advocates that 'we need to proceed in such a way that linear reading is no longer possible' (Irigaray 1985 p 78).

Religion

Reuther documents how Christianity has blamed women, in the guise of Eve, for the fall from grace in the Garden of Eden. This was the moment when she lost her original equality and became inferior and subject to the male as her superior. The thinking during the Protestant revolution led by Martin Luther was that 'This subjugation is not a sin against her, but her punishment for her sin. It is the expression of divine justice. Any revolt, or even complaint, against it by women is a cavilling refusal to accept the judgement of God.' (Ruether 1993 p 97).

Campbell demonstrates that this same takeover of the Mother Right by the patriarchy occurred in Ireland, when the Celts invaded and displaced the children of the Goddess Dana (Campbell 1976 p 40). Many of the rituals and forms of worship that developed before these takeovers were either converted to serve the purposes of the victorious culture, or were continued underground by the peasantry.

Christianity was joined by the other major religions (Hinduism, Islam, Judaism) in devaluing the feminine during the time of patriarchal ego development. This development was based on the devaluation of natural life and matter, of the mundane and the body and the concrete, which are all characteristics of the feminine. This was no passing fad, but an apparently necessary phase in human development according to Whitmont (Whitmont 1983 p 125). He concludes that:

> 'the devaluation of the Feminine, the Yin, the anima, and consequently also of women during the patriarchy, was a result of the need to separate the nascent ego from the encompassing field-consciousness of the magico-mythological world of need and instinct with its transformative (hence ego-threatening) dynamic of existence… A sense of individuality and freedom were to be achieved through reason, will and obedience to the Father God's rational law.'(Whitmont 1983 p 144).

So over time the feminine was defeated and withdrew and the gods took over. This is the point at which European culture turned toward 3000 years of patriarchy and in those 3000 years the central myths and history of the culture have invisablised women, and their contributions to the creation of knowledge have been erased from public consciousness. Women in medicine today step into this vacuum, expected to hold the authority invested in them by their training and skills to ease suffering and save lives, yet inhabiting a body and sex that has not been permitted to engage with power and authority or to command respect for 3000 years.

The mythical defeat of the feminine has its parallel in the real world and the lives of real women. One of the most savage ways it has manifested in European history was through the burning of the witches, a systematic attack on women and the feminine that at some points particularly targeted women who were healers. It is likely that this explosion of virulent misogyny continues to haunt the unconscious of women healers of today.

6. Witchcraft

Women healers struggled to continue their healing mission during a 200 year reign of terror in Europe during which tens of thousands of women were raped, tortured, dismembered and then burnt at the stake, drowned, hanged, beheaded or otherwise killed (Daly 1979; Barstow 1994). The purpose of including this part of women's history is to adumbrate the fear that women have today when confronted with implacable male authority. The story is particularly relevant to medical women because many of the women killed as witches were accused because of their activities as healers, midwives or carers, although others were protected from accusations because of these roles.

There is a substantial body of historiography devoted to the Catholic Inquisition and the Protestant witch trials in Europe. Detailed records were kept by the civil and religious tribunals and historians have examined these records as well as the writings of demonologists (who wrote about witches and Satan), many of whom were considered the leading thinkers of the time, and all of whom were men. This last point is important, because the interpretation of the meaning, and even of the facts of the witch trials seems to be strongly influenced by the sex of the writer (Bever 2002). I have not uncovered stories written by women themselves to describe their experience of witchcraft, except in novels (Learner 2003). It may be that the woman's view is not discoverable except through imagination.

An insightful contribution by one of the most transgressive writers on the subject, Mary Daly, is that the records of the witch trials were written by the same men who tortured the accused women, so that studying details of what was said or done will only provide this one-sided account of the experience (Daly 1979).

The Early Modern Era

Christians began burning heretics in about 1150 AD in Europe. The Catholic Inquisition was established around 1230 and in 1252 Pope Innocent IV explicitly authorised the use of torture during trials by the Inquisition. The accused was almost entirely stripped of their rights, due to the perceived gravity of the crime. Witches and magic were part of the European consciousness and had been since midway through the first millennium. By the mid-1300s there is a mixing of many elements of the notions of witch and of heretic. Between 1400 and 1500 there are small numbers of trials against witches and sorcerers in England, France and Germany and in 1484 Pope Innocent VIII appointed the priests Heinrich Kramer (or Institoris) and Jacob Sprenger, as Inquisitors in Germany, and listed the essential features of maleficia by which sorcerers and witches can be identified.

In 1487 Malleus Maleficarum (The Witch Hammer) was printed. It was attributed to Kramer and Sprenger, although written only by Kramer (Blecourt 2000). It proliferated into dozens of editions throughout Europe and England and had a profound impact on witch trials for more than 200 years. It was second in sales only to the Bible. The acknowledged purpose of the authors was to execute as many witches as possible. The Inquisition was guided by this textbook.

For the next 200 years thousands of people (it is estimated that about 80% of those tried and 85% of those killed were women) were tried and killed for witchcraft (Daly 1979; Barstow 1994; Heinemann 2000; Bever 2002). The greatest influence was felt in France,

Germany, Italy and England and witch trails were adopted by both Catholic and Protestant judges.

This was the period in Europe of the Renaissance, the beginning of the modern era. It was a period of revolution, radical social change, the emergence of capitalism and the breakaway of Protestantism from the Roman Catholic Christian hegemony. It was also a time when there was widespread anxiety that the end of the world was at hand. The evidence for this was the increasing level of sinful behaviour, and increasing evidence of the Devil at work as He sought to convert as many as He could before the Last Judgement (Clark 1997 ch 21-22). And thus it became urgent to closely follow the Devil's progress and thwart it at every turn. The burning of witches came easily to men who thought they were engaged in a struggle to the end with the Antichrist. Thought systems invoked magic alongside reason, and dualism underlay the processes of understanding. The valorisation of the heroic masculine and subordination of the feminine was continued from myth to the written word. And as we shall see later, continued from word to deed.[23]

The discourse of the time constructed women as intellectually inferior to men and spiritually and morally weak. It built on a long history of hostility to and denigration of women, from Aristotle's notion of women as deformed men, to the frank hostility of St Paul and medieval philosophers and theologians. One of the reasons witches were women was because it was impossible not to associate the category 'male' with normal behaviour.

The polarisation of thought and widespread use of opposites to elucidate meaning began with the early Greeks, was continued by the medieval Christians in their theology and moral philosophy, and became the dominant thought form in the Renaissance era. In that time it was 'insisted upon as a cosmological and cognitive paradigm of universal application' according to Clark (Clark 1997 page 36).

Dualism is very damaging to the status of women because classificatory groupings are hierarchical, with one set of terms superior and positive, the other inferior and negative. Unchallengeable terms include good and evil, sacred and profane, right and left, male and female. Each term is associated with the others in its group, so that evil, profane and female become associated with each other. Dualistic thinking led the early Jesuits to see the world as a battlefield of opposites, so that people and acts and events were either good or evil, and evil defined good by being its mirror-image.

All that was praiseworthy and to be aspired to was ascribed to the male side of the male/female dualism, and this was contrasted to all the devalued and subordinated terms that were associated with the female. This logic system was further fuelled by ascribing to women the sins of Eve, who had driven man out of paradise and brought upon her own head the curse of pain, suffering and toil (Clark 1997 p 121). Logic and monotheistic religion proved to be a deadly double for women, and culminated in women being named as witches and burnt at the stake.

[23] It is the purpose of this section to track the songline of the demonisation of the feminine from myth, to word, to deed.

Understanding demonology

Stuart Clark's exploration of the idea of witchcraft in the Early Modern Era begins by wriggling into the mind of the times through asking 'how did they 'know' witchcraft; how did they 'think' it ? (Clark 1997 page 26). He found that 'witchcraft was thought to have an objective existence with all the certainty that any knowledge system can convey' (Clark 1997 p 28). Witchcraft was the inversion of Christian thought, turning all that was good and useful on its head in a parody of convention. One purpose of parody is to affirm the natural order of things by dualistic thinking, contrasting them with their opposite. So the Devil was opposed to God, maleficence to beneficence, magic to Christian beliefs, nature to intellect, and female to male. Witches were needed to define the characteristics of godly, chaste and obedient women, just as Satan was needed to define the characteristics of God.

Witchcraft was 'an expansive forest of symbols' which were elucidated through torture, confession, trial and death. The details of the Sabbat in particular were rehearsed again and again in demonological texts, and people accused of witchcraft were tortured until they repeated back the details of their attendance at these events. The witches' Sabbat was an inversion of Christian worship, wherein white became black, up became down, and the rituals were held to mimic those of both Catholic and Protestant worship, but inversely. Witchcraft as described in demonological texts was 'ritualized contrariety', which was part of the process that led to the association of witches with women, so that women became 'accusable people' (Clark 1997 p 106).

Women who were accused of witchcraft were often women who were not under 'yoke or master', living independently, living by their wits, making their way the best way they knew how. This was a direct affront to the prevailing patriarchal order where the male headed household was regarded as both the source and analogical representation of good government, so that 'demonology superimposed image upon image of disorder' (Clark 1997 p 92).

Witchcraft then, was the inverse of Christian ritual and values. It was magical, disorderly and disobedient, overturning the natural order of things, and threatening established hierarchies and conducted primarily by women, many of them involved in healing or caring for others' bodies.

Clark speculates that the urgency of what he calls 'witch-cleansing' was related to belief in the Second Coming and the end of the world. Human kind needed to be cleansed of impurity and impiety prior to presentation before the Almighty. He does not speculate why killing women should be considered 'the final purification of religious life' (Clark 1997 p 376) but he does quote another scholar, L.P. Mair, saying 'The final elimination of witches is often among the promises made to their followers by the prophets of millenarian religions' (Clark 1997 quoted p 378). Clark speculates that the torture might be seen as part of the ordeal or initiation that would leave the community free to enjoy a 'sorcery-free future'.

It is not difficult to imagine that even tiny vestiges of this proposition lingering today might infect women's unconscious with fear and a sense that keeping their female selves invisible is a sensible move.

The accusations of witchcraft were random in the experience of women, meaning that there was nothing the accused woman could do to avoid the accusation, 'any woman could

qualify' (Blecourt 2000 p 288). This is critical to understanding the power of the witch-burnings to immobilize women and induce fear, even today. For medical women, the parallel is the apparently random acts of misogyny that destroy their confidence, block their professional development, and divert them from the places they want to go in medicine. To avoid this many medical women use strategies of silence and compliance, and are devastated when they do not work.

Much of the writing about women at the time was demeaning and hostile and demonology texts were no more virulent in describing women as despicable creatures than other texts. What makes their descriptions chilling and catches the attention of women in particular, is that their texts were used to move from theory (that women are weak, sinful and evil) to practice (that women commit sorcery, consort with the devil and should be burned at the stake). Demonology texts and other writings described women as emotional and difficult to discipline and thus a continuing threat to God's order. And women were descended from Eve, who was responsible for mankind being ejected from paradise because in her weakness she had been tempted to sin.

According to Roper

> 'Sorcery, too, taught that women were fearful creatures. When women grew older, when their powerful sexual desires raged even though they could no longer bear children, when maturity gave them a measure of wisdom and authority, their femininity could no longer be so readily tamed and chastened. As the sex whose bodies housed mystery, and who possessed the monopoly of physical care, women could also turn that power against those who were dependent upon them…. the most fearsome sorcerer, now understood as a mature women, a witch who had the power to castrate.' (Roper 1994 page 192-3).

Women today continue to have almost a monopoly on 'physical care' and female doctors more so. Those who are dependent on this care might feel hidden anxiety about the trustworthiness of the care giver, leading to a need to control and oversee her.[24]

Part of the role of the witch at the time was to identify the characteristics of the 'bad' woman, in order to highlight those of the 'good' woman.[25] The characteristics of the virtuous woman, complementary rather than inverse to the male, was to be 'pious, patient, silent, acting in conformity to male standards of female sexuality, domesticity, and religiosity, and above all, obedient' (Clark 1997 p 130). Transgressive women did not behave like that, and neither did witches[26]. Medical women do not behave like that either,

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[24] Women doctors, in fact, seem to have all the attributes of the 'fearsome sorcerer'.

[25] Heinemann is the only author I have located who, following Freud's explanations, explores the link between sexual abuse and stories of sexual congress with the devil. Read with modern eyes, many of the 'confessions' contain explicit descriptions of rape and incest. In some instances it seems as though the violated woman sought revenge by claiming demonic power and naming her attacker as the devil, and in others the man escaped attention by accusing her of witchcraft. In Heinemann's words 'Men escaped charges while the adult females, the mothers and women who were accused of witchery in these trials, were burnt at the stake.' Heinemann, E. (2000). Witches: A Psychoanalytic Exploration of the Killing of Women. London, Free Association Books. This pattern of punishing the violated woman continues in our law courts today, and is still in some pockets of obstetrics and gynaecology.

26 The German name for witch, 'hexen' is supposed to derive from the Amazons, those independent warrior women who lived without men.

and in-as-much as these expectations of appropriate female behaviour continue to manifest in modern culture, medical women are transgressive, as witches were.

Why witches were women

My reading of the literature suggests that up until the 1970s the fact that witches were, in the main, women, and that the demonology and trial records were deeply misogynist was unproblematic in the historical accounts (Whitney 1995)[27]. Feminist theorists and historians then began to explore the implications of the transition from the written misogyny of the demonologists to the killing of women and what it might mean for the lives of women today.

There seems to be little impact on male historians of the work feminist theorists and historians have undertaken to identify the gendered nature of the history of witchcraft and to problematize the misogyny. Their work is little quoted and when it is it is usually to discredit specific claims rather than to engage with the theoretical implications (Whitney 1995; Walker 1998). When male historians do engage with the problem that witches were women they seem content with an analysis that it was so because the witch-hunters defined sorcery in ways that implicated deviant women (Clark 1997).

Clark makes the point that vilification of women was so embedded in the culture, including that of medicine, that the theorists of the devil's work hardly needed to mention women at all.

The lack of interface between the work of male and female historians engaged in the study of the most virulent outburst of anti-women behaviour in recorded history is an exemplar of the struggle women have to engage the mainstream with their knowledge-making (Whitney 1995).

One exception is the work of Wellem de Blecourt (Blecourt 2000) who has written about why witches were women. He investigates the conflict of interpretation between the (predominantly) male witchcraft scholars and the (predominantly) female witchcraft theorists, arguing that the work of feminist scholars has not been integrated into witchcraft research. He considers the central question to be asked is how the 'overall male hegemony.. was (and sometimes still is) articulated through witchcraft discourse' and that the answer relies less on evidence than on interpretation. There is, he believes, 'an opposition between male research and female thinking' (Blecourt 2000 p 289) and, for example, the concentration on the numbers of men who were charged with witchcraft too 'reveals more a wish to refute the feminist position than a new understanding of past meanings and motives.' (Blecourt 2000 p 293).

Several of the leading feminist theorists describe how women living in a patriarchy protect their precarious position by attacking women who do not conform to the patriarchy's view of how women should behave, or by creating other women as 'outsiders' in an attempt to consolidate their own position as 'accepted' (Whitney 1995). They provide evidence that these processes operated in some of the accusations. They also operate among women in

27 Clark has only 40 references that have sex, gender or women in their title, out of approximately 1125 references dated later than 1800; all of the references mentioning sex, gender or women have been published after 1970

medicine, where women will attack other female doctors in front of men, or just join in general demeaning banter, with the (unconscious) motive of being seen as one of the 'insiders', as 'not like other (transgressive) women'.

The 'material implications' of the creation of the stereotype of witch lies in its application, such that all women were potential witches. Patriarchy at the time (and probably currently) protected women who stuck to the norms, so that the making of a witch was a social process focused on women who did not have male protection or ties within her community (Blecourt 2000 p 301). An allegation of witchcraft against a woman identified her transgressional crossing of male-designated boundaries at the wrong moment and served to keep all women compliant. Blecourt notes that the haphazard and contingent nature of accusations made them an ever present threat 'that could strike a woman at any time', compelling her to 'comply with patriarchal communal norms of womanhood' (Blecourt 2000 p 304). This mechanism and this threat still lingers.

Whitney is another historian who makes gender central to her inquiry. She concludes that 'The witch, not only as witch but also as woman, precisely encapsulated the nightmares of early modern Europe. In the early modern world, preoccupied with (male) hierarchical order and its converse, (female) unrestrained sexuality and disorder, the wandering or "loose" woman could not help being perceived as inherently subversive' (Whitney 1995 p 83). It is a thesis of this thesis that 'loose' women are still considered subversive and untrustworthy and that this legacy influences the experience medical women have of their profession.

Witches, then, were women, but not all women were witches. Good women were pious, patient, silent, sexually demure, domesticated and obedient. Transgressive women were the inverse of all these characteristics, they challenged patriarchal rule, were wilful, domineering, vocal and sexual, and their greatest sin was an intention to overturn the natural order of things, and 'end up on top' (Clark 1997 p 131). In fact, all the things that medical women are doing today.

The witch trials rid society of troublesome disruptive women and were a potent force in intimidating women into submission that may still be active today. Clark urges the modern reader not to be alarmed by the 'dismal misogynisms' evident in the texts of the time, maintaining that they have no more relevance to women today than Early Modern science or politics does to the science and politics of today (Clark 1997 p 114). Blecourt disagrees, noting that questions about the gendered nature of bewitching 'are not restricted to the late fifteenth and sixteenth centuries, when witches could end up at the stake, but extend to the present time' (Blecourt 2000 p 297).

Many of the views about women expressed in these texts continue to find currency in later times and their shadows lurk within the discourses of modern medicine today. In the 19th and 20th centuries women were locked in insane asylums instead of burnt at the stake for being spiritually and morally weak, loquacious and unreliable, unstable in behaviour and liable to depravity; accused of fantasising about sexual abuse by Freudians, and subject to surgery and vilification for excesses of lust (Scully; Chesler 1973; Daly 1979; Irigaray 1985; Grosz 1989; Astbury 1996). The rampant misogyny of the time has been toned down and women are no longer realistically regarded as intellectually inferior, but the distrust and fear of the feminine in medicine remains deeply embedded as an inadequately identified legacy.

Consequences

Witches lost their central place in theorising during the 18th century when natural philosophy was radically reconstituted. Natural theology (which required divine intervention in the order of things) was replaced by rational theology in which God was held to be omniscient and prescient rather than interventionist in a daily sense (Clark 1997 p 299). With the distancing of God from daily affairs, the Devil was also no longer required to explain the inexplicable. With rational theology came rational science, a science based on observation and an understanding of the ordered nature of nature, a 'mechanical' view of nature that has prevailed since. The witch burnings then, could be considered part of the process of science cleansing itself of magic, part of the triumph of mechanistic thinking ushered in by Descartes. The witch burnings were the backdrop to the fierce competition among medical paradigms – Galenist, Paracelsian, iatrochemical, mechanistic – that was part of the scientific revolution of the early modern age (Clark 1997 p 259). That modern science and with it, modern medicine, rose from the ashes of the witches pyre makes the relationship between women and medicine highly problematic (Easlea 1981 p 64). The witch hunts were, according to philosophers Green and Bigelow 'a moral disaster of epic proportions' because there 'are no witches' (Green and Bigelow 1998 p 199). Modern science began when the mass killing of witches began, and medicine was involved.

Bever is one of the few non-feminist scholars of the witch craze to consider the impact on women at the time, and in later times. He acknowledges that although many of the accused were not put to death, more underwent 'excruciating torture' and the others had time to fear it while they languished in jail. Even those who were freed were often banished, had their assets confiscated or were locked up in poor houses. The ones who escaped these fates spent the remainder of their lives under suspicion and close scrutiny. He recognises that 'these threats remained long after the torture and executions ceased' and that 'the early modern witch persecutions constituted a wide-ranging and multifaceted repression of individuals exhibiting certain behaviours and attitudes, basically women who exhibited strong sexual, physical or psychological aggressiveness.' (Bever 2002 p 973).

Bever traces the impact through four generations of women. The daughters of the first generation of witches 'would have lived her whole life in the shadow of the stake' , and by the fourth generation the girls would have been well taught about the behaviours that might attract suspicion of witchcraft. He speculates that the persecutions declined as a result of their success in restructuring women 'from a feared source of violence and disorder to a presumptive fount of gentle succour' and contends that the central dynamic of the witch burnings was ' a struggle for power'. Women lost the struggle, and so the persecutions made a 'critical contribution to the "domestication" of women in the early modern period.' (Bever 2002 p 974-5)

Fearing that they would be accused of being a witch, women learned to hold their tongues (Whitney 1995), learning again the lessons of Cassandra and the Pythia. By the 19th century European women had become completely docile and almost totally silent in the public domain (Barstow 1994), cowered by the reign of terror into hiding their achievements, bridling their forcefulness, taming their ambition. How are medical women to manage the contradiction that they are required to draw on their authority, to channel ambition and seek to achieve, while the witch-burnings smoulder in the background and fear lurks in the corridors of the profession.

I can only speculate on the mechanism of collective memory that might be behind the frisson of fear that many women healers of today, doctors, midwives and nurses, experience when they hear of the details of the attacks on the witches. For many women too, learning of the details of the burning times resonates deeply with previously unrecognised feeling states, so that they experience this new knowledge as explanatory in some powerful way. These are very difficult experiences for medical women to talk about, trained as they are as scientists and working in a profession that prides itself on rational, logical and measurable knowledge. It is my experience that not all medical women identify with the story of the witch burnings, but for those who do it shocks them to the core.[28]

Britain's last witch was accused and jailed in 1943. She was a spiritualist named Helen Duncan and her mother had warned her as a little girl that she would be burnt as a witch if she did not keep silent. Witchcraft was decriminalised in 1951 (Gaskill 2001). Whitney concludes that 'the shadow of the hunts still lies over even its modern observers' (Whitney 1995 p 86).

When women work as healers today, they have instinctive knowledge of how dangerous that can be (Daly 1979). The fear and loathing of the feminine which drove the witch burnings still lies under the surface of contemporary life, while the burnings themselves have continuing consequences. Many women are afraid to claim their full power for fear of being 'burnt', and an aspect of the feminine has ever since been contaminated by association with the masculine projection of the female as witch.

The dark aspect of the Goddess is associated with death and destruction and it was the negative associations with this darker side of women, nature and witches that led to the witchcrase. Our culture has not engaged with this dark side and by repressing or ignoring this "shadow" side of the goddess and witchcraft, contemporary theorists are effectively disempowering women by suggesting that certain traits are not "naturally" a part of the female psyche. These neglected traits are often terms that are deemed "masculine" in a patriarchal society such as aggression, competitiveness, anger, destructive and ambitious desires. They are also characteristics that are required for 'success' in medicine, and leave women in a terrible dilemma. If they enact these characteristics they summon unexamined archetypes of the dark goddess and witches, and attract the hostility that rises unbidden in all who do not know how to recognise and work with her. And if they do not, they are relegated to 'Mary work' in the profession, the tending and nurturing rather than the leadership and authority of which they are capable.

The burning of the witches is a long way from medical women in the 21st century, so let me make the link. In pre-Christian times there were many gods and goddesses. At first male and female gods ruled as equals, and then the male principle took over, paving the way for the monotheistic religions which named pantheistic religions as 'pagan' and

[28] Freud came to the conclusion that 'We must finally make up our minds to adopt the hypothesis that the psychical precipitates of the primeval period became inherited property which, in each fresh generation, called not for acquisition but only for awakening.' quoted from *Moses and Monotheism 1938* Heinemann, E. (2000). Witches: A Psychoanalytic Exploration of the Killing of Women. London, Free Association Books. Eller agrees that 'women today may not consciously fear the stake, but that it continues to have an impact on their subconscious and fosters that whole philosophy of women being silent and not being heard'

systematically sought to eliminate them.[29] We have the violent overthrow of feminine authority in the archetypal myths, followed by a demonisation of nature, the equation of women with nature and unreason, dualistic and misogynist writings that oppose men and women, reason and nature, good and evil, followed by the flare-up of witch-burnings which involved many women engaged in healing, birthing, and nursing care, and then, as we shall see, the separation of the healing arts into a profession that was locked in colleges from which women were excluded. At this point rational thought was developing, defining itself in part by opposition to magic, nature and the feminine. Rational thought became the science on which modern medicine is based, and it contains within it a horror of magic, nature, chaos, intuition and the feminine. Women doctors are taught the same horror, and quickly learn to hide their female ways of knowing behind a mask, or reject the feminine, as part of the trial of fire that comprises induction into the profession. Some do this knowingly, with an intention to return to *her* when professionally independent, and others do it blindly in their search for acceptance and validation within their profession. Either way the requirement to banish *her* must reverberate within soul, psyche and body.

Involement of medicine

When Christianity conquered the pagan pantheon of gods it required that medicine, along with other learned thought systems, integrate the pagan healing arts with the Christian world view[30]. This was achieved during the Middle Ages (Kocher 1950), laying the groundwork for the separation of science from mystic belief that was part of the great project of the Renaissance. One of the aspects of this story that makes it important for medical women today is that the nascent medical guilds were strongly implicated in the destruction of the witches. They were part of the trial process, and were explicitly empowered to identify whether a sickness was caused by witchcraft. According to Malleus Maleficarum, "And if it is asked how it is possible to distinguish whether an illness is caused by witchcraft or by some natural physical defect, we answer that the first (way) is by means of the judgement of doctors". (Ehrenreich and English 1973 p 35).[31]

Demonology and medicine were intertwined, with leading doctors of the day arguing in opposition to each other both that demons caused illness, and that witchcraft was a symptom of madness rather than a crime. According to Clark 'There was, in fact, a

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[29] A step in the process of this elimination was the demonisation of women, equating her with unruly and unpredictable nature. The witch trials were in part an expression of this dualistic and misogynist thinking, and were disproportionately aimed at women. In his discussion on the many sects that were persecuted during the witchcraze Brian Easlea argues that "There is an important feature of these heretical movements that must not be overlooked, namely the 'disproportionate' role in them played by women'. Easlea affirms that "the women in these sects gained by their membership.. greater self-experience, wider spheres of influence and an asceticism that could free them from family ties" Easlea, B. (1981). Science and Sexual Oppression: Patriarchy's Confrontation with Woman and Nature. London, Weidenfeld and Nicolson. Here perhaps is one source of resistance and one description of the bravery of women who refused to be coerced.

[30] There is a strong parallel with the persecution of Indigenous medicine in Australia, which was reconstructed as sorcery and fiercely persecuted in the 19th Century by Christians, doctors and pastoralists.

[31] Bever describes a trial in which a woman was accused of poisoning her step-grandson. 'A doctor found.. that something wrong had been given to him in his food' Bever, E. (2002). "Witchcraft, female aggression, and power in the early modern community." Journal of Social History 35(4): 955-988. Easlea concludes that by the sixteenth century women had been effectively barred from medicine and that women healers ran a substantial risk of charges of witchcraft because it was assumed that, in their weakness and incapacity, to be able to cure would require a pact with the devil Easlea, B. (1981). Science and Sexual Oppression: Patriarchy's Confrontation with Woman and Nature. London, Weidenfeld and Nicolson.

complete identity of belief between the specialist writers on witchcraft and a substantial portion of the medically orthodox.' (Clark 1997 p 189) and physician demonologists wrote justifications for killing witches (Clark 1997 p 277). On the other hand he quotes physician Johann Weyer as asserting that 'since witchcraft was both sex-specific and age-specific, it could be explained away in terms of the pathology of female senility and the tricks of devils.' (Clark 1997 p 198) . Weyer, it seems, deplored the ignorance and cruelty displayed during the witch hunts, maintaining that torture could force a worthless confession from anyone and superstitious physicians would corroborate it. Although he believed in the devil, he did not believe that the devil needed credulous old women to assist him, and 'his physician's heart is tortured by the consequences of the witch superstition' (Green and Bigelow 1998 p 215).[32] The increasing medicalisation of the symptoms of witchcraft was one of the influences leading to its decline (Bever 2002).

Several current scholars have identified the beginnings of the story about medicine, women and witchcraft (Sirasai 1984). Historians such as Ian Maclean, the author of The Renaissance Notion of Women, demonstrate some of the ways the authoritative works in medicine, theology and law reinforced each others' dismal view of women. Leland Estes' book The Medical Origins of the European Witch Craze: A Hypothesis explores the idea that significant changes to the scientific content of medicine caused a breakdown in existing certainties within the medical academic community about identification and treatment of illness. This anxiety led to a ready acceptance of the notion of illness caused by witchcraft or possession.

It was generally accepted by Renaissance physicians that the devil was involved in some illness and injury although it was recognised that most illness came from natural causes. Some physicians, particularly Johan Weyer (1563) were sceptical, and argued against causation by the devil acting through witches. English physicians engaged in spirited discussion of the role of witchcraft in particular cases with odd and puzzling symptoms, influencing both clerical and legal beliefs about the efficacy of witchcraft. Doctors did not argue that witch-induced illness was ubiquitous, but they did believe that the determination of whether it was witchcraft or natural causes should 'rest specifically with physicians' (Gevitz 2000 p 9).

French philosopher Michael Foucault maintained that medicine, and particularly psychiatry, was critical in bringing about awareness of witchcraft. He is quoted in Clark as saying, during an interview in 1970, the whole cultural system of the Middle Ages meant that it was not possible for witchcraft to become an object of knowledge until, during the 16th and 17th centuries, it was appropriated by those who wished to explain it away, especially in medical terms, as the product of mental illness' (Clark 1997 p 179).

The collusion of the medical profession with the Inquisition was, according to Thomas Szasz," among other things, an early instance of the 'professional' repudiating the skills and interfering with the rights of the 'non-professional' to minister to the poor" (Szasz 1970).

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[32] There might be one or two sympathetic medical men, but danger lurked for the woman who healed. 'One Alison Peirsoun of Byrehill was famed among Scots as a gifted physician. The archbishop of St. Andrews sent for her, as he had been treated by other doctors without relief. Alison, by whatever means, cured him of several disorders we'd today call "psychosomatic". Later, the bishop not only refused to pay her bill, but also had her arrested. She was charged and executed for witchcraft.' Common, L. (1998). The first healers: women and medicine in ancient history. Medical Post. Toronto**:** 40..

Freud even speculates that the torture imposed on witches was a precursor to psychoanalytic treatment (Heinemann 2000 p 105) and Kulkarni has apologised for the abuse of women resulting from the methods of modern psychiatry (Kulkarni 2003). Quadrio documents that male psychiatrists are 4.8 times more likely to use ECT on patients than female psychiatrists are, and that most of the people undergoing ECT, conducted by male and female psychiatrists (72%), are women (Quadrio 2001 p 362). It seems that there are lingering consequences of the role of medicine in demonising women, yet despite this, full of bravery and temerity, women insist on being doctors.

7. A brief history of the sexes in medicine

> 'To be written into history is to be desired, and history is now being written through women's desire' (Pollock 2001 p 54).

Women have always been healers but they have not always been doctors. As we shall see, the medical profession was developed in part to distinguish itself from the activities of others who claimed to heal, at a time when women and the feminine had been tortured into silence. It is essential to come to grips with this engendering of the profession if we are to understand how women draw on their own agency to subvert, circumvent, invert and overcome the symbols, structures and content of a profession that systematically renders women invisible or problematic.

The lineage of healing women can be traced back to the Egyptian gods, including Isis, who was worshipped as the great goddess of medicine. Her priestesses were regarded as 'physician-healers'. Women studied midwifery, and also medicine at the royal medical school at Heliopolis in 1500 BC and illustrations of women performing surgery were common on temples throughout Egypt. In ancient Greece Athena was a god of healing, specialising in curing blindness, and Hera was the chief god of healing. Hygeia and Panacea were the daughters of Aesculapius and venerated in more than 300 healing temples throughout Greece, Hygeia as the goddess of healing. Greek women doctors taught medicine, were surgeons and obstetricians. Women were honoured healers in classical Egypt and Greece, particularly at the medical schools at Sais. Women were also prominent as doctors in pre-Christian Rome, and in Germany, where they were also well respected physicians, accorded the same respect as their male colleagues, and the medical school in Salerno continued to train women long after they were banished from formal education in the rest of Europe during the medieval period (Wynn 2000).

The early medieval religious women considered healing to be part of their vocation. They drew on pagan remedies and substituted prayers to Christian deities for those to the pagan gods.

Despite the barriers that the ecclesiastical hierarchy began to erect in the twelfth century, the members of the leading monastic order of the time, the Benedictines, maintained a tradition of medical study and practice based on the translation of the works of Avicenna. This tradition began to reach the West around the middle of the century. In his Letters of Direction to Heloise, Abelard describes the role of the infirmarian in the religious community for women:

> There must also be a watchful nurse always with the sick to answer their call at once when needed, and the infirmary must be equipped with everything necessary for their illness. Medicaments too must be provided, according to the resources of the convent,

> and this can more easily be done if the sister in charge of the sick has some knowledge of medicine. Those who have a period of bleeding shall also be in her care. And there should be someone with experience of blood-letting, or it would be necessary for a man to come in amongst the women for this purpose (quoted from T.P.McLaughlin, ed., "Abelard's Rule for Religious Women" *Medieval Studies* 18 (1956):261; translation from Betty Radice, *The Letters of Abelard and Heloise* (New York: Penguin Books, 1974, 215)

So at this point women were part of the healing workforce. They were *infirmarians*, actors in the healing process. Some medical knowledge was ascribed to most of the renowned religious women before 1200 (Stout 1997).

During the Dark Ages learned women such as Hildegard of Bingen (1098-1179) and Trotula of Salerno (12th century) wrote medical manuscripts on plant, animal and mineral medicine, and on physiology and the nature of disease, as well as practising as physicians and obstetricians. Trotula wrote a book on obstetrics and gynaecology that was used for more than 400 years. They were renowned for their knowledge of healing. Upper class women in the Middle Ages founded hospitals, codified herbal remedies and from the 7th century nuns ran the hospitals established by the church (Carr 2004). Galen recorded the work of female army surgeon Margareta and St Bridget of Ireland practiced medicine and midwifery (Wynn 2000).

The structure of the profession in Europe, and substantial areas of content that persisted through to the late seventeenth century were developed as early as the fourteenth century (Sirasai 1984). At this time male physicians and surgeons began forming themselves into guilds that excluded women from apprenticeships and membership. Over the coming centuries they built up and jealously guarded their exclusive status (Carr 2004).

Transition to university-based medical education

The teaching of medicine became centred in the context of the university in the 14th century, which also saw the emergence of a secular learned medical profession (Sirasai 1984; Carr 2004). In many areas of Europe the practice of medicine began to require a licence and university training at this time, and these were not available to women (Easlea 1981; Wynn 2000). There developed increasing hostility between women who practised the healing arts – by necessity without the benefit of university training - and male doctors. Jane quotes a clerk from St Bartholomew's Hospital in London, circa 1370, describing these 'worthless and presumptuous women (who) usurp this profession to themselves and abuse it. Who possessing neither natural ability nor professional knowledge make the greatest possible mistakes, thanks to their stupidity, and very often kill the patient.' In Paris in 1322 five women were charged with practising medicine without a licence. They were charged at the insistence of 'the masters in medicine', convicted, fined and prohibited from practice under pain of excommunication (Jane 1997).

Significant innovations in medicine between 1300 – 1600 mark it off as a distinct period in history, although still drawing on classical, medieval and Islamist natural philosophy. Prior to about 1650 medicine was based on the natural philosophy of Aristotle as interpreted by Galen. After about that time, in a momentous shift in European intellectual thought, empiricism, rational thought and enquiry, based on Descartes notion of nature as a mechanical object governed by discoverable laws, became the foundations of medicine and the science on which it was based (Broman 1995). Innovations included understanding of disease aetiology, therapy, dissection, anatomy and physiology, and the teaching of

medicine in universities in Europe (Sirasai 1984). By this time there was a 'medical establishment' represented by physicians such as Harvey and Vesalius, and a reaction against it by doctors such as Paracelsus, who tried to introduce a New Medicine at the University of Basel in 1527 (Thorndike 1951).

University trained physicians remained a small elite among doctors and other healers (Sirasai 1984) resulting in an increasing hierarchy within the profession, and between university and non-university trained practitioners (Jane 1997). In Germany, as in other parts of Europe and the Americas, university education distinguished between medical men and other healers. The purpose of university education was to train physicians to be 'erudite men of gentlemanly bearing' rather than scientific experts who applied theory to the bedside (Broman 1995 p 839). Physicians were given the responsibility of examining and overseeing other healers, such as midwives, surgeons and apothecaries even though they were in competition with them for patients, and were not manifestly more expert in patient care than other practitioners. Their social and professional standing relied on their training in rhetoric, the humanities and sciences, their training to be learned 'gentlemen', part of the intellectual elite of the community[33i]. University-based training in clinical practice was introduced in the 19th Century. It was a response to requirements by the newly established medical boards that doctors be examined on their competence in the 'resolution of practical cases' (Broman 1995 p 859). Women, of course, were not in the frame of reference at the time, yet this culture of exclusive and privileged masculinity was the environment they would have to engage with to obtain the privilege of being a doctor.

Infiltrating women

Women, who had been excluded from universities since they were first established in Europe in the 11th century (except for some Italian universities), were not included when medicine began the shift to a university base (Schiebinger 1999). Women only began to be admitted to medical schools in Europe in the mid 19th century.

Women struggled in Australia for acceptance into the profession, firstly into medical school and then for the right to practice. A classic example of resistance was the establishment of hospitals by women doctors in both Melbourne (The Queen Victoria Hospital in 1901) and in Sydney (The Rachel Foster Hospital in 1922). The motivation was the refusal of hospitals to accept female doctors onto the staff and to provide them with clinical experience, as well as the perceived neglect of women's health. Female doctors had graduated from Sydney University since 1892 but were for the most part unable to gain residency at the city's teaching hospitals and even by the 1920s medical women occupied only 1.3% of honorary positions in hospitals in NSW.

As a young resident at the Rachel Foster Hospital Dr Stefania Siedlecky said 'feminists are man made, the need for stubborn perseverance and independence among women doctors has been forced upon them in their struggle for recognition of their professional worth.' (McCarthy 2003 p 282). The motivation for establishing the Queen Victoria Hospital was

[33] As described by Broman the curriculum had three levels. The first included ancient and modern languages, natural philosophy, mathematics, experimental physics. The second emphasised anatomy and physiology, botany and chemistry, pathology, the study of *materia medica*. The third provided practical training in therapies, the principles of clinical practice, surgery, obstetrics and forensic medicine. Clinical skills were gained by apprenticeship and practise.

the same. Women staffed and ran the hospital, which served the women of Victoria, until it was mainstreamed as a Monash University teaching hospital in the 1960s and subsequently disappeared.

In Australia equal numbers of male and female students were achieved in medicine in 2000 (see Table 4).

Table 4 Percent of women medical students 1992 – 2002

	First Year		Entire student body	
	No.	% Female	No.	% Female
1992	1311	46	7621	45
1993	1308	48	7781	45
1994	1260	49	7641	46
1995	1307	47	7159	46
1996	1282	48	6810	47
1997	1223	49	6613	46
1998	1228	50	6491	47
1999	1257	54	6572	48
2000	1361	56	6617	50
2001	1471	55	6803	51
2002	1470	56	6962	53

This changing sex ratio of doctors is a worldwide phenomenon and attracting the interest of policy makers at the highest level. The primary motive for this interest is the impact on the medical workforce of women's ways of practising. Women are also articulating the equity issues that arise when one sex, in this case women, is inserted into a professional culture designed by another (Bickel 2001; Reichenbach and Brown 2004).

The gendering of medicine is significant because women were excluded from the profession at a time when medicine and science were developing elaborate codes of behaviour as appropriately masculine and feminine. Women were unable to contribute to the development of those codes, yet were subjected to them.

The burning of the witches has consequences for women. It also has consequences for medicine, consequences that are reflected in the models and content of the science on which it is based, the structure of its teaching, in the content of the curriculum, and in the experience of women as health practitioners and patients. The culture of medicine reflects

the masculine experience and does not include or value the feminine. It can feel very dangerous to women, even today, to draw attention to their femaleness within medicine.

So after systematically destroying the women healers medicine was transferred from the fields into universities, and women excluded from those universities. It has taken until the 20th century for women to regain access to the study and practice of medicine. The intervening 400 years have produced an explosion of scientific knowledge about the human body which is the foundation of medicine as we know it. That foundation has been defined largely without the contribution of women. It has been the purpose of this chapter to demonstrate that medicine and science have histories of hundreds of years of excluding women, and a deep and unacknowledged horror of the feminine. The process of bringing women and the culture of women into medicine will require deep structural changes (Schiebinger 1999 p 11). This study is designed to be part of that process of structural change.

The next Section explores how women, nevertheless, are highly valued as doctors, and also the implications of the absence of women from the establishment of medicine and the horror of the feminine in the lives of women doctors today. I examine what the data have to say about how medicine is changing women, and in particular how women are valued as doctors, and the coercive practices that exist within the professional socialisation process.

Section 2
HOW MEDICINE CHANGES WOMEN

Chapeau 2

The troubled relationship between women and medicine that has been documented in Section One is reflected in the daily interactions today's female doctors have with their profession. Inserting women into a profession that was developed, like all professions, when professionals were men is intrinsically problematic both for the profession and for women. It is doubly problematic for medicine because medicine was professionalised at a time when European society was being cleansed by the witch-burnings; women and their healing knowledges were being demonised, masculine thought was being refined and reified, the dualistic split between rational thought and embodiment was being codified, and the esteemed profession of medicine was licensed, requiring university education as a 'learned gentleman'.

Women were not only 'not there' when modern medicine was developed, they were being systematically and violently 'othered', forced to be the containers of mankind's shadow, with lives constricted by economic and social dependence on men, restrained from being autonomous actors in their own lives. Women then and now, of course, find many ways to resist these restrictions on their engagement with action in the world. Some are supported by fathers and husbands and brothers to become all they can through education and position. Others take on their husband's work when he is absent and find their competency manifested. Others work in secret or undercover or in disguise, wearing a mask of docility while formenting revolution under the surface. Some, Lilith-like, cause trouble.

Over the centuries women have endured many trials in order to claim/reclaim their own lives. Women doctors today continue this tradition as they twist and weave their way through the labyrinth of the medical profession, skirting pathways guarded by minotaurs, following ariadne's web to safe places, being bruised and bloodied in battles of unequal power, comforting and healing each other away from supervisory eyes determined to prevent 'suspicious and murky things' from going on.[34]

Women are changed by this process of twisting and weaving and by their encounters with medicine. Some of the changes are those they seek and value. Others are changes they are required to make to remain within the system. Medicine has a highly reactive immune system that instantly identifies and targets for destruction any foreign body that makes its way inside its tightly patrolled boundaries. Women often inadvertently trigger this immune reaction. They quickly become sensitised to the requirement to hide or conceal their femaleness, their otherness. The process parallels that of domestic violence. Family violence is a contest over whose world view will prevail, and coercion, verbal harrying,

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[34] This phrase is a quote from Participant 8. All chapter headings are quotations from doctors who took part in the research.

physical attacks, ridicule, control of access to resources and attacks on self-worth are stock in trade for the ugly dance. All these tools are used within medicine to sculpt women into an acceptable and recognisable shape. Women resist of course, and that story is told in Chapter 6, but they also collaborate in the process because they want to become recognisably doctors.

Women are attracted to medicine probably for similar reasons men are attracted to it. Medicine is a noble calling, it draws on the higher self and speaks to the altruistic vision held by many adolescents. Medicine provides a chance to make a difference, to put into effect the desire to live a life of service, to leave the world a better place for having been a part of the human endeavour. Doctors heal the sick and bring comfort to those in trouble. They work with powerful tools and are known to be able to make a difference.

Doctors are held in high regard within our society and are generally thought to be well paid. High status and income attract women as well as men. This, however, provides a dilemma for women. The men who established the profession were uniquely successful in negotiating high reward and high status in return for long and unsociable working hours and an implicit agreement to pathologise individual behaviour as causative of illness rather than the social and political environment in which people live. This may be a social contract that cannot be cherry-picked. Yet the contract does not work well for a lot of women, and probably for a lot of men too. The trade off is too painful and requires a resculpting of women's lives that threatens to leave them wounded and bleeding. Women want the rewards of this male-defined profession but they do not want to have to become honorary men to obtain them.

Yet if women attempt to unpick the implicit contract, they risk losing the status and the rewards of being a doctor. This, of course, is what frightens those who benefit most from the existing contract and is one source of the savagery of the enculturation process of young doctors. So do women implicitly agree to become honorary men in the shape of their lives when they become medical students, or do they hold on to their feminine and keep her intact in the best way they can ? One thing is clear, the bargaining is not made explicit and individuals engage with the system on their own, on the whole, and the best way they can. Many are wounded in the contest, all draw deeply on wells of resistance and resilience. The contest requires strength and courage and determination and resourcefulness and skills, and women learn all these. Some of them die in the battle.

There are other things going on as well in this clash of cultures. Being a doctor gives women access to authority, prestige, income, a sense of high self-worth, power in society and in their own lives. These are things few women in the world experience and medical women know and value that. Medical women thrive in environments where they are valued and gravitate to areas of the profession where this is experienced. Women are able to look for validation and valuing outside the formal reward structures of the profession – which rarely reward people like them – particularly among their patients, with female colleagues, and mentoring younger women. Women do bring their femaleness with them into medicine and this is valued by patients in particular.

The chapters in Section 2 and Section 3 are data chapters. Data from interviews and the survey are used to explore the themes that have emerged, elucidated by myth and history. The survey data is both quantitative and qualitative, while the interview data is qualitative. The two primary concepts that emerged from the data that will be considered in these sections are how medicine changes women, and then how women are changing medicine.

In Section 2 the chapters will explore how women are shaped by medicine. Chapter 4 concentrates on women's experience of being valued as a doctor, while Chapter 5 explores the coercive practices that are used to construct women as 'proper doctors'.

4

Through the Eyes of a Woman

I've always said my most valuable medical asset was my gender. – rural doctor

The nurses "love me" on the ward. I'm more likely to be on time, "quicker" and less demanding on the nursing staff eg I can find things for myself ie We can do more than one thing at a time and don't need our egos massaged! – rural doctor

The number of female patients that come in and say they prefer to see me because we both talk women talk - and for understanding of medical problems through the eyes of a woman. – rural doctor

We have seen in Chapter 2 how women are determined to bring their knowledge and experience into their professional scientific practice. Women who engage with science and medicine experience a 'come-hither/go-away' relationship with these disciplines. They are attracted both in terms of intellect, personality and the privileged place that scientific medicine holds in the public domain, and repelled by aspects of professional culture and practice that ignores or silences women. In Chapter 4 I will demonstrate the first part of the relationship between women and medicine, the 'come-hither' dynamic, in which women are welcomed into the profession, obtain great personal and professional satisfaction from being doctors, contribute to the medical care of the community, and are valued by their patients and colleagues. Chapter 5 will examine some of the 'go-away' experiences.

One of the stories the Athena myth tells is of the problematic relationship between an intellectual woman, Athena, and her mother. As she was shaped as a warrior and goddess of learning by being authorised by her father, Zeus, we can expect this to affect her relationship with her feminine aspect and her mother. Her mother was required to shape-shift in order to survive, and was swallowed whole by the father energy; we can theorise that this might make it difficult for her daughter to see her, and the mother in herself, for who she really is and to see that what the mother/self knows has value, and that this 'mother-self' could be critically important as a balance against reification of the father. In this chapter I will examine data that explores the positive relationship between women doctors and the feminine. It is likely that other myths will slip into the story, myths that deal with the feminine and mother line in a different way. Demeter and Persephone might be there, perhaps Lilith.

Informed by standpoint theory and paying attention to the particularities of women's lives, I will use data from myth and legend, from interviews and from the survey to triangulate and increase the validity of the findings. The legend of Athena, the intellectually powerful father's daughter, provides a framework within which to examine the data.

I look for themes in the data with the understanding of the feminine and the map of the universal occidental unconscious drawn by myth and archetype, as described in Chapter 3. This helps me see more deeply into the data. The data framework is pictured in Table 5. The survey data is qualitative data drawn from responses to the question 'Please write one paragraph about an experience in which you were valued as a female doctor'. Five hundred and seventeen (84%) women out of 612 responded to the question in the survey. In the interviews I asked the women to give me examples of 'experiences in which you were valued as a female doctor'. I use quotations from interview data and from survey data to illustrate my findings and to give the reader direct access to what it is possible for women doctors to think and say about their relationship with medicine.

Table 5 Data sources for valuing women as doctors

Myth & Theory	**Interviews**	**Survey**
Skills of the father	Professional achievement Leadership in the profession	Respect from patients Making a difference
Zeus's daughter	Father's daughters, male mentors	Valued by colleagues
Metis's advice to Athena	Reclaiming mother	
Athena's owl of wisdom	Embodied practice	Embodied practice

Like Athena, female doctors take great pride in the skills they have learned at the hands of the fathers. They delight in being able to take their place in the professional world, to have the authority and respect that goes with being members of this honourable profession. They stand tall and proud, not with spear and shield in hand, but with stethoscope and scalpel. Many of the women in this study stand as warriors defending and protecting women patients, using their skills and authority to take care of the vulnerable, the wounded, the abused and violated who would not otherwise have anyone on their side. Patients know this and the doctors in this study report that their patients value women doctors very highly, particularly for areas of care that traditionally have not been a strength of medicine.

'Thinking from women's lives', from the lives of women doctors, provides evidence of the particular ways women doctors interact with their profession and their patients. This approach allows questions to be asked and answers to be found that are beyond the 'God-doctor from nowhere' myth that denies doctors their body, family, gender, feelings, class and culture and illuminates areas of professional structure and practice where healing is needed within the profession.

1. The rewards of the father

Women who become doctors enter a noble profession. To gain acceptance they have had to perform at the highest level on tests of knowledge and intelligence, and outperform thousands of other applicants. On their first day as medical students they are welcomed by Faculty Deans as special, different, elite, privileged. Universities spend up to five times as much to educate a medical student compared with other students[35]. Medical students are comparatively few in number, subject to intensive teaching in small groups that encourages identification and friendship with fellow medical students. From the outset medical education is explicit in teaching students professional identity as well as knowledge and craft skills. Even as students they have the opportunity to carry symbolic tools that set them apart from other students, the dissecting set, the stethoscope, the laboratory coat.

For the most part the women in this study assumed they were entitled to these privileges. They knew they were bright, worked hard, achieved outstanding academic results that gave them choices about their future, and they chose medicine. In their girl/woman minds, these were the simple criteria that mattered.

They chose medicine in part because they dreamed of being good people who contributed to community well-being, and in part drawn by the promise of high status, high income and professional prestige. The surgeon in the interview sample told me *The actual reason why medicine exists and the reason why most people want to become doctors is because they want to help people and they would like to have a satisfying life and do something good in their life for other people. P8.* Some wanted to understand science and how the body worked, to have a career, to talk to their patients. More than half the women were explicit about wanting the autonomy and financial independence that medicine promised *I'm going to be my own boss. I wanted to be able to travel, and I wanted to earn a reasonable amount of money. P5*

Two of the women interviewed wanted to practice medicine better than it had been practiced on them, to help heal medicine from the consequences of the absence of feeling. Some wanted to outdo their fathers, some carried their mother's dream. Three of the women brought women-identified beliefs with them when they entered medicine, others came to this position after their experiences within the profession.

Rewards

And medicine delivered on its promise. It provides, as one woman put it, access to *astonishing numbers of resources P6*. All the women gained the status, the income, the professional standing, the autonomy that are the hall-mark of the profession. The surgical trainee is delighted with the rewards *The money's great. The social prestige is fantastic. You know you get huge boosts in society announcing yourself as a doctor, let alone a surgeon. P6.* The surgeon agreed. She said *I wanted to be a doctor 'cos I thought I would have an autonomous life or that I'd be rich … and I thought I'd be respected in society, and I wanted that. P8.* Medicine has provided the relative autonomy, flexibility and respect that she wanted and that are available to very few women in society. Even

35 (private communication, Professor Sue Richardson, Director of the National Institute for Labor Studies, Flinders University)

more rare for women in general are high incomes and opportunities to fully extend themselves to find out what they are capable of. Medicine provides an opportunity to test the extent of ambition.

Ambition

Ambition is not a word that women generally feel comfortable using, trained as most women are to put the needs of others before their own. However it takes ambition and a will to succeed in a career sense to attempt to enter medicine. One of the participants felt safe enough in the interview to articulate her drive for recognition, status and a chance to have an impact on her profession.

> *I really wanted a career. .. I saw medicine as providing many opportunities in that way… I am ambitious and I don't stay patient very long, so I you know I'd like to be in a more senior position than I'm in.. I'd really like to go into management …I really wanted to be successful. I really wanted to, not just have a career, but be the sort of person who was seen as a bit of a leader in the field, to get a bit of notoriety… I wanted to be somebody. P7.*

Zeus's daughters, centred in the intellect as they are, are allowed to have this sort of ambition. In her quest to achieve it she has obtained her fellowship in three medical specialties and completed a PhD. Medicine has provided her with a professional context within which to both challenge and find herself, a rare gift for a woman.

Professional satisfaction

One of the rewards women receive from medicine is the satisfaction of medical practice. They really like being doctors. They enjoy caring for patients, making a difference to their communities, and demonstrating their professional skills. A surgeon described the pride and satisfaction she derived from her work:

> *I love the work. You don't get to operate unless you're a surgeon. I think it is the best thing in the world. I guess the things that are in it for me are the technical aspects of the job which I just love doing, and I love the environment. P6*

Like Athena protecting her city with spear and shield, rural doctors are protective of their patients and communities. They told story after story of successful and challenging professional encounters with patients which made a difference to the patient's wellbeing. They told stories of travelling to remote communities to provide women's health services, of being the only or first female doctor in their town or district, of patients who travelled hundreds of kilometres to see them; and told them with quiet pride and dignity. The sense of making a difference and being valued is palpable and the doctors respond to it; *I treasure my rural experience. This is the best time of my life.- rural doctor*

Many rural doctors recounted clinical care episodes where the patient was from a marginalised group who might otherwise not have received appropriate care, including migrant women, aboriginal women, the elderly, and vulnerable teenagers. This will be explored more fully in Chapter 9.

Leadership and authority

Women are still a small minority in leadership roles in the profession, however the doctors in this study were trained and competent in decision-making, leadership and authority. They had authority in their own lives, authority in their clinical work, authority in their

communities, and some had leadership roles in their professional colleges and hospitals. They were experiencing the rewards of the long and challenging training that enabled them to practice medicine, and the prestige of a profession developed by the elite of their culture.

> *And there's an enormous difference(after passing the Fellowship exams) in one's feeling and one's status in the organisation because no Fellowship ever gets taken away… So once you've passed that exam, there's a lot of changes that happens in one's mind. P8*

This is Athena energy, skilled, confident, authoritative.

The status of their profession and their own roles within it allowed these women to exercise their will and to command action, much the way Athena acted with clear intention when she saw the need.

> I *can be very clear about my decision making... I want whatever I've decided to do to happen, and there's no give or take in there…I use language very clearly, concisely and black and white. And if there's a an emergency or an urgent situation .. I'll be going, you get out of here now, you do this, you do that… and it can be intimidating I think. P5*

This authority to command is not commonly given to women in the public sphere in Australian culture. It is a feature of leadership, learned from the fathers, earned with the intellect. Young doctors learn how to do this within the context of patient care, while it takes many years of demanding training to earn the right to act with similar intention and purpose among their colleagues.

> *And that's a very prominent story you hear from many (female) consultants… that now that they're qualified they're allowed to actually express their values. Whereas beforehand they had to express the values of their profession. P6*

This young surgeon warned that she was going to be able to exert more authority as she became more senior in her profession *there's going to be more clashes I think over the years as I become more senior and less malleable. P6*

Women who chose to go to battle for what they believe in, or to achieve an outcome, are conscious of the responsibility.

> *I think that in my new role as Chair .. I am finding it a very interesting process to deal with because it is a very significant honour and a very significant responsibility,.. it is interesting and fun to be in there, doing the jousting that you sometimes need to do. P2*

Not all women doctors enjoy the 'jousting' and many retire hurt from the fray, however there are many opportunities for leadership and authority within medicine, from individual patient care to national leadership roles, and women generally find their way to the level of challenge that fits with their natures. Some, it is true, are broken in the contest, extended beyond their resilience by the burden of misogyny, and this is explored in Chapter 5.

Respect

Women doctors command respect in a way that is given to very few other women. This is what Zeus offered to Athena. Adopt my values and ways of thinking and you will gain some of my power. Almost all the doctors could describe experiences in which they had been valued for being female, in both the survey and the interviews. Some could not and

there was an undertone of bitterness in their accounts, and some reasons for this will be explored in Chapter 5.

The doctors were not asked, and on the whole did not volunteer, examples of respect from their everyday interactions with people outside medicine, yet it is a given that they would experience honouring of their profession and their place within it on a daily basis, from the postie to the maitre d'. *Certainly having a medical degree ... does make a difference in the world, ... you get heard in a different way. P9.* This honouring can prove difficult to manage in small rural communities, where the doctor is both doctor to the town and likely to play in the netball team, join the kindergarten playgroup, or sing in the local choir. The strategy of 'make the community your own' was identified by female rural doctors as contributing to sustainable rural practice. It helps avoid the 'god complex' they said.

Rural doctors are the most highly valued members of their community and this sense of being valued, both as doctor and as female doctor, is an important aspect of rural practice for women.

> *I feel very valued by my working associations as well as by patients and the staff at the hospital. I also have valued input into medical organisations. – rural doctor*

> *In the hospital environment in which I work, I feel both patients and nursing staff appreciate the presence of a female doctor. I feel I can bring certain attributes, associated with my gender, to my work, which has positive spin off and provides a balance. – rural doctor*

Urban female doctors experience this also, although it is more likely to come from patients than from colleagues.

These are the payoffs for Zeus's daughters.

2. Zeus's daughter

> *he said, "Listen, doll, I want you to be an orthopaedic surgeon" P8*

As Zeus's daughter Athena was given access to learning and guidance. She is a goddess of learning, and is sometimes shown carrying a book and the owl of wisdom, rather than spear, shield and battle helmet. She would have been led through her education by teachers and guides who themselves held authority that they could pass on to her. Women doctors experience this too.

Male Mentors

The women in this study described various ways in which male mentors and colleagues had provided support and guidance that helped them negotiate some of the difficult intersections between the culture of women and the culture of medicine. In the survey, women identified finding work colleagues who treated them with respect, and shared values, as being important to their satisfaction with rural practice and contentment with their life as a rural doctor. Forty five percent of the women had been able to find a practice partner who treated them as an equal, and 34% worked with a practice partner with similar aims to theirs.

> *My colleague who is a male GP, who had invited us to join his practice in (rural area) is very supportive and respectful. – rural doctor*

> *About twice a year my boss, for no particular reason, says quietly to me, "What this practice has needed for a long time is someone with an interest in mental health." I feel valued and appreciated despite not racing about delivering babies, setting broken limbs, resuscitating MI's – rural doctor*

Having a partner who treated you as an equal is statistically significantly associated with satisfaction with rural practice (Chi-square 0.013) and highly significantly associated with contentment with life as a rural doctor (Chi-square 0.001, logistic regression p=0.017, 95% CI 1.095-2.548). A partner with shared aims is statistically significantly associated with contentment with life as a rural doctor (Chi-square 0.009).

Women who were interviewed recounted instances when men had encouraged them into 'difficult to get into' positions or provided guidance in understanding the culture. A surgeon describes how she was invited to nominate for membership of her college council:

> *So I think he thought, "here's somebody who is good". That led to me going to the College and subsequently to Councillor. He happened to be current president but I'd no idea at that time. He said, "I'll put your name forward". P8*

She became the first female Councillor, and went on to be re-elected twice, with support from male as well as female Fellows. From this position she was able to study and attempt to modify the culture of surgery with much greater agency than as an ordinary Fellow and used that position to initiate changes that would benefit women training and operating as surgeons.

She described another instance when, as a basic trainee, she needed time off each week to attend to personal affairs. Some of the consultants took this as evidence that she was not committed to a surgical career. She was protected by the medical director:

> *he just read the situation and not only defended me but said, "This is really good" and told me what he'd told some people who'd challenged it and said "This person must be off the program" for example, because they tried to put me off the program. And he wouldn't have a bar of that. P8*

This level of protection and support allowed her to structure her training to meet her personal as well as professional needs within a culture that was highly critical of any activity other than total dedication to surgical training and experience. It may have been one of the experiences that led her to work tirelessly within her College to introduce flexibility into surgical training. This is a goal that has not yet been achieved, but there are now increasing pressures within and outside the College for flexibility to encourage women to enter the training programme. This is a thread in the tapestry that will be woven more tightly in Chapters 7 and 8 to demonstrate how women are changing medicine and how some men are helping them do it.

She reflects on that experience and concludes:

> *When I look back at it now, it's a story about men looking after people and a story about men who sum up the situation and say," this is good for health, women are good in medicine". A very deep form of permission to be there, pretty deep permission to have a man challenging other men. P8*

She took full advantage of this support and provides surgical care, teaches and mentors students, mentors female surgical trainees and works hard to change medicine to assist it to value the feminine and women doctors.

A general practitioner also found her way with the support of male consultants. She had a miserable time as a medical student, quite confused between what she thought medicine was going to be about, which was caring and healing, and what she actually found. This was transformed during her time as an intern:

> *The consultants, for me when I was a resident and an intern, were lovely. They were really kind and really nurturing. They were fantastic, I must say. A lot of them almost took me under their wing and were really, really kind to me. P9*

She is now rethinking general practice, deeply engaged in the project of bringing spirituality and healing into medical practice, having identified that its absence is causing grief for both her and her patients. She also takes the opportunity to teach medical undergraduates, intending that they might envision medicine differently after she has brought these other perspectives into their educational experience.

Male mentors have intervened at critical points to assist women negotiate their way through the labyrinthine passages of medical culture to a place where they could stand as themselves, without being overcome by the Minotaur, the guardian of the gate whom the hero must vanquish in the journey to their destiny.

Claiming fathers

Most of the women in the interview group had the support and encouragement of their fathers and this was an important element in their feeling competent enough to apply to study medicine. The psychiatrist was clear that her father put the idea in her head *I think it was mainly driven by my father who felt great respect towards doctors and the medical profession. P7.* One of the general practitioners valued her father's encouragement for her to take the risk of having such a difficult dream to attain. He told her *'look go for it, if it doesn't work I'll be there to pick up the pieces.. do whatever you want'. P1*

Another general practitioner became a doctor almost despite her father. He had abandoned the family when she was 13 years old and she has not forgiven him, although she had been his favourite before that and she would go with him on his rounds as a country doctor. *It was just 'cause everyone had said to me ever since I was at school, 'oh well are you going to be a doctor like your father'... I really look like him as well. You know I'm just very much like him in lots of ways. P5.* She is a country general practitioner, as her father was.

Two other doctors had fathers, grandfathers and uncles who were doctors although none had encouraged them to do medicine and one had actively opposed the idea.

Fathers were also internalised in the thoughts and values of the women. They valued their father's lives and ways of being in the world, their intellect and achievement and ability to make things happen. Some identified with their fathers rather than their mothers as models for the life they could lead. The physician acknowledged that *I think when I was a teenager I was a little bit dismissive of my mother because I didn't think she was intellectual enough. P2.* Another doctor remembered as a teenager *being certain I didn't want to be like her. P.1* In Chapter 3 I identified how Athena declared that she sided with the father against the mother in all things except marriage – which she shunned. For

women who want to achieve in science and the professions, it is almost a requirement to shun the mother, as Athena advises. Throughout this thesis I will trace some of the consequences and resistances to this requirement.

3. Metis's advice to Athena

Despite her denials, Athena did have a mother, Metis, the goddess of wisdom. Chapter 3 contains the story of how Zeus swallowed her so he could ingest her wisdom, despite her attempts to keep her wisdom for herself. Like Athena, women in medicine have been trained to value the father, but three of them have revisited their relationship with their mothers as they grow older, and have reclaimed their mothers as knowers, after having initially valorised their fathers when they were girls growing up. The relationship between Athena, Athena-women and the father and mother archetypes is a complex one.

Reclaiming mothers

What does it mean that some doctors are able to reclaim their mothers? Taking part in the interviews caused one of these doctors to look about her with different vision and she discovered she had no photos of men in her house, and that *I've become aware of how powerful a woman is in my family. I haven't got a picture of dad, or pop, or any of the men in the family… The absent men are still absent. P3.* Another also reflected on her experience of being interviewed:

> *I remember actually thinking quite deeply about a lot of the things we'd talked about and in particular the role of my mother in what I became, and I've always in my own mind played her down, and yet the more I think about it I think that actually she was quite a powerful figure in some ways, and I was looking at why she'd always been played down, and whether that's part of the, dare I say, the patriarchy game. The mother gets played down and the father gets all the power, because in lots of ways lots of the things I value actually are things my mother holds within our family and not the things my father holds. P1*

Three of the doctors brought their mother/grandmother into medicine with them – the mother line - and that energy informed their purpose in becoming doctors, and the way they relate to their profession.

The theme of women searching for images of the feminine, drawing strength from each other, and taking care of the young women in medicine, reappears in Chapter 6, Chapter 7 and Chapter 9. It is the most persistent theme to come through the study.

4. Athena's owl of wisdom – knowing through the body

Drawing on the image of Athena's familiar, her owl, a creature of feminine wisdom that can see in the dark, I found women doctors who use the wisdom of their bodies to inform their clinical practice[36]. As we saw in Chapter 2, scientific endeavour, including medicine, has been required since the time of Aristotle to deny the body and embodied experience. I suspect that women doctors have always known that was nonsense but have been taught, as

[36] Perhaps the owl learnt how to see in the dark from Metis

Zeus's daughters, to go along with it. When free to practice and think in an autonomous professional environment, female wisdom surfaces. A rural doctor commented *I have raised four children who have attended local schools. I am aware how much I am valued in paediatric and adolescent medicine because of them.* Another said she worked through *Understanding children from a mother's perspective as well as a doctor's.*

This embodied knowledge was claimed frequently by the rural doctors:

> *Most days I have experiences where I feel valued as a doctor and most of these relate to me as a female doctor / mother / woman. Shared life experiences enhance empathy and trust and therefore contribute to the depth and success of one's role as a doctor.*
>
> *Being female and a mother of young children has given me experience and knowledge that has been valued by quite a number of patients*
>
> *Having had 4 children a lot of women came to me with motherhood problems and I felt my understanding and maternal knowledge gave me a lot of confidence*
>
> *I think the greatest/ strongest area where my gender is valued is in obstetrics. For the majority of birthing women, I think this is also because I am a mother.*

The rural doctors report that patients work with Athena wisdom too, instinctively believing that a doctor who is similarly embodied is more trustworthy.

> *Generally women seem to feel more relaxed about women's health issues with a female GP. They assume I've experienced what they have in terms of childbirth, pregnancy, gynae and sexuality problems. At least it means they attend a GP - in some all male doctor towns the female patients won't see the GP. – rural doctors*

Working from the body was identified in the interviews too. A general practitioner described a learning experience that delighted her when she was a registrar:

> *I remember being at the Children's and the poor kid, the ENT surgeon gave this little kid an auroscope and said 'take it to the doctors and they can look in your ear' and there is about 10 of us, and the specialist, and this kid by himself. And I can remember him walking over and clambering up on my knee and handing me the auroscope. So I was safe. And then he sat on my knee and everybody else had to come and he would not move off my knee, and they'd come and look at him on my knee. And I remember the professor ribbing me for it being my motherly face that had caused this, but I am sure it was just that this kid felt safe. P1*

In the confessional space of an anonymous questionnaire, encouraged perhaps by the careful attention to representation of female doctors that underlay the construction of the questionnaire, and invited to give an example of how they are valued as women doctors, the participants in the survey have done something quite radical. They have claimed their gender identity as a therapeutic tool. They have abandoned the requirement to be the objective, disembodied knower that science and scientific practice demand, the rhetoric of which they have mastered during their training. With the authority of doctor, the autonomy of independent rural practice, and the encouragement of their patients, they are claiming the wisdom of Metis, embodied knowledge embodied in Athena's familiar, the owl of wisdom.

In the next chapter, Chapter 5, we will see just how transgressive this thinking and behaviour is, and in Chapter 9 I will discuss how working with embodied knowledge, and being on the side of the women, contributes to healing the profession of medicine itself.

5

Weeding out the Weak

That might be my muted way of saying I'm dealing with the fright of this whole issue about whether silence is the only reasonable way to be. P8

(W)hen I was doing my obstetrics I found that awful. And the reason I found it awful was because I could identify very strongly with the patients, because they were all young females, and the way they were treated was just horrendous. And I just hated every minute of it. P6

Those that don't survive, don't get to be consultants to do the laparotomies at 3 o'clock in the morning. And I think that that's largely what it's about. A weeding out the weak. P6

We have seen in Chapter 4 how women value being doctors and are valued by their patients, how it authorises and resources them as autonomous women, and how they use their authority to reclaim female ways of knowing that allow them to practice like women. In this chapter, Chapter 5, I will examine some of the 'go-away' experiences women have, the interaction between what Quadrio identifies as the 'masculine ethos of the profession' and embodied women training to be doctors and practicing as clinicians (Quadrio 2001 p xi). As with the previous chapter I will use data from the interviews, the survey, and myths and archetypes to identify the processes whereby women are socialised into the 'masculine ethos', as outlined in Table 6.

Table 6 Data sources for structuring women to fit

Myths	Interviews	Survey
Warrior pose	Masculinisation	Heroic, stoic rural doctor
Camouflage	Playing by the rules	
Trashing women	Deny female self	
Betrayal	Engage in damaging activity	
Adopting the culture	Enforcing masculine cultures	Emergency training
I have no mother	Deny family	On-call
Meeting the requirements	Fit life into masculine structures	Extended hours

The mythic tales of Athena, Zeus and Metis provide a useful guide to understanding what is going on.

> "A number of problems are identified with training in psychiatry, one of the more fundamental being the masculine ethos of the profession. The fledgling psychiatrist is acculturated in ways which maximise competitiveness and dedication to work and which pay insufficient attention to relatedness and affiliation. … There is evidence that candidates experience the training process as abusive and oppressive and the effects of such a culture are related to the poor mental health indices of practitioners." (Quadrio 1998 p xi)

The findings of Quadrio's research have been replicated in this study. There are aspects of medical education and training that are coercive and oppressive and which cause pain and suffering for women. The processes that have been identified by the women who took part in the interviews have been gathered into three groups. These are 'suppression', 'reshaping women' and 'acquiescence'. Aspects of the Athena myth will be used to deepen understanding of what is going on beneath the surface of individual women's encounters with medical culture. The data that will be relied on comes from the interviews, with the occasional confirmation or illustration drawn from the survey, where appropriate and relevant. The survey was designed to identify what is working for female rural doctors and the findings are more fully explored in Chapter 4 and later chapters. This chapter concentrates on the struggle between women and medicine.

1. Suppression

We have seen in Chapters 2 and 3 that there are systematic processes that suppress the feminine, and women, in medicine. Some of the ways these are played out today in medicine in Australia have been identified by doctors who took part in the interviews, and are detailed in Table 7. They show the more individualistic side of the feminine being

reduced and stifled by hierarchical masculinity. I have quoted extensively from the interviews. This has inherent validity as the women describe their own experiences and relieves me of the temptation to impose my interpretations on their accounts, accounts I find compelling.

Table 7 Processes for suppressing women in medicine

Interviews	
Power and control	
Humiliation	*Medicine was a hard journey for me in all sorts of ways. Oh god, I hated… this incredible power play, that kept happening all of the way through….There was no place for me to work, but I had to be present… that was about power. When the other doctor came back, this GP and this doctor were standing and discussing me; I was standing there like I was invisible. Fascinating stuff. P9*
	one of the professors walked in and said 'oh god, they are still letting women into medicine'… they all said it… you really start to doubt yourself… you just felt that you weren't quite good enough P1
	it was called ritual humiliation because that's what these ward rounds were. You'd present a case and it would get pulled apart and whoever was presenting was always humiliated because of what they had forgotten or not done… maybe this is a game guys play all their lives so, so they don't find it nearly as threatening when it happens, but I found it very difficult. P1
	the guys would say one thing and would get listened to, you'd say exactly the same thing and the person wouldn't look at you… they wouldn't communicate or accept that what you were saying was valid. Or they'd give you something that was really hard or really embarrassing to do in front of them, like doing a scrotal examination on a young guy when you were 21. P1
	one of the surgeons, he'd pick on someone out of the group, and there were 6 or 8 in the group, and he would pick on someone and pin you against the wall and pound you with questions. And if you didn't answer the question he'd abuse you, 'come on don't be stupid, you know the answer to that', and all this kind of stuff. And it was so appalling because even if you did know the answer you certainly couldn't think of the answer under those sorts of circumstances. P3
	He just turned around and looked at me and said "I'm gunning for you. Do you know anything at all?" This is in fifth year or sixth year… if you spoke, you were open for humiliation. If you didn't speak, you were open for humiliation, because you didn't know in one, and in the other, you'd be wrong… I have a real terror around not just the judgment but the humiliation. P9
	a process of public humiliation if you didn't know all the answers… a culture that's very showy, if you like, or arrogant…. I always thought that was something about breeding the arrogance. P7

Humiliation	*in the ward round it was actually my performance that was being judged, not anything to do with the care of the patient. P8*
	And then there was the crass, sexually sort of perverted type of jokes about when doctors are around a lot of women. That was going on in my day, just you know, laughing at pictures of women or flashing boobs and so on and sexual innuendo behind it in lecture theatres. P2
	in the middle of the clinic, in the middle of the hallway with patients and other registrars around, this person started yelling at me 'things have been said about you, you've been answering back people, you are not behaving properly and you've been putting people's backs up' and all this kind of stuff…. it was like being treated like a little school girl. P3
Punishment	*And then after the dissection you'd have a tutorial and you squeezed into these round demonstration rooms where the tutor would stand at the front and there would be two rows of tiered seats in a semi circle, so you were physically uncomfortable. They still have these rooms and they made them purposely tiny. The tutor would have the relevant body part and would pick up this bit of muscle or vein or nerve or artery and would go round in turn 'What's this, what does this connect to, and what are the branches of this?' If you didn't know it, you just felt like you had failed. There were never consequences but it was public humiliation. P7.*
	After the end of it I felt very, very frightened because I knew he would punish but I didn't know how he would punish…. Another form of punishment was sacking the very person who'd been an enormous support within the organisation. P8
	Mind you, the senior man of course has failed to answer my emails and I believe is about to eradicate me from the education structure of the college because I bug him. P8
	People fail, its not a high proportion but its often about personalities and certain people, I was a sitting duck for it without realizing it, get picked on and get singled out, rumours go round, this person's a bit of a rebel, this person is not toeing the line…. he had a certain amount of power and he bad mouthed me, he said oh that Dr. X, dreadful person, won't do as she's told, did a bad report card for me, won't listen, you know, ticked all the C & D boxes instead of the A & B boxes. P3

Betrayal	
Intimidation	*I entered medical school, this vibrant, energetic, forceful, exuberant woman and left medical school suppressed. The only place I could ever express myself was when I was acting. P9*
	And then I think the two heads of department under whom I served, their fight got even worse and more vicious and so I was sacrificed. So…the meeting where I was sacked was, I thought, a meeting about something completely different… and I say, "I didn't know this appointment was about my job". "I'm sorry, my secretary forgot to tell you." That's what this very senior person said to me in the presence of another colleague that he had got to come…So I'm thinking, "Why would these guys need two very senior guys to give me this news?" Well, because they were doing something illegal and they wanted to intimidate me. P8
	And so he held my hand and he held it for a long time, and I'm sort of thinking, "I am chair of (the committee). We're alone in the College and you're telling me to be a good girl and holding my hand". I'm thinking this is really odd but didn't take my hand away. He tried the mental intimidation. He tried the, "Well, of course, I'm just about to change this with you" and "Of course, I'm the boss of you". And it's very hierarchical and maybe to him it was so clear-cut that he was the boss that I was transgressing that as well… And then I understand he asked a few senior women to kind of get rid of me then. P8
Fear	*the first thing he (consultant) would ask you when he met you was what school you'd been to, and you really had to have been to a good boys school to have registered on his radar screen… it was, it was very powerful at the time. P2.*
	I was working with a different group of consultants who I didn't have a lot of rapport with, I was quite shy and very scared of them. I was afraid. P4
Invalidation	*It's the not looking at you when you were distressed by something and you'd look across, that your eyes would be deliberately avoided. If you ever said anything that was about what I regard as emotional caring of the patient it would always be dismissed. If somebody was distressed or upset and you held their hand it was like you were 'excuse me where did you come from'. And sometimes you'd see patients lying in bed with tears trickling down their cheeks and to hold their hand wasn't a big deal, but somehow you knew that it was the wrong thing to do. P1*
	you also turned a lot of it internally, at least I did, that my knowledge wasn't valid, my feelings weren't valid and the things I felt were important nobody else did, so I tended to think it was me that was out of step… Incredibly painful. P1

Harassment	*I was the recipient of the put down with a male surgeon when I was a student who basically used me as his own little whipping boy… And that guy single handedly turned me off surgery… as a junior doctor you're expected to be the whipping boy or girl. And so you expect that you're going to be victimised, because that's just what happens to junior doctors. P6*
	The girl who got the job ahead of me, the professor used to get a bit tipsy at the residents' turns and peer down the girls' dresses and have them sit on his knee and I just wouldn't have a bar of it. P1
	Some of them were when some of our lecturers would actually touch you, when you were on ward rounds particularly, come and pat you on the back or put their arm around your shoulders and you were uncomfortable and yet you felt you couldn't turn around and say please will you not do that. You just felt paralysed and just accepted it. P1
	there was another resident there at the time, another intern who was also being harassed by this registrar, who had her reputation absolutely destroyed, because she was a little blonde beautiful woman. P6
	(In) her sixth year of training and she'd get very frustrated and angry (when) one of the particular consultants would just take over, doing a vaginal hysterectomy, and it would really knock her self confidence around and it took a couple of years after finishing training to get that back. P4
	Anyway, I gave what I know was an honest answer and I know that they didn't like me giving that answer; there were certain things they wanted me to say, and I knew what they wanted me to say and I refused to say them because I wasn't going to say them. I just knew it was bullying, and it was. And then some months later that person sort of , it felt to me, like he sort of hunted me down and I had this vision of me being in a corner and he looked me in they eye and he said, "You were weak". This was a big, big bully accusing me of being weak and what I really was strong, I'm sure, and somehow it made him feel weak, that's what I'm sure it did, but it had a big impact on me because he's a very powerful, senior man. P8
Isolation	
Boys club	*I think the boys club has been very strong in surgery over the years… and you could see that this was their club and they felt perfectly comfortable within it. P6*
	the doctors' changing room's only for men … this is sort of a boys' club. P7
	I felt I didn't belong, that was huge and I felt that I wasn't respected as a person and I felt that I wasn't given support or that they didn't think they could train me… and they didn't want me… you don't look like us, you don't sound like us, you don't play golf, know anything rugby, didn't go to a private school, you don't fit what we want at all. P4
	I've never been to the senior medical staff room. It just sort of is like sort of male bastion. P7

Denied authority	*being accused of being a nurse when you're a female doctor is one of the most insulting things you can be told in a hospital… because you're female, you're subservient and female doctors find that terribly insulting, terribly insulting. It'd be worse than being called a slut… nurses don't have authority in the hospital and so to be accused of being a nurse I think emasculates you. P6*
	Simple things that I felt being a female as a registrar was doing a ward round with a (male) resident and … explaining to a patient about something and all the time he was looking at the resident and didn't want to listen to me. That sort of thing happens time and again. P4
	But after a little while this pattern emerged that in every single unit at a major tertiary teaching hospital in Melbourne the female specialist was the worst consultant in her unit. This was nothing to do with what you saw them doing. This was just the general feeling about them. P6
Marginalised by mainstream	*(Women) can't be relied on, don't have the right kind of style, emotional, neurotic, anxious, can't let things drop… I think as far as more senior positions go, we've got a long way to go in both sexes being comfortable…. Well, female also doesn't get a good rap through history or literature. We've got Lady MacBeth, and we've got the martyrs or horribly perverse or radical individuals. P7*
	I've certainly been silenced in meetings by other women who know that they've got to show power because there's some powerful male in the room who they want to impress. P8
Discrimination	*And the practicalities of things like arranging maternity leave, arranging leave, I felt were enormous. For me they felt enormous, and yet it seemed so simple when you think about it. If only I could be the person rearranging the names on the roster, then it would be OK. So this is like, I never imagined that I could be that person, like I felt excluded from being that person, so I felt as though I was part of a profession and an organisation of work, that I didn't identify with that person at all. I didn't feel as though I could ever be in control of where the rosters went. P8*
	they said that these were eight issues important to the college. And you think well, you probably have just not mentioned the one thing that's important to women, sexual discrimination or harassment or bullying. P4
Alone as a woman	*I was the only girl trainee, the only female surgical person at that stage… I felt very alone and very unable to talk to my peers even. P4*
	I've certainly tried, just simple things like talking about cricket or whatever (laugh) and trying to be similar to the boys, it didn't really work for me… I suppose early on I probably had the confidence and the arrogance but I didn't ever quite get the, didn't ever quite get the arrogance. P4
	I was told I wasn't good enough to go and offer my services as a surgeon in the Pacific Islands, as a registrar when I applied. And I'd failed to miss the cue which was that no woman was ever sent on these trips, so for many, many years I thought I wasn't good enough, but in fact I learned very much later that they took a woman once and she had sex with one of the doctors in the surgical team so they don't take women any more. P8

	the first time I ever worked with a female surgeon, my boyfriend said I came home aglow because I'd finally seen somebody who was reasonable, personable and very good at her job. And he said that that had an obvious effect and you don't sort of realise that that effect is not there on a day to day basis. P6
Rules of Engagement	
Resistance	*I thought 'look surgeons don't like women anyway, why should I bother going into it, particularly if I'm going to be treated like this'. P6*
	one of the first female surgeons said that because there were so few of them, they were a novelty and so there wasn't much resistance. Whereas increasing numbers brings increasing resistance. P6
	I'm beginning to understand the game now. You've got to be seen to be doing the right things. You've got to have a supportive group of important consultants around you or important colleagues around you. You can't ever be left out on your own. P3
	I was young and very naïve, didn't know how things worked. P4
Shifting goal posts	*There's four core years and then two so-called elective years. Now they've made it that you can't actually start your sub-specialty training until your sixth year, then its usually three years. P4*
	I think the bar got moved. It was a moveable feast. There was never a standard as such. P9
	the hierarchical system that says, 'if you want to get the best jobs in the place nowadays you virtually have to get a PhD'… The people who run the in-patient units basically want their people who do in-patient work to be working full-time and geographically full time so they want them to have their private rooms on site so they can whip in and out of the wards all the time … But it means that people who want to work part-time or to have a different type of practice are just not on the radar screen. P2
Hierarchy	*I guess the biggest thing is the overall hierarchical system which is very male dominated, the whole crawling up the ladder idea, in competition and attitude is very, very male, the whole atmosphere of medicine is still one that is very, very male. I suppose I'm speaking from experiences within hospitals … not a lot of scope for femininity in any of that. P4*
	My colleagues feel that they need to kowtow to all possible sources of power and influence. P6
	medicine, to me, feels extremely hierarchical, extremely determined; the relations are determined by how far out people are from being a med student or what year they're in. A resident would always be the boss of an intern's time and that's a continual cascade of who's who in the hierarchy… and I was frightened of something terrible happening if I took a year off. P8
	men feel more comfortable in that hierarchy, they spend a lot of time in, say, a meeting, wasting my time, establishing where they are in the hierarchy….and I resent the time and effort that I make going to a meeting where it's basically to construct that, which to me is useless, … because I'm always at the bottom anyway in that kind of hierarchy…. they feel as though we're disrupting that hierarchy and respond in various degrees of venom. P8

Medicine does indeed eat maidens. Quadrio found that 'the structure and culture of the world in which the psychiatry trainee is developing is at best characterised by a masculinist ethos and by gender-based discrimination, at worst it is frankly abusive and destructive, including harassment and even sexual abuse.' (Quadrio 2001 p 214). The women in my study are also describing systematic brutality to the less powerful in a rigidly enforced hierarchy in which they, as women, are likely to be 'always at the bottom' whatever their achievements and professional competence. Their otherness cannot be overcome, it precedes them at every step, and in the places within medicine where decisions are made and resources and rewards are allocated, being female is a seriously disabling condition.

The following case studies from the interviews document the detail of processes of containing the feminine in medicine.

Case study - humiliating female patients

While it is not possible to quantify the extent to which this technique is used in medicine from this study, data from the interviews suggests there may be a hidden curriculum within hospital culture of humiliating female medical students by humiliating female patients, particularly young ones with whom students would identify, demonstrating that women have no power, no autonomy, no bodily integrity and can be violated by doctors with impunity.

> *I remember one of my fellow students when I was at the Women's Hospital was a revolting guy who used to visit prostitutes in St Kilda and set himself the goal of going to as many obstetric outpatients as he could to do as many vaginal examinations as he could, the 13 weeks that we were there, or six months that we were there, and I just looked upon him sort of with absolute disgust… it certainly made me feel violated individually as a woman, in that one shared the violation he must have been imposing on the women he did that to. And guess what profession he is in now ? He is an obstetrician, a gynaecologist. But there is no doubt that you felt it partly for yourself at the same time. P2*
>
> *I do remember, particularly the elderly women in the gynaecology wards; I felt there was a lot of indignities thrust upon them, being examined by lots of young students, and that didn't only happen in obstetrics, it happened in a lot of the cases, but these sort of poor old ladies who had probably never been seen by anyone apart from their husbands, or if they didn't have husbands, nobody in their entire life, it seemed pretty awful sort of humiliations I think. P2*
>
> *the most appalling things that happen in an operating theatre is when women have got their legs sort of strung up and they're on display there, and there are male techs and everything. I used to run around, and I try to do this with my private patients, just keeping them covered until we are ready to (make) the surgical incision, covered up. P3*
>
> *The whole attitude to all of them, tutors, and lecturers and everybody there, was that women are uterus's carried around in female bodies. And they're to be told what to do and do not enter into discussion about options… there was this secondary discouragement because you could identify with these women. P6*
>
> *being told by a very fat professor that women shouldn't get fat with the poor fat patient lying in bed, but it was directed at the girls. She was a woman in the bed, but it was directed to the girls. P1*
>
> *the occasional breast examination, again in outpatients, where you sort of just didn't really want to be there while this woman had her top stripped off… as all these medical students trouped past. P6*

> *the things that happened at (the hospital) that upset me so much with a lot of the men who were so (pause) - it was like raping the women. P5*
>
> *it was still a total meat market. All the outpatient stuff was. I mean some horrifying things happened, like you know young girls saying they didn't want to be examined by medical students and having a specialist line, you know six medical students up to (pause) a lot of terrible things happened… I spent most early hours of the morning in the car park in tears. P5*
>
> *Stuff like on ward rounds. Sometimes patients would get quite distressed and you felt you couldn't speak out, the classical ones that were essentially raped, that I still remember when we had a public patient at (the hospital) who didn't want the students to exam her and our obstetrician/gynaecologist turned around and said not only would one of us examine but all of us would examine this woman. What's more we did it. That's the stuff where you just wanted to rage at this man, how dare you do it. Yet you also were part of it with him. You just felt awful but totally paralysed as well… oh how could I do that. P1*

These are particularly poignant accounts of a disenabling environment for women doctors. Other testimony has demonstrated how women doctors themselves are marginalised, disallowed and silenced, and these accounts show a pervasive atmosphere of antipathy to the feminine, and to embodied women. As young women the doctors recall particularly those instances of humiliation perpetrated on women patients close in age to themselves, and in encounters they can anticipate being involved in as patients, triggering empathy and a sense of helplessness at not being able to protect the patients.

Even harder to bear are those events where the young doctor is forced to participate in behaviour she believes to be damaging to the patient with whom she identifies. She is presented with an impossible choice, to behave ethically to the patient who may be herself, and risk being refused acceptance into the club of medicine, or to do what she is told and in so doing cause harm to the self she identifies in the patient. If she identifies publicly with the patient by seeking to protect her, then she is implicitly putting herself on the wrong side of the doctor/patient divide. This exercise of ruthless power lets young women doctors know that medicine can do this to women, and can do it to them, in their femaleness. It invokes a feeling of helplessness, violation, and rage. It smacks of the witch burnings, forcing women to participate in rituals of aggression toward women. All of the doctors I interviewed are deeply ashamed of their collusion in this process.

Requiring novices to participate in illegal or unethical conduct as a form of initiation is a well established method of ensuring loyalty. It operates at several levels. At the most simple it makes it difficult for the participant to criticise the culture or blow the whistle, because they have colluded in it. It causes confusion at an ethical and soul level that makes the initiate more vulnerable to suggestion in similar contexts by distorting their moral compass, and thus reducing their internal authority. And at a psychological level it leaves a residue of self-disgust that can interfere with resolve and intention. Almost certainly young women who have been exposed to this dampen their ambition and their will to succeed, leaving the field more open to those who do not suffer the pangs of identification with the abused patient.

Case study – tantrums in the operating theatre

This case study is provided by P6, a surgical registrar who is deeply embedded in surgical culture but not yet completely enculturated. She has a keen eye.

"It's very much a culture in medicine, in surgery that tantrums are acceptable, if not enjoyable within surgery, and people can rant and rave and shout at nurses and embarrass them in front of people and so on and so forth. And then turn round and be good, enthusiastic, friendly working colleagues the next day, even later on the same day, providing that that doctor's male.

Q: Talk to me a bit about that culture

Oh well to provide you with an example of this in action, there's a cardiac surgeon who I don't work with directly, but who has a terrible reputation at work at the moment. He managed to injure somebody the other day with a scalpel that he threw in the middle of theatre. ... And but that was considered to be an acceptable behaviour. And you hear stories like that all the time. And it's got a lot to do with power, because that behaviour is not involved in good surgery. And it's got a lot to do with the hierarchy within the operating theatre, which is necessary in order to enable things to go smoothly. And when things are going badly you need a hierarchy where somebody takes control and everybody recognises that they have the right to do that without questions. And to take responsibility for things that go wrong as well, it goes two ways. But that seems to have developed into a culture whereby those at the top of the pecking order can do what they want to. And nobody underneath them can say boo. And part of the reason behind that is because the bosses also control your future career. There's no where else to go within surgery if you don't get along with those that control the College, (and) the local surgeons. And so there's sort of this culture that at the top of the pecking order you can get away with things, because that's part of an acceptable behaviour pattern within surgery. And further down you have to put up with it because you can't join the club unless you do.

Some surgeons are for it. Others never do it. So it's very much personality driven as well, but at the same time those that don't necessarily throw overt tantrums also can assert their authority in other ways. And many of the surgeons around that are the most dangerous to work for, not necessarily those that throw scalpels but have a vindictive streak who will verbally abuse people, or undermine them or indeed use their contacts at the College to undermine them professionally. And they're the ones you really have to watch out for. They're dangerous to be around, rather than the tigers that are an obvious threat for you.

Q: What's the function of them (tantrums) ?

Intimidation I think. And then sometimes you see them thrown in frustration when a patient is doing badly in an operation for example, or in the case of registrars where they've had some grief brought down upon them by the bosses and they're taking it out on somebody else. So some of them are borne of frustration. But I think at the end of the day their aim is to intimidate.

Q: Does anybody think that's odd?

People comment that they don't like it. But I've never seen somebody directly challenged when they're throwing one

Q: Do you think that's a boy/girl issue?

No it happens, but just as equally between male consultants and their male registrars and their male residents. I think that ... women are easier targets for it, and I don't think that women throw as many tantrums as the guys do. But I think it's a power issue, not a gender issue. Yeah and if you have a female registrar and a male consultant then that power issue becomes even more manifest, and it becomes a secondary gender issue then, an assertion of power in that situation as well.

Q: And if you had a female consultant and a male registrar?

I think that women in general throw less tantrums as you probably would expect. But I don't know whether that would be still valid whether they had a male or a female registrar. I've only worked with one female consultant, who is the furtherest from the tantrum throwing you could possibly imagine. But I think that at the end of the day, that female boss, it would depend on her personality; and women can throw tantrums, equally with men. P6

We learn from this detailed description of the way power and hierarchy is played out in the setting of the surgical theatre some of the aspects of medical culture that are experienced by women as abusive and unsafe. The hierarchy of power is central to these abuses, and the dependency by the younger doctors on the goodwill of consultants for their opportunity to obtain their fellowship. As she puts it so well, if you want to do surgery 'there is nowhere else to go' so you had better shape up.

The system of abuse travelling from top to bottom of the hierarchy replicates that found in the bastardisation training established in military academies, where senior students bastardise junior ones, and junior ones harass the new students, who have 'nowhere else to go' if they want to be soldiers.

Case study – creating women as aliens

Asked what she had learnt about how women are invalidated in medicine, P8 responded with a depth of knowledge drawn from a decade of senior college representation and politics as well as her experiences as a doctor within private practice and hospitals.

Looking out the window when I say something important. Certainly for ten years of my life I spent a lot of time with senior men and I think I know lots of ways that they kind of make me feel excluded because I'm feminine, so it's like I'm there on very conditional terms. If I play ball and that I'm a good girl and I fit in with their idea of what a good woman does. And so, I guess, creating me as the alien, that's what I think happens. You know,' if you think that, you must be an alien because I've never thought that'. Or,' if I've never heard of that idea before, then not only are you not welcome, but that's stupid'. And 'I know I'm right' so it's kind of a battle of who feels most entitled to grasp reality.

I think it's done really simply, just by looking in the other direction, acting as though that person isn't there, belittling people if they do say it again. Like I feel as though that is something I've had to learn, is to anticipate being belittled and because it makes me feel bad, trying to avoid it, so there's forums that I don't go to and that I make the decision of just staying away. A lot of times it's done very nicely because they don't invite me anyway, so it doesn't have to happen, so I guess I do live with the tension of feeling intellectually and emotionally excluded when I am there versus not even being invited in the first place. It's not much of a choice any more.

I'm thinking about the ways it's physically done, mechanisms. So, physically excluding, emotionally isolating, belittling. Physically looking out the window. A lot of it is in the body language and I've thought lots about this in the last five to ten years because I think it's absolutely essential for me to learn more about it, and I don't think I've even got it to the level where I can teach other women how systematic it is and how pervasive it is.

Another mechanism is to divide women, and the way that that's done is to have one woman on, say, a lot of senior committees but to look in the other direction when they ask are there any other women here, or to not include other women's emails when they're doing the round and not tell the other women who are senior in the organisation what you've done to one particular one. And I've seen this done again and again in hospitals, in colleges. So

dividing women, I think, is an active process and a positive mechanism that makes me feel unentitled to be there. P8

This doctor has come very close to the prime sources of power and authority and status in medicine. She initially assumed she was entitled to be there but having been created 'as an alien' she began to look more closely at what was going on. She has important lessons to share with other women who might want to tug on the levers of power within the profession, so they can protect themselves from this 'othering'.

The data from this study also demonstrate how social isolation contributes to the process of forcing the doctor's developing professional identity into set pathways. The post-graduate training programmes are so intense that doctors have to give up much of the social contacts and other, non-medical activities that would assist them to keep some perspective on what they are experiencing. This is often combined with geographical dislocation, a requirement by training programmes that they move from town to town and from town to country in order to obtain a range of experience and contribute to the medical workforce in areas of medical shortage. One doctor described how, by the end of her sixth move in two years of training, she did not even bother learning the names of her colleagues. Cutting off contact with the outside world is a well-established technique of brain-washing, enabling even apparently bizarre behaviour, such as operating on patients not because they need surgery but because the surgeon needs either the practice or the fee, or throwing scalpels in the operating theatre, to appear normal.

Shades of the witch burnings came through in the interviews. Just as daughters were forced to watch their mothers burn and so learned to suppress their instincts for autonomy, so female medical students and young doctors observe what happens to women who become consultants in various fields, and may decide that is too hard, too ferocious, too damaging, and turn aside and find a safer place to be a woman in medicine.

2. Reshaping women

Women are the wrong shape to be doctors. As Quadrio has pointed out, women seem to 'lack' many of the essential requirements for heroic masculinity that underpins medical practice[37]. There are aspects of medical education and training that focus on reshaping the doctor to fit the dominant model. The ones that have been identified in this study are outlined in Table 8.

37 Address given at the National Teaching Gender workshop in Melbourne in 1999, Wainer, J. (1999). National Teaching Gender Seminar. Traralgon, Monash University School of Rural Health.

Table 8 Reshaping women

Athena Myths	Interviews	Survey
Warrior pose	Masculinisation	Heroic, stoic rural doctor
Adopting the culture	Enforcing masculine cultures	Divergent aims Confidence
Meeting the requirements	Fit life into masculine structures	Extended hours
Camouflage	Playing by the rules	
Trashing women	Deny female self	
I have no mother	Deny family	On-call

It is a striking feature of both Athena and some women doctors that, at first glance, they have adopted a masculine pose. Athena armed and helmeted is clothed in garments that women of today have not been allowed to see associated with the feminine. The history of warrior women, of the Amazons, Boadacaea, Joan of Arc, is not taught. For those women who are attracted to the warrior aspect of the feminine, medicine offers both the training in how to become that, and a place within which to practice it. What seems to be missing is the opportunity to balance the call to action, embedded in the masculine warrior, with the reflexivity of the feminine. And what seems to be missing too, is the opportunity for women who relate to the feminine differently to also be called to act in the inner circles of the profession.

Medicine's masculine culture

The doctors I spoke with readily identify the masculine culture within medicine, their attraction to some aspects of it, and their struggle to not be consumed by other aspects.

> *being a female doctor you become very disillusioned with the medical hierarchy and the way that medicine is run and the people who appear to be in control of all the colleges, really and of medicine as a whole, is very male dominated, even though we've had some outstanding women doing different things its still extremely traditional and extremely male dominated. P4*

To understand what this doctor means requires a brief exploration of the components of a masculine culture as seen through the eyes of women doctors. It has been a help to me, in understanding the masculine nature of medical culture, to make the link between medicine and the military. Marilyn Waring found the link between the military and the national accounts – how nations count and value the activity of their citizens – after years of searching in the bowels of the United Nations. She discovered that the national accounts were developed to win the war (Waring 1988). As a result, all activity that contributed to the war effort is counted as economic activity, and all work that did not contribute directly to the war is not counted. This has the distorting effect of valorising and embedding some types of activities, such as cutting down forests and fighting fires, as contributing to national productivity, and making others, such as cooking and taking care of families,

invisible. It is one reason why governments refuse to make child care, that most obvious of work related expenses, tax deductible.

Figure 1 Ritual humiliation of female junior cadet

Medicine/military break down the self-concept of initiates by humiliation and harassment, and then reshape them into doctors/soldiers

Medicine was also developed to win the war. I mean by this that many of the professional structures and leaps in knowledge have been developed on the battle field. The United States military, for example, is the biggest employer of scientists in America (Morse 1995). As a result many of the cultural components of the military are embedded in the culture of medicine, including the toughening up process represented in this photo. This may account for some of the more extreme examples of hierarchy and aggression that are encountered by doctors within their profession, and which women are likely to find more troublesome than men.

Components of masculine culture

Elements of the masculine culture of medicine were clearly identified by the surgical registrar. She is deeply embedded in it, attracted to it and repelled at the same time, and sufficiently new and junior to still be able to see what is going on. She describes it thus:

Vignette: Playing it like a man

The shutting down of one's personal world, you don't exercise, you don't eat properly, it interferes with work, …the willingness to move willy nilly as part of your training, and to drag your social relationships with you or to abandon them … The intolerance of diversity in people's lives includes intolerance of people who have relationships because it's inconvenient to your work; of people who have social commitments that prevent them staying at work late if you want them to; intolerance of people having the afternoon off and leaving if there are things to do because it's their afternoon off; intolerance for allowing people to move off when there's something to do at work, as there always is;… The intolerance of over-emotion at work, of grieving with relatives or of anything beside efficient sympathy for people which may interfere with the efficiency of ward rounds or theatre.

And I think the aggressiveness of interactions with people both at work and also socially where one's dominance is established in social situations as much as it is in a work setting, is also part of masculinised culture of medicine …establishing social dominance… establish hierarchical dominance at work… establishing one's lifestyle on the basis that domestic tasks are done by others, either by a wife or by a cleaner, and you eat out rather than cook, rather than sort of performing those domestic tasks yourself. P6

This doctor has found herself being drawn into the culture she can describe so well, giving up exercise, home cooking, rest, outside interests and becoming intolerant with doctors who work less than she does. She describes having 'much more fun' with people who exhibit this dominant behaviour than with social subordinates. However she is aware of the dangers of being dragged too deeply away from her core values and into this hyper-masculine culture where to fit into the culture *'(women have to)… become hyper masculine … And participate in the rituals, the drinking, the rows, the heroic surgical sort of actions to save lives, staying calm and cool under pressure.' P6.* There is a sense in which she is playing with the culture, taking on the challenges, meeting the requirements, identifying the flaws, and intent on reaping the rewards.

This game playing and risk taking mirrors that described by Conley, who during her surgical training put up with sexist and crude comments, 'nuances, antics, guesses about how good I was in bed' and concluded that she had to be 'one of the boys' if she wanted to be a surgeon, which she did (Conley 1998 p 105).

The older surgeon was also able to identify components of the culture that she found problematic as a woman:

> *They're sort of ideologies that one's always on call for one's patient, one's always available for one's patients. One has no personal needs, one has got no emotional needs that need satisfying, at short notice. That it is a profession that doesn't have emotional needs. Clearly untrue. P8*

Another specialist confirmed the components identified by the surgeons:

> *doing my general surgery … I didn't ever complain, you don't complain if you are tired, you don't have other things to do in your life, that's just not seen as right. P4*

This doctor came very close to fellowship in a hotly contested surgical sub-specialty and was rejected in her final year of training for refusing to transform herself sufficiently to merge with the masculine culture. She was deeply wounded in the encounter, her confidence shattered; by the time the system had tested her to the limit she described herself as *this frightened little thing who would sit in the corner. P4.* This was a woman who had the intelligence to get into and graduate from medicine, who performed so well as a junior doctor she was able to enter the surgical training program, and whose surgical skills, determination and ability to meet the demands of the training programme resulted in her being invited to enter sub-specialty training. Once there, she encountered some of the adverse aspects of hyper-masculinity, including abusive consultants who were supposed to be her teachers. Of one of them she commented

> *I used to say 'he wasn't good in green' because whenever he was in theatre he would rant and rave and yell and would really be quite abusive to his assistant and to the nursing staff. And I'd respond by being fairly silent actually and just trying to do things the right way so that he wouldn't yell and carry on which didn't seem to work because he did anyway, he always did. P4.*

As the assistant who was being abused she felt both responsible and powerless to change the behaviour.

The small field of sub-specialists, the intensity of the scrutiny, and the very narrow band of behaviours deemed appropriate within the group made her femaleness problematic and she found herself disallowed at every turn. She was the only female in that subspecialty in her state and one of four women in Australia. She came to realise that being rejected toward the end of her training was not a reflection on her surgical competence. It was not about skills, '*the problem was being different, or feeling very different, from the mould that they wanted and expected. P4'.* She did not want to become 'one of the blokes' and so she did not pass. She had come very close to the flame, very close to the centre of power and prestige within her chosen discipline, and was metaphorically burnt. Her disguise was seen through. Athena might be able to hide her feminine wisdom in the owl that was her familiar and get away with it, but this young woman could not.

The psychiatrist in the interview group described how she had been castigated for allowing some playfulness and non-hierarchical teamwork in the unit where she worked '*the male consultant told me … 'The handover was too frivolous this morning. It needs to be far more contained and professional.'. P7* The consultant had no power over her so she could choose to be amused by his remarks and his attempt to define her professional environment. This is what many of the women in the study do. They work very hard to engage with medical culture, establish their competence, gain the skills and find a place for themselves, and then they pull back a little, have another look at what is going on, see things differently from the other side of the training divide, wonder at how easily tamed some of their male colleagues are that they can be persuaded to give up their relational life and work themselves to death. Why would anyone want to do that they ask.

Quadrio has examined in depth the culture of masculinity in medicine and the damage this does to the 'relational self' of the doctor (Quadrio 2001 Chapter 8). Women in my study have a more ambivalent relationship with the masculinity of medical culture than she describes, both drawn to it and repelled by it. Athena disguised her feminine behind helmet and shield and went to do the bidding of the father. She was handsomely rewarded with longevity and honour. Medical women too disguise their femininity and do the bidding of the fathers, and in turn are rewarded with honouring and status, and even if this honouring does not come often from within the profession, then certainly it exists outside it. Like Athena, medical women call upon the masculine in themselves and in the profession to allow them to act. They can and do act in the interests of their patients as well as in their own interests.

Medical women do struggle with the abrasive masculinity of some branches of medicine, and they learn from it too. As older doctors they make decisions along the way about how close to get to the flames, how much of their feminine selves to risk in order to glimpse the fools gold of status, to get their hands on the levers of power. The ones I have spoken with have all kept their feminine intact, although one has had to withdraw from medicine to do so. However some women, it seems, do become engulfed.

Masculinised women

Foucault's analysis of the relationship between power and knowledge introduces the idea that discipline works through a series of 'quiet coercions' manifesting through people's bodies. Discipline, in his terms, combines the two meanings of correcting or punishing, and a body of knowledge. Discipline and knowledge create us as particular kinds of people, and this knowledge is inscribed in our bodies (Danaher, Schirato et al. 2000). Women engage with medicine and accept the discipline in order to learn the discipline of

medicine, and embody the role of 'doctor'. When the body of knowledge that creates the discipline that is embodied in the doctor is male, this creates a problem for the woman who wants to be a doctor.

All the women who took part in the interviews spoke about female colleagues who have become masculinised through their training and professional environment:

> *You know its like the army, just to get through they had to be really tough. There are some mad things about it…. Some of the women gynaes come out and they are like men. P3*
>
> *I think the few women role models in obstetrics may have taken on the male persona to get themselves through. I think that's a bit of a shame .P4*
>
> *most of other female surgeons I know are unmarried pseudo men. Very nice most of them, very approachable, but still got very masculinised behaviour. P6*
>
> *Even now, I think, when we look at how many female specialists there are, when we look at how many females there are in positions of power, as we see it in the medical model, I'm sure one of the reasons is that there is still a high price to pay.*
>
> Q: What is it?
>
> *It's giving up part of the feminine; giving up a lot of the feminine in fact because you have to be identified as one of the "guys" or one of the "blokes", and yet you still can't belong to all their clubs. P9*

Medicine devours maidens and these descriptions of the requirement for women to hide or abandon their female selves in order to gain access to prized positions in medicine illustrate how the trade-off is made. Become like one of us and we might let you in. Only the individual women can know if the Faustian bargain is worth it. One option for those women who did not want to engage in this bargaining was general practice. This is the branch of medicine that is the least hierarchical because it is practiced outside hospital environments. The training to become a general practitioner is shorter than for most other specialties, and doctors can establish their own practice cultures. Women are going into general practice in greater proportion than any other area of medicine and enjoying the extended patient care and autonomy that provides for them. The trade off is lower prestige and lower income than other specialties.

Rural general practice is more masculine than urban practice. The culture of rural practice was established when rural doctors were men, and rural Australia valorises masculinity (Dempsey 1992). Female rural doctors find themselves in conflict with the requirements of the role of the heroic, stoic rural doctor prepared to die with his boots on. The idealised rural doctor is required to provide emergency medical care to his community and be on call at all times. This, like the surgical culture described above, is predicated on the unspoken assumption that the rural doctor has a wife, and works poorly for most female rural doctors who either do not have someone providing family care, or are themselves the doctor's wife.

Medical knowledge

I explored in Chapter 2 how the construction of medical knowledge took place not only in the absence of women, but in part to distance itself from women's knowledge and being.

The myth of Athena holds within it deep understanding about this distancing and how it was undertaken. She has as her familiar the owl that sits on her shoulder. According to Guttman, the owl has always been known as a bird of 'wisdom' - and yet this is typically understood to signify a deep inner knowing or understanding, rather than wisdom of a purely intellectual type. He proposes that the work of the ancient Greeks to transform her into the goddess of intellectual wisdom is not so much a statement about Athena as it is about the Greeks, who glorified the intellectual process. Athena's knowledge, however, was never purely cerebral; it was useful (Guttman and Johnson 1994). Some of the doctors recognised the consequences of this discrepancy between intellectual knowledge and Athena's wisdom in their professional lives:

> *Women… have to work through the male paradigm … if you want to try and prove something and have it recognised as knowledge you have to do that because that's the paradigm we have. P3*
>
> *if it's not logical, it's not rational. If it's not proven, it doesn't exist… to actually feel or be emotional or any of it, was so non-scientific, so irrational and so stupid somehow. P9*

Women then, are not to bring their knowledge-making to medicine, but must learn within the established masculine discourse, earning both a medical degree and a degree in self-denigration. This 'othering' of women's knowledge and preferences for practice is likely to be reflected in a reduced sense of competence and confidence to practice. The possibility was tested in the study of rural doctors, which found that nearly a quarter of female doctors preferred to have female teaching faculty involved in emergency medicine training, and an even higher proportion of unconfident women wanted this[38]. Women are challenging the hegemonic presentation of masculine styles of knowledge production and transmission.

3. Fit life into masculine structures

Pierre Bordieu introduced the term 'habitus' to describe the self-governing practices that form a set of behaviours, perceptions and attitudes that are 'regular' without being overtly governed. They are the product of mundane experiences that become embedded as 'second nature' and are enduring, difficult to uncover through conscious reflection, and capable of reproducing themselves in a variety of contexts. The habitus operates within a field of practice or across a number of fields. For the individual, habitus is internalised, and sustains practice without overt regulation, but through routines and tacit knowing (Usher 1997 p 59 - 62). This is similar to Foucault's notion of discipline inscribed in the body. In medicine, this habitus is male and women engage with it in a variety of ways in order to be able to feel 'at home'.

Women in this study identified ways in which their female life-course was required to give way to rigidities of training programmes that had been established when doctors were men and men had wives. The length and intensity of the training, the lack of flexibility, great pressure to work extended hours and to centre your life on your work, with critical

[38] Details are provided in Chapter 9

activities held at 7.30am and during evenings, all assume the doctor has no family or someone else is taking care of them. This does not apply for many women and they struggle and anguish about how to meet these requirements in order to further their professional lives, and at the same time have the family that most of them wanted.

> *I also talked to a couple of plastic surgeons, one who was the first female plastic surgeon in (the state) and she told me not to do it … she basically said 'Right well have you got a relationship, what do you want to do with your life ? You know you have to travel around Australia and don't do it its horrible'. She liked the plastic surgery, she felt very isolated and was really quite disappointed that she had chosen that. She said she put the rest of her life on hold and she was now in her late 50's and didn't have a relationship, didn't have kids, didn't have all these other things she'd missed out on. P4*

> *I wasn't at all aware of the problem of infertility based on how long your training is, which I'm now very much aware of. I only just made it by the skin of my teeth. P8*

In order to win the prize of training in the discipline that attracts them, women had to reshape their lives so they could become single focus, family free, disembodied entities and they were angry about it, but did not have sufficient authority in their own lives to require that the system change to take them into account.

Playing by the rules

How things got to be the way they are is a mystery for most doctors, and it has been a purpose of this study to shed some light on that. Mystery or not, women are constrained by rules they had no part in making if they want to move into positions of responsibility and authority within the profession, or even just to pass their exams. Athena camouflaged her true identify in the cloak of the father, and learnt to play by the father's rules to ensure her survival. Medical women have to do the same. This does not escape their notice:

> *somehow the written down rules, which to me are totally what some guy felt like fifteen years ago was the right way of organising the world and are written down and somehow women adopt those as what they think are policy or what they think are right. P8*

The rules of medicine make them sweat for every ounce of authority and they are both attracted and repelled by this:

> *I think that part of the condition of giving us power is that we play ball and that we do the same sort of things as men do with the power, and there's a part that makes me want to not partake, part of it makes me want to partake and explore, and part of why I want the power is so I can do exactly what men do. P8*

Women who play by the rules, who engage with male cultural norms as much as they are able to without making fools of themselves, who camouflage themselves in Zeus's mantle, may be invited one step closer to the sources of power:

> *she puts in … one picture of an eye, one picture of a soccer ball. She does it really beautifully … and she gets the audience all barracking for each other's team during a lecture on eyes. So she does it beautifully. And she gets invited to be on the Board of Examiners. P8*

And then again, maybe not. Many of the rules are hidden and women discover them only when they transgress them. Women are constantly on trial as to whether they fit. Conley

found that after challenging the system she now understood that 'the essential functions of our medical world depended on women's willingness to capitualate to masculinity without asking questions, without fighting injustice, with complete servility, because maleness is the purest and most highly revered form of power in our profession.' (Conley 1998 106). This was a lesson hard earned and from which she nearly did not survive.

Deny female self

The flight from body and nature described in Chapter 2 did have the democratising effect of allowing that women, too, as human persons could participate in the ascetic practice of intellectual thought. By negating their own identities as sexual beings and mothers, they might become neutral or "honorary" male spirits, equal to males in the 'flight to eternal life.'(Ruether 1993 p 80). Women in this study describe how this plays out in their lives as doctors.

One of the requirements for passing the test of admittance to medicine is for women to deny their female aspect. The surgeons have the most to say about this. Rural doctors experience it as well but the rewards for giving up their female selves are not sufficient to tempt most of them. It is a sellers market for rural doctors and women are better able to insist on their right to live and practice as women than doctors who are vying to gain acceptance in the high prestige/high income branches of the profession. Women who want to be surgeons, and women who are surgeons, are asked to pay a high price:

> *I'd also developed a thick skin as a person and partly thought 'Right, I've got to hide being a woman because that's obviously wrong.' P4*

Vignette: A very non-girlie girl

I have a very close friend of mine who's another surgical registrar who has become increasingly masculinised over the years. She was never a girlie girl to start with, but she's now a very non-girlie girl, who has really done the stereotypical female surgeon thing in that she has devoted her life to surgery. She has not had a boyfriend, she lives alone, she works an astonishing number of hours and if her work clashes with anything else then the other thing goes. ... And she's now at the end of the whole process and the friend that I have now, compared to the friend I had 5 years ago, are very different. She is much more aggressive in all of her interactions, both at work and also socially as well. Not less flexible. But certainly much less tolerant, I think, of differences than perhaps she has been in the past. And this is something that I see myself doing as well, much less tolerant of weakness and the desire to slack off... And in terms of whether I'd be tempted to do that or not, I think that it's happening anyway, whether I want it to or not and part of that is the necessity to do the job and if I'm going to do it in the way that I'm expected to do it, then it's not acceptable in the profession to become at all emotional just because you're tired. You clamp down and you become more controlled and less tolerant of other people who wish to have concessions made because they're getting tired, while you are really tired. And so I think the process is not something, again, that you make a decision you're going to behave one way or the other. It's just something that gradually develops as a mechanism to enable you to do what you are told, or you feel you need to do. But I guess I don't see myself ever really being able to fully take on that role because whenever I do it's too distressing. It just doesn't fit. And that dichotomy between what's expected and what I can actually do, is I think, a source of great distress for many women who go into surgery. And the reason that many women drop out, because I've known many more women who've started surgical training and then dropped out than I've known women who've continued through. And I think that it is that dichotomy that causes them eventually to stop their training and to move into something where that schism isn't as great. And I'm sort of wondering when that moment's going to come for me to some extent but that hyper-masculinised behaviour is not a direction that I really feel that I could do very comfortably because it just doesn't fit right for me. P6.

This compelling account of the process of masculinising women, of requiring them to surrender their feminine selves in order to be surgeons, holds within it many of the seeds of the titanic struggle between women and medicine. It contains one archetype of the female doctor, the doctor who has surrendered her self to her profession. Athena quite early in her development as father-identified daughter, traded in her relationship with the feminine in order to serve the father. Athena frequently sharpens the intellectual skills of women, or thrusts them into the patriarchal world with great force, as she does with women training to be doctors.

So this Athena woman is not without insight. Perhaps unknown to her the owl, which could perhaps be her mother, Metis, sits on her shoulder and whispers encouragement and support for her to find a way to integrate the feminine in this male-defined project. For her

story contains also the seeds of resistance, a small Lilith moment of clear vision, rebellion and refusal, as we shall see in Chapter 6.

Deny family

The myth of Athena provides further insight into the problematic relationship medical women have with their feminine, and how it manifests through relationships. Athena is a virgin and refuses relationship not in order to be alone, but in order to be with others without entanglement. She represents a "being with" that fosters mutual creativity, for from her perspective passionate relationships are a diversion and self-betrayal. Yet Athena's in-one-selfness is not introverted: it encompasses deep friendship; it is dedicated to the outwarding of soul in creative activity (Downing 1981).

Athena women are likely to have relationships with family that vary from the current cultural norm of 'woman in service', a norm where women are supposed to find fulfilment through the achievements of partner and children rather than herself. Athena women, and medical women, have lives of purpose to live, they need their energy for their own life and are careful what they hand over to support the lives of others. One of the women in the interview group, for example, a mother of two, has outsourced all domestic work, including cooking, and her husband is so confronted by this that he is keeping it secret from his family.

According to those who have studied her closely;

> "It is in the arena of love that Athene seems to have been at her weakest, and her armour is symbolic of the difficulty she had in establishing any kind of close relationship. Many gods and Titans offered themselves to her in marriage, but she rejected them all. Often, she failed even to understand the sexual implications of relationship. For instance, she once asked Hephaestus to forge for her a suit of armour. Hephaestus replied that he would do it "for love". Athene naively thought that the celestial smith intended to work for her out of the goodness of his heart, but Hephaestus, who was accustomed to being paid for his work, meant something quite different by the word "love". When he tried to have his way with her she resisted. Hephaestus ejaculated on her thigh. In disgust, she wiped his seed away with a piece of wool and threw it down to earth. From this unlikely source was born Erichthonius, child of Athene. He was part man and part serpent, hence a representative of the older, chthonic Athene; the Lady of the Snakes; but he was also the first to institute "father-right" in ancient Greece and to reckon bloodlines through the father's side." (Guttman and Johnson 1994 p 102-103).

Athena then did have a child, although not as a result of an intimate relationship. Her creativity manifested primarily as a civilizing force, as giving birth to spiritual children rather than physical children, who may be rather easier to care for, especially if you are a doctor on call for the medical needs of her community. Using these understandings of Athena's relational life we can anticipate that medical women, Athena-like, will also use their energies in creative ways that may include children and partners, but not be focussed through them. The confusion in this story reminds me of the young surgeon in sub-speciality training who burst out in frustration that she did not know whether she was 'Arthur or Martha'. Intensive post-graduate medical training can do that to women, and Frances Conley has concluded that 'Academia (and medicine) continues to use motherhood to massacre female possibility' (Conley 1998 p 241).

Of the nine women interviewed, four are married and one is in a lesbian relationship, three are divorced and one is single. Two women are married to doctors. Only the single woman has no children, the others have between one and three. They seem to be managing their relational lives a little more creatively than Athena did.

Data from the survey provides reliable statistics on the family structures of rural doctors, and the findings are explored in more detail in Chapters 8 and 9. What is clear is that much more of the care work in families is carried out by female than male doctors. Women spend twice as much time as men caring for dependent children (4.7 hours on a normal working day compared with 2.5 hours for men) and twice as many men spend no time on family care compared with women (39% cf 22%).

The distraction that families provide, particularly for women, conflicts with a culture of medicine that preferences and rewards doctors who give all their energy to professional work, who approach medicine as a vocation. It is very intolerant of families in women's lives although they seem to be a requirement for a man, just as long as they do not distract him from his involvement with the profession (Wainer, Nobelius et al. 2002). Medical women are required to keep their families invisible and endure many forms of harassment and invalidation if they are unable or unwilling to do this.

One of the women in the interview group did her speciality training while a single mother of three young children and she was harassed by consultants and medical administrators and the college throughout her training:

> *You can't take too much time off (to have a baby) otherwise they dock it from your whole training record. (silence) ... Women just have to do it the best they can ... if you are in the training program you can't be a mother, let alone a single mother, and have responsibilities for children.* A supervising consultant cornered her and said *'its been noted Doctor that you have been leaving early'. Well I didn't say anything. I didn't say if I don't go I can't pick up the kids, I didn't say that I've got to go home and put three little kids to bed and cook their dinner and then get them to school in the morning; I couldn't be bothered. P3*

Thinking from women's lives, from the perspective of the non-dominant group that standpoint theory says provides the surest way to reliable knowledge, the experience of this doctor raises the question of what medicine is missing in its insistence that doctors have no visible life outside the profession. The dedication to the Cartesian ideal of the disembodied rational mind, free of distractions of heart, soul or body, leads to distortions that can be seen clearly by those whose lives do not fit readily into that model, like the surgeon who said '*I've never forgotten the kind of sense I felt that this was part of the culture that would just, as a reflex, say no to one's emotional needs or one's family.' P8.* The patients of doctors who are required to abjure emotional and relational needs are likely to feel the impact through dehumanised practice.

There is a conflation between rejection of the feminine, the struggle women have to feel a sense of entitlement within their profession, and having babies and family, which makes women particularly subject to coercive practices. This realisation brings to the surface a lot of anger and rage and a feeling of having been misled and duped.

> *And again it's (childbearing) something you put off to fit in with your training program, and a good friend of mine who is an obstetrician in Brisbane who had her first child in her sixth year of training, said that we had been duped for all these years, that it was ridiculous that she felt she had to put off having a family*

> *until then, to actually do the training, and then she took six weeks off, only six weeks off, otherwise if she had taken more than six weeks off then six months would not have been accredited by the College. So it was either six weeks or six months and she was almost finished and she did it very hard. P4*

The extreme pressure on women to deny their relational selves, to hide behind a mask of masculine behaviour, is well illustrated by the psychiatrist who described how she had managed to have a baby without it having any impact on her professional productivity *'had finished my PhD in two years, 10 months, and 2 weeks. The only reason I say (that) is because my husband did his in 2 years and 10 months, and I tell him that I took the extra two weeks because I had a baby in the middle of it.' P7.* This could be Athena, having a child in the background but whose creativity is not that of the fertility goddess, but that of Athene Ergane, the worker, who will create knowledge that is useful, as well as children.

A psychiatrist who was interviewed for this study described the conversations that women with children endured, and the pressure to make their children invisible:

> *she's got kids, she's unreliable, … does she want to work or does she want to have her family, she can't have it both ways. I mean I've heard people say that about .. women who go off to pick their kids up .. They say 'She should decide whether she wants to work or not, or whether she wants to be at home with her kids'. You're just seen as having not sorted out your priorities, not having good enough arrangements and wanting too much. Not being able to cut the mustard. P7*

Other specialties are equally relentless. A surgical trainee had entered surgery already convinced that family and surgery were incompatible.

> *And that was how I was going to be a surgeon and that whole set of beliefs went together. I was going to be a surgeon, I was not going to get married, I was not going to have children. And I couldn't separate them. P6*

As an older woman with a boyfriend she is now reassessing these priorities and has not yet found a clear way out.

This double productivity is discouraged, penalised and despised within medicine. The doctor who described how she had a baby with not a beat missed in her work schedule, has felt it necessary to keep her children invisible ever since.

> *If I'm late, I'd never say that (son) was sick and I had to find childcare, you know, couldn't find the library book or got dragged into school or I would never give a childcare excuse or a family related excuse. It'll be a male acceptable excuse like traffic was just terrible, there was an accident … and it'll be something that's very non-mother specific and non-competing. P7*

Rural women doctors also struggle with the requirement that their families are invisible. Most of them live in a family yet only 59% (n = 362) are able to take a break from their work to spend time as a family.

Women are forced to the wall, pinned by their ears, held to ransom, required to make unholy choices by a profession intent on sculpting them into a recognisable shape, without breasts, womb, heart or soul.

Women have complex and multiple lives and identities on the whole, and these lives are at odds with the masculine imperative to hand all their energy to the god of work. If they

cannot be coerced or cajoled into doing so, then they will be kept out of the circle, held at arms length from the places where decisions are made about medicine and how it interacts with their lives. Some women can see this, can even describe what is going on:

> *Well, I've discovered that what I suspected, was true, which is that there's a whole lot of things that are arbitrarily designed to exclude women or exclude people like me. Not just women, people who want to try and make a mix of a satisfying life, being very involved with one's family, being able to have some flexibility to participate in paid work and not participate, with a bit of control over it when one does it. P8*

There are places for women in medicine where they are allowed to take their families. These are places of service, front-line delivery of care which is a role women are very familiar with. However when women want to have families and also take part in the decision-making and resource allocating and knowledge-creation tasks that shape their profession, they are either punished, ignored, derided or simply kept out.

This struggle, between women as embodied knowers embedded in families and relationships, and a professional culture skilled at shutting the door on such unfamiliar shapes, continues. Athena, remember, is a warrior goddess. Her martial aspect relates to her civilizing function. It derives from her original commitment to the royal citadel and then to the polis, and, consequently to their defence. Athene Pomachus is a protectress, the helper in battle, the instructor in the art of war, not a battle lusty aggressor. A beautiful relief of her leaning on her spear, her head drooping, pervaded with sorrow, introduces us to a very different Athene: the warrior goddess herself touched by defeat and loss.

Reflective Athena, contemplating defeat

But all is not lost. Medical women are very smart, and they have multiple strategies of resistance to the processes described in this chapter that seek to reshape them into 'non-women' or simply exclude them from full professional life. Chapter 6 describes these strategies of resistance and Chapter 7 considers how, while medicine seeks to change women, women are also changing medicine.

Section 3
WOMEN ARE CHANGING MEDICINE

Chapeau 3

For the most part women doctors do not have a conscious intention to change their profession. However some do, including some of the women interviewed and some who took part in the Delphi Expert Panel. It is likely that most women engage with the profession with all the courage and skill they can muster, seeking to find a place for themselves at the table. For some this results in establishing small 'microclimates' where they can flourish away from hierarchical structures, for others it means engaging with the mainstream to transform the profession. This is a 'push-me/pull-me' game, a constant dance, with women probing the structures of training programmes and practice environments, testing for weak spots where they can assert themselves, finding alliances to strengthen their resolve, withdrawing to lick their wounds when the structures seem too solid.

Some women engage formally with the governing structures of the profession and work for reform from within. They may use their authority to require change, they may quietly implement change without drawing attention to it, they may argue for change in open forums. These are the super women doing the triple shift. They conduct their professional lives as doctors, for the most part providing clinical care on a daily basis. They engage in family life and for the most part have the major responsibility for care of dependent children. And then they do the triple shift, the gender work, the unpaid, relentless, exasperating, terrifying, exhilarating work of shifting ancient structures to include women. And as we have seen in the previous Section, some women love medicine the way it is, have adapted to the requirements, and work within existing structures.

Women are changing medicine with every small act of resistance they enact in face of the requirement that they adopt masculine culture. They may not be conscious of what is happening, they may instead be fighting for survival, yet every act of resistance demonstrates that it is possible to be a woman and be a doctor. Changes are easier to implement close to the margins of the profession, and much more difficult close to the sources of power, authority, prestige, and particularly, resources. Thus rural general practitioners in solo practice are relatively free to structure their lives and practice to suit themselves. Women who want to burrow into the inner sanctum, inside the circle, risk being destroyed, as we have seen in Section 2.

Metis must have taught Athena about acts of resistance. She modelled shape-shifting as a way of escaping and although she was swallowed up, she was not destroyed and lived to give birth to her daughter. Medical women also shape-shift as a way of avoiding being swallowed by masculine culture and in so doing give medicine a butterfly wing nudge toward change. Just as the breath of a butterfly wing in Chile affects the oceans of Australia, so each act of rebellion by medical women invokes a frisson of change within

medical culture[39]. They may literally shape-shift, changing their bodies to provide armour to hide behind or a weapon to use in the battle of the sexes. Or they may hide their real selves behind a mask of compliance, keeping her coiled and at the ready, a Kundalini energy at the service of the feminine but out of the line of vision of the enforcers. Metis taught Athena how to do that. Athena's daughters have learned the lesson well. All may appear calm on the surface but behind closed doors there is whispering going on as women exchange stories, learn lessons, quilt answers and unpick the veil of otherness.

Like Metis, they work with steely determination to protect themselves and the younger ones coming through. They draw on reservoirs of courage to keep going when their pocketful of bravery feels empty. They duck and weave and keep out of sight, all the while learning more keenly to understand and anticipate and get to the depth of things. Women, not being the privileged caste, can see with the clarity of the oppressed the true nature of things. Just as Metis could see what was coming and girded Athena in the cloak of the coming era, to enable her to remain safe. And having seen, medical women bide their time until they have the authority, and then they change things. They change medical education. They change clinical practice. They contest the structure of medical knowledge, the structure of training programmes, the culture of patronage and hierarchy, the culture of overwork. Women walk into the surgical theatre pregnant and demonstrate embodiedness, challenging the notion of the free spirit of the intellect. And without saying a word, cut and care, deal with death and birth, with the same body.

Like Athena and her mother Metis, medical women hold out and hold on. They use determination and courage and rage to maintain their right to be who they are in the profession they love and are qualified to practice. They do not give in or give up and in not giving up or giving in, they require the profession to engage with them. I am here. I am not going away. Deal with it.

And some of them are rule-breakers. They leave work at 5pm to pick up their children, they put limits to their practice, they name sexual harassers to younger women, they job-share and engage with outsiders in their meaning-making. Each rule broken becomes visible for everyone to see. Once seen it can be questioned.

Some women are questioning the construction of medical knowledge, revaluing emotion, reclaiming intuition and challenging the mind/body split and the absence of spirituality. They teach a quiet revolution quietly, just making it part of necessary medical knowing without confrontation or challenge, slipping it in. It is possible that the whole project of medicine might be rethought as a consequence.

It is a paradox that women want to be changed by medicine. They want to learn how to hold authority, how to cure and care, how to make a difference, and how to earn a high income. At the same time many women do not want to have to abandon or set aside their female selves to learn these lessons. Some are prepared to, others resist vigorously as we shall see.

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[39] This analogy provokes recognition of the interconnectedness of the web of life for many people, although the mathematics behind the Chaos Theory on which is it based has been challenged as 'bad science'. I use the metaphor as a thought-provoking device.

6

Suspicious and Murky Things

"the surgical culture had a fixation on breaks in training and people doing suspicious and murky things if they had a moment out of the culture". P8

This research has identified that women are indeed doing 'suspicious and murky things' when they slip out from under the surveillance of hospital hierarchies and post-graduate training programmes. Just what they are up to will be detailed using the three legs of Pythia's stool: the myth of Metis and Athena, findings from the survey of rural doctors, and text from interviews with women doctors.[40] I will be describing the local techniques and strategies of power, or the micro-powers that are exercised at the level of everyday life to resist the exercise of coercive practices.

Standpoint theory proposes that marginal positions are sites of resistance, places where power and authority can be used to enable new possibilities (Tanesini 1999 p 154). This chapter documents some of the activities that go on in these 'sites of resistance' occupied by medical women.

Table 9 describes the parallel between resisting women, and Metis and Athena, and guides the reader through the structure of the chapter. It maps how in this chapter I will use the guiding myth of Athena to examine data from both the interviews and the survey in understanding how women resist being 'weeded out' and how they hold their ground as doctors and as women.

[40] The Delphic Oracle, the Pythia, sat on a stool to inhale vapours from a fissure in the earth to induce a trance to assist her to see into the future. Her silencing is described in Chapter 3.

Table 9 Women resisting

Myths	Interviews	Survey
Metis: avoidance/shape-shifting	Disengage/shape-shifting	Restrict clinical hours Solo practice
Athena: Zeus's daughter	Male mentors	Valued by male colleagues
Metis: mother love - handing it on	Sisterhood	Networking
Lilith: holding out/on	Cour/Rage	Years in practice

Despite up to six year intense indoctrination while undergraduates and a further five to ten years of post-graduate training in the medical culture, women hold on to their feminine selves against all odds, and use it in clinical practice as soon as they get the chance. It may be in tatters, it may be hiding terrified in the corner, it may be buried in a large body, but for the most part it is still there. Ministers of health, workforce planners, training programmes and hospital management might unconsciously seek to coerce women to behave like men, but ultimately they refuse.

As Foucault recognised, where there is power there are resistances, for power inevitably creates and works through resistance. He acknowledged that the existence of strategies of power does not necessarily correspond with the successful exertion of power, and that intended outcomes often fail to materialise because disciplinary strategies break down or fail (Lupton 1997). Lupton notes that in Foucault's terms,

> the central strategies of disciplinary power are observation, examination, measurement and the comparison of individuals against an established norm, bringing them into a field of visibility. It is exercised not primarily through direct coercion or violence (although it must be emphasised that these strategies are still used from time to time), but rather through persuading its subjects that certain ways of behaving and thinking are appropriate for them.(Lupton 1997 p 99)

As we have seen in Section 2 disciplinary power is exerted over young women doctors to persuade them that certain ways of behaving are appropriate for them, and such is the power of the profession that women doctors learn how to do that. At the same time, they learn how to resist when they find the behaving and the thinking are in conflict with fundamental aspects of themselves.

Just as Metis resisted Zeus's attempt to kill her off, by shape-shifting to skip out of his way, so women in medicine have developed strategies of resistance that involve camouflage and invisibility. Women conceal themselves to avoid persecution, disengaging with the brutal contest for power, position and prestige and finding their purpose elsewhere. Like Metis, they draw on their courage and determination, sometimes fuelled by rage, to hold on and keep their intention strong.

1. Shape-shifting and disengagement

One of the most common ways to resist entanglement with adverse aspects of medical culture is to opt out of the hierarchy game. This does not mean withdrawing from full engagement with medicine, but rather identifying and choosing not to waste their energy with battles for supremacy. Seven of the nine women interviewed used this protective device. Often they used it from a position of strength. P2, who is a national leader in her field, saw what was going on and decided that she would resist the pressure to do what was expected of her and stay true to herself. She took on the leadership role in a national medical organisation and this is what she saw:

> *And there is a couple of really powerful males, you know, top of the tree sorts of guys in similar organisations that I've got to deal with and I'm, I am feeling a little bit vulnerable about that (pause) because I know that I am not going to… I will do as I have always done and be myself, I am not going to try and beat them at their own game. I am no longer into that sort of game. P2*

This is a variation on the action of a former college president who reacted to what she termed 'the men's tie game' (in which men compete for status among themselves by drawing attention to their prestigious ties) by throwing a cup of coffee over the ground and demanding that they get back to business and include her. It worked and they did.

Women are not included in these status games, and resent the waste of their time and the assumption that they should be content to be observers.

> *Cope with my feelings of wanting to walk away and cope with my feelings of wanting to engage and trying to – if I do actually physically take myself into one of these spaces where I'm trying to learn, trying to engage, then don't bloody waste my time. P8*

Standing aside, keeping your distance and seeing clearly what is going on works for another senior doctor.

> *A lot of the time with my more senior responsibilities and positions, there is a bit of me that stands to one side and watches what's going on, very ironically, thinking, a lot of this is so much hot air. I've always had that little bit of my mind that is able to do that standing aside and think, there is a lot of posturing that goes on, a lot of game playing that goes on that is completely unnecessary really. P2*

A surgical registrar who is not yet grappling with the challenge of combining work and family has still decided to shift out of the way and disengage from the power plays.

> *And so at this stage of the game I'm perhaps not quite so interested in being a world leader and the heads of units and the like because those guys work ridiculous hours to do it. And I don't think it's necessarily that they're academically better .. they're just much more tenacious and power hungry and the like, and I'm not really interested in the power plays you have to get going to get into that level. P6*

These women are actively observing and assessing what is going on. The hierarchy may be ignoring them, but they are watching and learning, dealing with feelings of anger and rage and regret, making decisions about how close to the flame of aggressive competition they are prepared to go, making strategic forays into positions of power, retreating when their well-being requires it. Some medical women gain strength from challenging the culture, may even begin to enjoy it.

> *if you've already challenged, then it's easier to see what happens when you have a baby whereas if you haven't, or if you haven't had those experiences, then you ground all the hostility that you get when you've got young children, in being female and doing female things. P8.*

Standpoint theory tells us that the view from below is more clear sighted, clairvoyant, than the view from above. That a 'maximally critical study.. can be done only from the perspective of those whose lives have been marginalized by such (scientific) communities' (Harding 1996 p 244-245). If this is true then the descriptions given by women doctors of what they are seeing about medical hierarchies from which they are marginalised is likely to be both different from, and a truer tale, than that constructed by those who are privileged in these encounters. In my experience women rarely speak about what they know about the medical hierarchy in public. I have witnessed many occasions when such discussions were held among trusted friends and colleagues, but like Metis, female doctors duck out of the way when confronted with the purposeful use of masculine power, putting safety first and surviving to live another day.

Also like Metis, medical women who refuse to expose themselves to power plays when up against a force greater than their own are not being cowardly or deceitful or lacking in courage. Rather they are being strategic, conserving their energy, biding their time, studying what is going on, learning the lessons and then building alliances so that next time, perhaps on ground of their own choosing, the power will be more evenly balanced.

The story of the 'bad girl' surgeon will illustrate this point. It is a complicated story, with many facets to it, each reflecting on a side of medical culture that is rarely articulated. I will return to this story a number of times in the analysis to come, so it is worth recording in some detail. I begin by setting the scene as it relates to post-graduate medical education, and how women fit into that professional structure.

Critical Incident – The Challenge

Women specialist trainees are faced with extended, intensive training at a time when most other women are having their children. This keeps many of the best and brightest young women from considering specialist careers, to the detriment of both the specialties and their patients. Over the years individual women have done their best to negotiate their way around, over and under the obstacles placed in their path in order to become both mothers and specialists. Many are unable to do so and either drop out of specialty training, or drop out of motherhood. This causes a lot of pain and anger.

The problem is not confined to surgery, but is at its most intense in that discipline. P4 had trained in surgery and then transferred to another specialty and was completing that training when the yearning for motherhood could no longer be kept at bay:

> *I think I thought that six years of a training program was long enough and that I'd neglected other aspects of my life long enough, relationship and having family and all that sort of stuff. P4*

Another doctor described how she had prioritized her career and specialty training and fitting babies in did not seem possible, then *over a six month period, just sort of felt this ache that I want a baby, you know and it just kind of evolved. P7*

The solution that women have devised is code-named 'flexible training', by which they mean the opportunity to engage with the training programmes in a variety of ways, rather

than the standard format of full-time, extended hours, continuous training. Bear in mind when reading this story that 'full-time' has a particular meaning in the context of medicine. Its precise meaning varies from discipline to discipline but in the USA in 2004 legislation was passed to prevent trainees being required to work in excess of 80 hours per week. The neurosurgeons protested, saying they required a minimum of 86 hours per week to train a young neurosurgeon. A similar culture exists in Australia. For example

> *(It is) an issue very close to my heart, of exhaustion at work. I've just done four days on – oh it's five, … I guess you get used to working with sleep deprivation…But I've just done 36 hours on and I've slept for 3 hours of that time and I'm still here and working and I'm not complaining about it. I drove home from work yesterday and almost crashed my car twice. And I'd been operating on somebody two hours earlier. P6*

Working extended hours and 'not complaining about it' is part of the hidden curriculum for specialist trainees, particularly in surgery. It toughens them up. However it is incompatible with childbirth and mothering so women who want to be surgeons as well as mothers have been working for years to change the requirements and regulations about 'continuous uninterrupted training'.

Several years ago the Commonwealth medical workforce branch called a meeting of medical colleges and hospital administrators to discuss issues relating to post-graduate medical education, taking into account the increasing number of women graduating as doctors. Very few women were among the invited participants, and certainly none of the women who had been most publicly identified as working to change the rigidities of training programmes. A number of these women caucused over the issue and decided to get themselves invited to attend, to attempt to redress the balance. They were successful and took part in discussions and planning.

This is what happened.

Vignette: The Challenge

The one that did come to a head was a particular meeting which was about flexible training in the colleges and looking at the issue of the colleges blaming the hospitals and the hospitals blaming the colleges and ignoring the fact that many, many of the powerful people have both hats. So if you assume they have both hats, it's easy to understand the problem, so they selectively use one or other, many people in the structure. So I saw this meeting, in my naivety, as a potential way that I could move forward in my thinking and do some good, which he (College President) clearly did not see. So I basically was part of a group of senior women who recognised this as an important forum and the culmination was me challenging him in public, and the most notable part was him punishing me afterwards, very privately and in a way that confirmed for me what had been going on, that is – I confronted him in public saying that he was basically obfuscating what I saw were the issues. (He) had organised for a trainee to say that the surgical culture is right and the surgical culture has clearly faced all these challenges and taken the issue of women's life course well into its centre, as evidenced by a trainee saying, 'This is wonderful and this is perfect' whereas I knew that no-one else in the room had known what efforts I'd made to get other trainees to speak and no-one else in the room would have known what efforts he'd made to sequester this trainee away from me, because he'd refused to tell me her name.

I had tested it out because I offered directly to the organisation running the meeting, to find some trainees for them and that was when I knew that he'd put forward a particular person's name that he was not going to tell me beforehand. So when the public meeting happened, by that stage I had communicated with a number of senior women and we had organised the meeting to have senior women present, which was not going to happen had we not done a lot of work lobbying through both our colleges, once again using the two networks. Women use this too, and rightly, using our colleges' networks and our inter-college networks and hospital networks to try and make it so that at least there were some senior women there to give people like me solidarity. And it worked and I felt as though we got some very good gender messages across. And the sort of confrontation that I'm getting to was him getting up, saying, "We have a Woman in (the College) committee" and the tacit assumption was, "so everything is hunky-dory, and there are women in the room who know both why I'm doing this, why I'm getting up and saying everything's fine, and I have completely overpowered them and silenced them so much already that they will not challenge in this public forum". So my sense was that I knew that that needed to be challenged, or I wanted to challenge, and I felt able to do it because I had the support of women in the room. And also he had personally and deliberately constructed the setting so that the way I would have done it more subtly, which was to get a trainee to say, yes, there's issues, was blocked to me. And so he had personally done some bad things.

I'm also very interested in language and how you can make use of even just languages within documents to argue that a culture needs to be challenged or that it's constructing women in a particular way. I happened to have the regulations (on uninterrupted continuous training) with me and just read them out 'til everyone laughed. I just kept reading out and reading out because from my public health class I'd learned that if a regulation says 'normally this will happen', that there's lots and lots of scientific literature which just says that men are normal and women are abnormal.

So for me it was so flagrantly an example of that, and I'd already work shopped it in my public health class. I knew that there would be enough people in the audience who would see this as me challenging him in a particularly female way, a way that to me felt like it was an OK way of challenging him and that I somehow had the immunity that comes from knowing that there's women in the room that will support me. So I guess it was a lot of time in the coming but, anyway, I challenged him in public and then lots of men came up and said, "He needed that" Immediately.

Including the president of another procedural college, who had worked with me because, before I'd done any of these naughty things I had been actually cast as representing the College on another college's council… The particular president that I'm thinking of came up to me and said something like that was very good, I'm pleased that you said that.

It was a male and he recognised – he was somebody who I think saw the enormous disadvantages of some of the male traditions. He, for example, I think cancelled his council when his mother died or something like that, that a lot of other men wouldn't do … But knowing that there was a sentiment of men who will challenge this same culture and confront this sort of ruthlessness and destruction that another man can play and do, not simply to women but to other men.

(T)here has been enormous satisfaction, of having women that I thought would help me and did. And there's one particular person who I will never forget, coming up to me in a very short break at that time, just at the time when I had decided what I could do and was trying to decide whether to do it but I felt like I needed courage, and somebody came and said, along with another two women who didn't say anything, and gave me the message that was, "Yes, we're all in this and, yes, it's important to challenge and, yes, now is a good time". So I won't forget that. P8

This event encapsulates many aspects of the relationship between women and medicine. It takes us on from the resistance strategy of avoidance/shape-shifting/disengagement from the hierarchy, to another aspect of the old goddess, that of courage, of holding out/holding on. This doctor went on to describe how she was punished by the president of her college for having dared to take him on in public, and how she has grown in her thinking and understanding about medical power and has begun to enjoy the learning that comes from challenging established power.

Maintaining identity

Some of the participants in my study stubbornly refused to give up their identities as women in order to become doctors, or else gave it up and then claimed it back again. They refuse to invest their entire selves in the identity of doctor. For example, when asked about her experience as a female medical student, P9 responded

> *As a medical student, it was painful; it was challenging; it was humiliating; it was awful. My way of coping with that was to wall myself off; was to detach from it; that I was not emotionally connected to any of it. But what I did with that is also disconnect from myself because it was the only way I could cope with it. So it was a huge price to pay because it has taken me years to reconnect; to even be aware that I'd done it because it happened almost without my being aware of it. P9*

At the age of 49 she has now withdrawn from conventional clinical practice and is pursuing her need to re-integrate her feminine and her spirit before she finds another way to work with her healing skills.

P8 also had a struggle *'as far as reconciling me and medicine'*, having wanted to be a *'hippy earth mother doctor'* and ending up a surgeon. She describes her struggle between being a 'success' in medicine, and a 'success' in her own life:

> *As far as mainstream signs of success and being a visible leader and using my intellect, I might well have been much more successful to ditch all the good girlie parts and I've got enormous sympathy for women who say, well, 'I'm smart, I'll sum up, I'll cut my losses. If being very closely linked to being a woman isn't going to work, I'll ditch it'.*
>
> Q: But you haven't done that
>
> *I don't think I have. Well, if I have, I'm constantly shedding it. Constantly shedding the very thing I'm trying to put on. Like having a haircut. I'm shedding (a) cloak, some kind of burden. Something heavy and wrinkly. I think it's being told what to do is what I'm throwing off. It's got a feel to it that it comes from within.*
>
> Q: A requirement to perform like a bloke ? Is that part of it, or not ?
>
> *It's as if I've been told that but it's on the other side of a glass screen so I'm not quite listening and I can do my own dance, but it's separate. P8*

These women describe knowing what is required of them, trying it on, and finding the mantle does not fit. It is too 'heavy'. It is an Athena trick that they use, continuing to wear the cloak, but inside it they are restructuring both themselves and their relationship with the profession. It is a contention of this research that with this resistance to being engulfed by the profession they are changing the profession itself. Each doctor who succeeds in resisting the more damaging aspects of the medical culture provides an example to others, men and women, that it is possible to do so. This perhaps is one source of the ferocity with which doctors who step outside the mainstream culture are punished.

Female doctors in the rural doctor survey also use this strategy of maintaining their identity and setting limits as a way of making rural practice work for them. Eighty percent establish boundaries between their personal and professional lives, 61% balance medicine with other goals, and 57% are able to be really firm about limits of availability in time and personal space. Women who could balance medicine with other goals intended to stay 1.9 years longer in their current practice, demonstrating that the strategy of not investing

everything in medicine is effective not only for individual women, but important in the sustainability of the rural medical workforce. Being firm about limits of availability allowed women to stay 2.0 years longer in their practice.

Thirty nine percent of female rural doctors diversify their medical work to avoid letting medicine take over their lives and women who can do so intend to stay an extra 1.7 years in their current practice. Women also put limits on the number of clinical hours they work, despite enormous pressure to work longer hours. In general practice 35 hours a week or less is considered 'part-time' by the Australian Medical Workforce Advisory Committee (AMWAC). About half the women in the survey (54%) work 'part-time' by this definition. Women, like men, work longer hours than they are booked for but women are better at resisting pressure to work extended hours. This is almost certainly a reflection of the complexity of women's lives and the priority they give to family life.

Female rural doctors are insisting that aspects of their lives apart from medicine, including their families, have a higher priority than total service to medicine. This study has identified and quantified the substantial work load women carry in providing care for family members, a workload that men also undertake, but with much less responsibility and for far fewer hours.[41] This is a key difference between male and female doctors and permeates many of the challenges women face working within a system that ignores their family responsibilities or assumes there is someone at home providing family care. It also provides the source of one of the most effective of the strategies women use to make rural practice work for them, that of putting boundaries around their personal and professional lives, and the effectiveness of being able to structure their practice to reflect the way they want to work, which is also an important factor for men's satisfaction and contentment.

Passive resistance

Women also resisted the adverse effects of the medical culture by disengaging through passive resistance. The data from the survey on refusal to work extended clinical hours is a reflection of this. So too is the way in which women contain requirements to be on call and to provide the types of medical services that intrude chaotically into their lives, including on call, emergency care and some types of hospital care.[42]

In the interviews women described how they *wall off* and *say if I'm on a rock and I'm isolated, I can't be touched* and *that's how I coped through medical school. P9*, or, rather than deal with confrontation 'get out of the way' P1.

This passive resistance to medical cultural requirements for full immersion in medicine regardless of the effect on self or family is having a major impact on workforce planning. In particular, the behaviour of the women is influencing the younger men, who are looking at the lives of older male doctors, comparing them with the lives of women, and say in effect 'if they can have a life as well as being a doctor, I can too'. This trend was first identified by the National Rural General Practice Study in 1997 (Strasser, Kamien et al. 1997) and it is throwing workforce planning into chaos. Governments are responding by increasing the number of places in medical school and post-graduate training programmes,

[41] The details are provided in Chapter 8.
[42] The details are discussed more fully in Chapter 8.

but the lack of gender competence in workforce assessment, a false belief that women can be coerced to behave like men, has left Australia with a serious shortfall of doctors.

Finding a place that fits

Some people create their destinies by sheer force of will and determination, others wait for them to unfold, and others endure trial after trial as their souls learn the lessons needed to get them to where it is safe for them to be. One of the safest places for women in medicine is general practice. Women can create their own spaces, their own working environments and their own relationship with patients, outside the hierarchical, competitive and rigid structures of hospitals, and beyond the scrutiny of power-holders who want them to behave like men. More than 60% of trainees in general practice are now women. One of the participants described why:

> *the nice thing about general practice is that you have the space not to deal with them (patients) along conventional medical lines... And also there is nobody there sitting in, that you must do it this way…and that was a huge freedom to be able to do that, and treat people as a whole person. P1*

A specialist who had worked in general practice prior to entering the training programme in obstetrics and gynaecology describes the effect women are having on medical culture and practice:

> *That was such a shock about going back into the training program, after being out in medicine and having worked in places where people were so supportive and where everybody is equal and everybody is working as a team. Places like Family Planning, we all worked together and everybody is just as important as everybody else, the receptionist, the nurse, doctors, we all talked together and we are all just the same, we are all just a team. At Women's Health Clinics that I worked in it was the same thing again, everybody was really comfortable, you just felt that was the right way that things were, and then to go into this totally different paradigm. So in clinical practice, out there in private practice, there are lots of lovely places for female doctors to work in general practices and some clinics where women can practice medicine in a way that they feel comfortable and no one is going to uhm…you know. And then to go into the hospital system, which was just so foreign and so completely different. So competitive, so raw and so hard. Wasn't soft, like those other places. P3*

She survived the training programme, blazing a trail of difference as she went. She initiated the first job-share training position to enable her to combine mothering with training, and suffered considerable harassment and intimidation that led to her moving interstate for her final year. As a specialist she continues to challenge the culture of medicine. For example she is the only consultant in her hospital who supports women using birthing centres and she is as likely to talk with her patients as operate on them. This provides patients with an alternative model of practice, and allows them some choices about the type of care they receive, putting pressure perhaps on more standard styles of practice to adjust to differing patient expectations.

Some of the women began their reconstructive relationship with medicine early. One was a student when she started trying to find different ways to engage with medicine. Each year she tried to find a way out and eventually succeeded before entering specialist training, needing to escape the attempts to sculpt her into a mould she did not want to fit into:

It's something to do with you have to do this and you don't have any power and you have to work really hard and this is a really important job and how dare you challenge. In fact, my flat mate, a male medical student, took a year off and went and worked in a circus. P8

Women in the survey also identified the importance of finding a place where it was safe to be who they are. Twenty seven percent went into solo practice, possibly as a way of gaining control over their working environment. This was the strategy used by the rural doctor in the interview cohort. She had tried partnership with a male general practitioner as well as working in aboriginal medical services, and then set up solo practice. She had spent six years in general practice in the United Kingdom, a safe place to work as a lesbian doctor, *'a very feminist practice' P5*, where one of the other doctors was also lesbian.

Metis and her daughters

Mother energy, the protective love and authorising of the feminine, was in the lineage of the doctors who took part in the interviews. I explored whether there was a mother-line in the families of these women who became doctors. I was looking for the source of strength and self-confidence and self-authorisation that allowed the women to dream of such a thing. And I found it. Authorising mothers, grandmothers, aunts, family matriarchs are in the lineage of most of the women. *I come from a family where all women were tertiary educated back three generations. P5*

A doctor who rejected her mother's knowledge in favour of the father was able to identify her grandmother as a powerful role model, *she taught me how to fight P1*. Another doctor came to revalue her mother's ways of knowing as she grew older, *looking back I know that my mother had a different type of intellect which was equally good and which I realised myself when I was a bit older …when I look back now, she was quite a, very intuitive sort of person. P2.*

Some mothers were clear in the message they gave their daughters about the need to be able to authorise their own lives. The mother of one of the gynaecologists *drilled into me all the time, you've got to have your own money, your own independence, don't be dependent on any man. P3*

Women in medicine resist being taken over by the masculine culture of medicine through alliances with other women. These may provide practical support, mentoring, taking care of younger women, but most of all alliances seem to work through helping women understand what is going on, and that their experiences are neither unique, nor a sign of deficiency in themselves. The women in this study told again and again how important women colleagues were in their lives. They are claiming a community of women that gives them insight and strength to keep working and pushing the boundaries in medicine, and they pass their insights on to younger women. Although women are in some part attracted to medicine because of the implicit promise that they will be inducted into male culture, they also become very confused when the culture they bring with them is seen as problematic and they are subjected to the coercive practices described in Chapter 5.

One way they resist these coercive practices is to team up with other women. These may be nurses, other doctors, women in their family or women as friends.

I think women as friends are fantastic friends and that capacity to be open about yourself with your women friends is something I think is very important. P2

I always found the nurses were supportive and helpful and that that continued all my clinical life in hospitals. P1

The metaphor of Athena and Metis works well if we can imagine Metis the mother whispering to her daughter the laws she must follow to stay safe in the face of the defeat of the feminine, whispering the wisdom of the older woman to provide guidance and comfort.

Women also find the lives of other women to be an inspiration to them, to help them imagine themselves as the sort of doctors they want to be. The specialist who had been the most battered by the training programme was very relieved to find a role model she could identify with in her second training programme. She said *this particular friend I could see 'right well I want to be like her'…she's got integrity she's really good with patients, I respected her a lot and thought 'yeah well that's what I would like to be like'. P4.*

The psychiatrist was conscious of the relief of the younger doctors when they encountered her, *I think certainly with the younger women coming through they value having somebody who has made it through, you know, and still had a family. Certainly you get a lot of feedback along the lines of 'it's it's good to see that the career doesn't stop when you have children. P7*

The two surgeons are particularly pleased to be able to provide role models for students and young doctors:

> *Now that I'm a registrar I'm finding it really exciting that medical students and interns have started to look to me as a role model. And because I don't like the way that surgeons generally interact with their patients, I make an effort to do it differently, and more junior staff members have said to me that they've taken that on board and they quite like having a female surgeon around providing surgical training who's actually approachable. And who will provide good service without the crap that comes along with it. So and I find that fantastic that there are women around who sort of see that there are people who are female who are doing surgery and that therefore it's an option. And I sort of spend a lot of time advertising surgery to women. They don't need to advertise it to the men because they all turn up anyway but getting female medical students, you know haven't really thought about surgery because they just make an assumption that it's not something that women do. Getting them to at least think about it and to show that you can be nice and still be a surgeon. And so I find that very exciting. P6*
>
> *I have medical students in my practice - mostly women for about 6 weeks/ year. My students make me feel very special and value the example I set as a role model. – rural doctor*

Part of the intention of this study is to see if I can uncover what Metis might have whispered to Athena while she was still in the womb inside Zeus, what mother-wisdom was passed on to guide her daughter through the troubled years ahead. What I find is described in Chapter 9. The guiding role that the older woman can play for the younger one, the mentoring relationship, can be seen as Metis and Athena at work.

Female rural doctors draw strength from alliances with other women as well. The survey found that 61% network with other women and that doctors who can do this intend to stay in rural practice 1.9 years longer than women who cannot network. Being able to talk with other women doing similar things keeps women in their current rural practice an additional 1.6 years. It is a powerful strategy for helping women make sense of what is going on. In the survey, women who are able to avoid being a victim when male colleagues discriminate were statistically significantly more likely to be contented with life as a rural doctor than women who could not resist.

This process of engaging with other women to help make sense of medical culture is related to, and in fact often leads to, finding the courage and determination to resist coercive practices.

Courage

Athena had courage. She probably learnt from Zeus how to act, how to exert her will and how to be courageous in the face of difficulty. As a warrior goddess she had to be able to withstand attack and onslaught and transform and redeem that energy into wisdom. This is an effective metaphor for what medical women are up to in the sanctuary of their own heads and hearts.

When asked whether she had a sense of being marginalised by mainstream medicine, P1 responded as follows:

> *Oh, all the time. Any of the work that interests me is always not quite valid.*
>
> Q: How do you deal with that ?
>
> *Umm, (sigh) for a long time I ignored it in the hope it would go away and it hasn't gone away, and now I am going to have another go at challenging it.*
>
> Q: And how does it make you feel ?
>
> *Scared, I haven't succeeded in the past in challenging it, and I am not sure it is a safe place to be and I ..know there will be a lot of pressure to marginalize what I say and do again, and its just hoping that I have the strength to keep going. P1*

She had previously described how she was ejected from the paediatric training programme because she was not considered to be a good enough 'academic' although her clinical skills were evaluated highly. She is mending that wound by now undertaking a doctorate after many years working in general practice. One consequence of her sense of her knowledge being invalidated is fear of speaking and publishing what she knows about clinical practice. She is tackling this by publishing her research. At the time of the interview, in 2003, she commented that *'it's a huge struggle writing journal articles, and I have not managed to succeed .. because of this fear around it'*. She has worked hard to overcome her fear and recently had an article published in a learned journal.

Another form of courage displayed by the women was going on a journey of discovery about who they are and how things got to be that way. For some of the women that was both a reason for, and consequence of, taking part in the interviews. P8 articulates the process powerfully, including some of the risk involved:

> *I'm frightened of what myths are governing me and my hunch is I'll read and learn and start having to think of bad things that I do, (laugh) because it's all about self what is it? it's both confessional and me creating an identity so it's kind of a game of cat and mouse as to what I can influence you to put in your thesis or influence you to make it as a public presentation of your research. P8*

It is an explicit purpose of this research to document what is going on between women and medicine in the hope of being of service to women such as P8 who live the consequences of the misfit between the culture of medicine and the culture of women on a daily basis.

Rule breaking

Rule breaking is also an act of courage displayed by women who are resisting pressures to conform to medical culture that attempts to reconstruct young doctors. It might be playful, like P8 saying *I actually love medical women who go into pompous, stuffy meetings at the university with tropical fish earrings, Jo. I want to be part of this. I've started noticing and I want to do it too. Learn how to wear one gorgeous earring and be confident in that. P8*

Or it might be totally serious, imperilling a place on a training programme and attracting criticism and harassment, like P3 and her struggle to be a mother and a trainee specialist. She broke the rules by working in general practice while a trainee in obstetrics and gynaecology, doing terminations of pregnancy, leaving work at 5pm, and other non-compliant behaviours and was punished for her temerity because, in her words

> *I'd come back after a research year and got back as a job share, so they didn't like that either… I wasn't fitting into the mould of what an O & G trainee should be… I couldn't do that because firstly I had children to come home to and secondly its not my nature. P3*

She describes how trainees *have to behave as in the male paradigm* in order to do well in that environment and when asked what happens to women who do not want to do that replies *They get into trouble, don't they, like I did all the time. P3* This is part of the thrust and parry of the struggle between women and medicine, women pushing the boundaries, testing the limits, and those in authority over them, those in charge of maintaining the culture, snapping at their heels and harrying them in to prescribed roles. Each time a woman succeeds in doing it differently she tears a little hole in the fabric of monolithic medical culture, a hole that others might be able to crawl through, until there are enough on the other side to make a difference.

These acts of rebellion are very serious and take great courage. Women are driven to them by fear of losing themselves, their sense of who they are, their core values, as they become immersed in medicine and concentrate on meeting its requirements. As P7 puts it *'My nature has been I'll show the bastards'* while P3 was equally determined, and said *'I kept on saying to myself all the way through, I'm not going to turn into a sausage, (laughter) I might be in a sausage factory but I am not going to turn into a sausage.' P3.* And she didn't.

Rage

Behind the laughter and determination and courage, there are powerful feelings relating to exclusion, lack of valuing and blocking of career pathways. Women are enraged at the treatment meted out to them and this rage is a source of energy fuelling their intention to shake medicine to its foundations. That prospect is kept hidden even from the women themselves, there is too much fear around to admit that is their purpose.

> *at some stage I really realised how much anger I was carrying around inside myself, and that I was just making myself unhappy. And I really worked to get rid of it. This is why I live quietly in a small place, a small life. P5*

In the meantime, they do what they have to do to keep their feminine selves intact, and if that means medicine will change, so be it.

These are transgressive women, doing 'suspicious and murky things'. Despite the many times they are punished and excluded and silenced and prevented from becoming the sort of doctors they wanted to be, many women persist in challenging, rule breaking, pushing

the boundaries, finding cracks in the system, creating change. They are prudent, for the most part, and keep these transgressive activities private, or share them with a few trusted colleagues, partner or family. Very few women have the courage or strength or immunity from punishment to act openly. Some do, and their activities are detailed in Chapter 7.

7

Because Women Will Demand It

Because women will demand it, women will make sure and they will just have to come along and join us. And then women will have the time, for the next fight. P3

'Since humanism in medicine depends on joining the heroism of cure with the vulnerability of care, reshaping the image of the physician to include women constitutes a powerful force for change.' (Gilligan and Pollak 1988 p 262)

In Chapter 6 I described some of the ways women are resisting the coercive practices described in Chapter 5, and hinted at how these strategies of resistance are changing medicine. In Chapter 7 and Chapter 8 I consider in depth how women are changing medicine. Chapter 7 identifies six main themes describing what is happening between women and medicine. These themes are: women maintaining their culture; alliances with women; using their authority to change the profession; claiming medicine for women; contesting knowledges; and creating a scientific revolution. Chapter 8 deals with changing work practices, including clinical practice, using data from the survey.

Table 10 provides the framework for the way in which I will draw on myth to reflect on data from the interviews and the survey to illuminate how women are working to be included in the project of medicine.

Table 10 Transforming Medicine

Myth	Interviews	Survey
Metis	Maintain women's culture	Family work
Athena, the intellectual	Scientific revolution	
Metis, the owl of wisdom	Contesting knowledges	
	Alliances with women	Networking
Athena with sword and shield	Using authority for change	Establish boundaries
	Claiming medicine for women	Provide women's health services 'other hospital work'

The hegemonic paradigm of allopathic medicine, built on more than 600 years of detailed, careful and scrupulous work, is being unpicked at the seams by seamstresses, prodded and challenged to give up its fantasy that European men constitute the whole world, invited to join the exhilarating task of bringing to the table those others whose experience and spiritual and embodied knowledges will expand the understanding of health and illness and extend the reach of medicine exponentially when their knowledge is combined with established scientific authority. Women (and almost certainly some men, but that is another story) are bringing this gift into medicine, giving this invitation, as they continue to combine the scientific excellence, clinical skills and professional discipline they have learned in their long training as doctors, with their embodied experiences as women, and their women's ways of knowing and doing. This chapter describes some of what women in Australia are up to.

1. Formal structures for women to speak

Women in the profession have set up structures that allow them to meet and consider issues without having to struggle for space. Internationally, for example, the Wonca Working Party on Women and Family Medicine[43] has worked tirelessly to document women's experience of family practice and to create time and space for female doctors to meet at triennial international conferences (Wonca 2004). Starting in 1998 female members of Wonca took action to insist that they contribute to the programme of the triennial international meetings, firstly in Dublin in 1998, then Durban in 200. The most recent example is the meeting at Orlando, USA in 2004, where the Working Party coordinated a two day pre-conference workshop and ensured that women speakers were included in the plenary sessions of the main conference. The Medical Women's International Association (MWIA) is a non-government organisation accredited with the United Nations which meets annually on a regional basis, and holds its international conference every three years. The MWIA regularly contributes to the work of the UN and the World Health Organisation. A recent project was the development of a training manual to assist women doctors to mainstream gender competency into their work and teaching, accessible at http://www.mwia.net/gmanual.pdf . The female doctor who chaired the Scientific Programme of the Wonca 5th World Rural Health Conference, held in Melbourne in 2002, ensured that there were equal numbers of female and male keynote speakers, and that Gender Issues for Rural Health Professionals was one of the four themes of the conference.

In Australia, the Royal Australasian College of Surgeons has a Women in Surgery Committee for example, and although it has male members, the agenda is managed largely by women. It has a formal brief to consider those aspects of surgical training that affect women differently from men. The Australian College of Rural and Remote Medicine has a Women in Rural Practice Committee with membership from female members of the College, and a brief to ensure that women are included in the College's affairs. Women such as P7 take the opportunity to set up 'women doctor groups' within their working environments, while P4 arranges 'women only' meeting opportunities at medical conferences. P8 has been responsible to initiating women's breakfasts at college scientific

[43] Wonca is the World Organisation of Family Doctors

meetings, and in the year 2000 organised a joint one day session between the Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists devoted to how women engage with surgery and anaesthetics.

Female doctors also organise and attend women's leadership training sessions (Wainer, Bryant et al. 2002), formal mentoring programmes, international conferences (Wainer and Nobelius 2001), and have formal 'women in medicine' organisations such as the Australian Federation of Medical Women, affiliated to the Medical Women's International Association (ACRRM 2004).

These are just a few examples of how women in medicine band together to foreground their concerns, and collaborate to gain strength from each other in their unspoken mission to change medicine to include them.

Drawing now on data from the interviews and the survey, I will consider six ways in which my research documents how women are transforming medicine.

2. Maintain women's culture

One of the radical changes women are making to medical culture and practice is locating doctors within their families and making those families visible (Candib 1995). It is probable that this is occurring in rural medicine more rapidly than in other parts of the profession. There are two reasons for this. The first is the shortage of rural doctors, and thus the requirement for system change to attract women into rural practice. The second is that rural doctors are not dislocated, isolated professionals who disappear when they move out of the professional role. They and their families are located and highly visible within their communities. Everyone knows the rural doctor has a family, or does not have, as the case may be. Attempts to make the family invisible do not work in that context.

Making the family visible[44]

One of the ways women maintain their culture within medicine is to resist the very significant pressures within their profession to make their families invisible. They tell again and again of the pressure on them to do so, and for the most part they refuse. Women who are in areas of workforce shortage have more leverage to maintain their culture, including the visibility of family life, than women in areas of the profession where there is high demand for training places.

Female rural doctors, for example, have been successful in embedding child care as a component of conferences and continuing medical education (CME) programmes, and in making rural medical conferences family friendly. As an example, the Australian College of Rural and Remote Medicine conducted a CME weekend in 2003 designed by the Women in Rural Practice (WIRP) committee. It featured comprehensive childcare, a male-

[44] What constitutes a 'family' is problematic and I acknowledge that there are many forms of family. However this is not the place to deconstruct the term, and I work within the definitions given to me by the doctors who responded to the survey. In the main, they defined 'family' as two adults living together with or without children. This 'nuclear' family is culturally and historically specific and does not reflect how most people live their lives.

friendly partner programme, and women providing the clinical skills and other learning opportunities. Men of course benefit from this too, as men are also parents.

Women in other specialties have not yet succeeded in implementing family-friendly conferences and training programmes but some of them are aware of the successes of the rural doctors, and are seeing that as a model of best practice (Wainer 2001). They want it too.

Families have been invisible in medicine, but data from the survey demonstrate the critical relationship between doctors and their families, and the impact this has on the professional roles and responsibilities of the doctor. This data is fully explored in Chapter 8. The importance of this issue had been identified in previous research with female rural doctors (Tolhurst, Bell et al. 1997; McEwin 2001; Wainer 2001; White and Ferguson 2001; Roach 2002). Identifying the issue is part of the process of women changing medicine. It was female researchers such as those listed above who identified, researched, quantified and theorised about the importance of family life for female doctors. The research reported here follows in that tradition.

It is not at all apparent to women who provide family care that what they are doing is not 'work'. There is an international movement to have unpaid family work included in the national accounts as 'work' (Waring 1988) and the cost of child care tax deductible as a work-related expense. Thus the act of naming family work as 'work' for doctors is part of the process of women changing medicine. Athena may not have had children that she claimed as hers, and was able to make her contributions as the patron of arts, cities and the intellect unchallenged by the demands of family, but female doctors are reluctant to go on pretending that they are free-standing, disengaged intellectual constructs, aloof from the messiness and demands of families. So part of doing feminist research, that is, research based on women's experience, is to take the perspective of the researched group and include family work as 'work'.

Family work provides the source of one of the most effective of the strategies women use to make rural practice work for them, that of putting boundaries around their personal and professional lives, and the effectiveness of being able to structure their practice to reflect the way they want to work. This will be discussed further in Chapter 8.

Fifty nine percent of female rural doctors take time out to spend with their families, and 69% take holiday time away from town, strategies that make an important contribution to their contentment with their life as a rural doctor. Within the culture of medicine this claiming of time to be with family is a revolutionary act. Women from other medical disciplines who were interviewed for this study describe the tremendous pressure on them to either not have children, or to keep them hidden, as we have seen in Chapter 5.

Quadrio has identified the impact of family life on women's relationship with psychiatry, wondering how a discipline, devoted to understanding the impact of early childhood experiences on mental health, can have as part of its training culture requirements that make it impossible for psychiatrists to spend time with their own families (Quadrio 2001).

A surgical fellow, herself a mother of two, has identified the revolutionary potential of women refusing to be coerced into this

> *I saw women who had children while they were training as kind of a paradigm for people who challenged the culture and who are enormously punished and that it was completely*

> *unjust and that it was completely surgery's loss that there was no provision for this kind of including one's personal life in one's professional life. P8*

Having children is not just about diversifying priorities, childcare, and managing after hours and on call work. Becoming a mother can profoundly alter how women value their female culture and heritage, and bring them a new awareness of how much of that they have had to sacrifice to become a doctor.

A general practitioner describes the revolutionary impact the birth of her daughter had on her relationship with intuition. Intuition had been a primary mode of understanding for her which was demonised during her early medical education. She reacted by reifying the intellect and denying intuition.

> *That's the part of the feminine that I have – it's really only since the birth of my daughter that I've even allowed to surface or get in touch with in any meaningful way and actually learnt to trust and honour again. P9*

A surgeon is also conscious of how her perception changed as a result of having children.

> *I'm very glad I have children because it was kind of like a break, saying I'm now part of a world of women whereas I think I felt insulated from other women as a med student and I regret the years that I spent like that… I felt very elated after I had my children... after each one. ..(I was asked), "And when did you come down?" and I said, "Never." I think that's what comes to my mind, that I don't think I have come down from that experience and, of course, I don't want to. I'm in a different space now. P8*

These women are describing a life-changing experience that is powerful enough to compete with their drive to become doctors, the years of socialisation into a professional culture that holds mothers as suspect, and the loss of financial and prestige rewards plus additional work that accompanies parenting for women. This profoundly human experience will continue to compel women to challenge the culture of medicine that makes families invisible. Women patients know this and it is one of the things they value about female doctors. A rural general practitioner who responded to the survey noted:

> *I think being female, wife, mother and juggler makes patients accept and respect our "professional" opinion with more credibility. This would include the day to day "mundane" consultations. – rural doctor*

Doctors who make their families visible, and prioritise time to be with them, are drawing on the depths of the culture of women, to transform medicine. This is the elemental energy of the mother, the fierce determination of women to mother and protect their children, to lay waste to the world if necessary, to walk out of their rural community if necessary, to fracture the omnipotent power of medical culture to render the doctor's family visible. They will not be denied, and medicine will be changed by that.

3. Difficult to tame

During the interviews women provided more than 30 stories that illustrated how difficult they are to tame. Each one spoke of how women not only resist being required to give up their feminine selves, but took the learning they gained from experiencing this pressure, and transformed it into action for change. They also identified that men might be more compliant with the system because they were more driven by the existing reward

structures, of money and status and authority. Men, they are saying, are easier to tame than women.

Collaborating with women

Women doctors found ways to forge alliances with other women in order to hold onto their own identities, resist pressure to adopt masculine culture, and find a place where it was safe to be who they were, it's a story about women and friendship. P8. They then took this experience and passed it on to younger doctors and medical students whenever they had the opportunity. Some women were able to find women-controlled workplaces which emphasised team work and collaboration rather than competition and hierarchy, such as family planning or women's health clinics, or all-women practices. They found hospitals or training programmes that were more comfortable to work in. One doctor described the special feeling at the Queen Victoria Hospital, a hospital founded by women:[45]

> *Just the women around, and the feeling about the place, there was a really different feeling, it was smaller, it was more personal and there were just women everywhere… and there was this history of 'for women by women' that was still very strong in the place even though the men now had the powerful positions. And there was a lot of comfort in that history, knowing the struggle the women had had to set up that hospital and be recognised for their degrees and their contributions and there was still that sense of it there. P1*

The general practitioners took advantage of the independence of practice to work in a way that felt right for them. Others collaborated with nurses or found women outside medical culture who could help them see what was going on and used this new insight to work for change.

Asked to imagine walking into her operating theatre and finding all the staff were women a surgeon described what the experience would be like:

> *Not having to pretend. Not the challenge that my reality always comes second best. It comes from just one man being in the room. The onus always feels to me as though because I'm different the onus is on me to prove that my reality is right, constantly, everywhere I go in medicine… I can relax and I don't have to keep constantly on guard that I say something that sounds like I just simply believe women are really good. It's like a constant assumption that I can't assume that women are good is what I relax about. P8*

Conley, describes similar experiences of the change in atmosphere when women control the operating theatre, and also how behaviours change among staff, becoming cooperative rather than hierarchical (Conley 1998).

The three general practitioners either formally teach medical students through tutorials, or take medical students into their practice. Each of them was explicit about how they transferred their learning as women about medicine and medical culture to the students in quite transgressive ways. One teaches the importance of intuition and recognising and engaging with feeling. Another is responsible for setting the exam and includes questions about sex, gender and medicine while the third doctor only takes female students because

[45] Described in Chapter 3

most of her patients are female and the whole practice environment is deliberately feminine.

Female doctors in the survey also gave examples of how they were valued as role models by female medical students:

> *I feel valued as a female doctor in my practice at all times but I think that the value and experience is when I have medical students in my practice - mostly women for about 6 weeks/ year. My students make me feel very special and value the example I set as a role model. – rural doctor*

The specialists all make a point of teaching in non-combative and non-punitive ways, valuing and encouraging the women trainees, and enjoy being role-models for younger women. One explicitly teaches about gender and medicine in an elective in her discipline and teaches this to both male and female students and describes how her teaching style reflects her reclaimed feminine:

> *A very nurturing kind of approach. A very maternal approach. And I think a lot of the reading that I've done in Voc(ational) Ed(ucation) has given me permission to somehow do this very tricky integration of how to be a mother and how to bring mothering into teaching. P8*

These teaching activities are intended to make medicine a different experience for female medical students, and to take care of the young women in ways in which the doctors would have liked to have been taken care of themselves. Some were modelling their teaching on good experiences they had had, others were deliberately doing it differently to avoid perpetuating bad experiences they had had, as one specialist describes it: the purpose is to give them the experience where they'll learn confidence and not aggression, where they can learn skills in a nurturing environment rather than being beaten up all the way through. Abused. P3 Taking care of the young ones is a foundation for making incremental changes to medical culture.

Behind the mask

The force of the requirement to adopt masculine culture in medicine has been demonstrated in Chapter 5 to be compelling, at times overwhelming, punitive and savage. Women learn this early and one of the adaptations is to create a mask of acceptability and wear that for public consumption. Behind the mask lies the real woman, sometimes desperately hanging on to her core values, bringing them out to share in safe spaces. This is very Athena behaviour, clothed in the regalia of the Piscean age, apparently in service to the masculine, yet beneath is the shape-shifter still linked with the feminine, however tenuously.

> *I've made a switch now to thinking, well, I'm not going to wear a mask so no, I think I've got more and more confident in myself that I know what's going on and I don't have to feel that I'm pretending so much. But, I also want more and more. P8*

> *I valued those (interpersonal nurturing) feelings. I mean I didn't want to have those feelings damped down and put to one side. P2*

Women are very selective about who they trust with disclosure as the following story illustrates:

> *at that leadership conference I was very conscious of not knowing where some people sat and … not using words and things I would normally use to discuss things because I wasn't sure whether they (other women doctors) were a girl girl, a girl boy or a boy boy. I know some very powerful women that when I have been talking about… some of my work they could tell me stuff that they never ever wanted ever reach the public arena. One is a very senior woman who says that she sounds like a boy, she acts like a boy, she talks like a boy. It is not her and yet she can't step away from it . P1*

So just as men have multiple tests to pass and symbolic language to learn before they are allowed into the trusted inner circle, so too women have a symbol system, vocabulary and layers of trust-building that govern how completely they will describe their experiences.

When developing this study I was aware of this dynamic and much of the methodology has been designed to enable me to pass through as many layers of the veil as possible to the source of women's experience. This is why I used a snowball technique to recruit participants, worked with women of similar cultural and social background as mine, constituted the interviews as dialogue as much as interview and drew on my history of working for women's safety to demonstrate my trustworthiness.

4. Doing it differently

Two of the women in the interview group became doctors with a specific intention of practising medicine differently. Each had had an experience with health care that they had found traumatic and knew it could have been better with a different approach. One of them had been hospitalised as a child and was very distressed that *the medical staff did not talk to me. And I came out of that visit, I wasn't going to just be a doctor, I was going to be a paediatrician and I was going to talk to the kids. P1* She came close to her goal and was not invited to continue with the paediatric training programme after a number of years. She became a general practitioner but her intention to do it differently did not waver. She said that *the focus for the work that I have been doing recently has been making women's experience better in their contact with the medical profession. P1* The other participant also wanted to make women's experience with medicine better and became a gynaecologist. Her experiences with the training programme informed her intention to teach differently.

> *And the older ones (female consultants) that have gone through the system, and it was hard for them. I forgive them. I do forgive them and ... I think I must remember that, because I don't want to be like that ... And I don't think I will. P3*

Almost all the women could identify ways in which women practice medicine differently. They identified differences in patient expectations, approaches to clinical practice, motivations for being doctors, professional structures and behaviours.

Women are introducing cultural changes to practice. They bring their femaleness with them and manifest it in their work. A specialist identified that the young women consultants *are bringing in new ideas, they are not stuck in old ways, they are looking at things differently. P3* and although this was resisted at many levels they seem proud of it themselves. *It was actually very nicely put down on paper by one of my consultants who actually said that I was a female with female perspectives .. and that this had caused a whole lot of problems. P4*

They also believe that patients and medicine are better off as a result of the difference women are making and the different ways they practice;

> *the interactions between female doctors and patients seem to be very different from what I can tell. Patients seem to respond more warmly to female doctors. P6*

> *I thought I had some characteristics which would enable patients to be better cared for. Listening and talking to people and trying to work out what they want rather than telling them what's good for them. I just felt it was lacking within the surgical community. I'm trainee rep as one of my sins, I want to see what's happening to the trainees, which are about 70% women. P4*

> *I've thought so much about what counts as leadership and what counts as constructing one's identity that now I'm just doing some of them, playing, playing with it and, for me, the next step is playing with teaching other people to do it, if it's good and if it's effective and if it works in a way that I think is good for women and good for women's health and good for patient care. P8*

When participants were asked about differences between female and male doctors some struggled with the essentialism implied in the question, others immediately knew how they wanted to respond and told stories about how women practice rather than compare them with men, and others resisted the idea at first, then began to identify examples or stories of how that difference might be generalised.

Changes women are making to work practices in medicine are more fully identified in Chapter 8.

Valuing their feminine

Working in a profession in which the female life-course is so problematic has led all the women interviewed to become conscious of their femaleness and to explicitly value or revalue it. The most confident of the women had stayed in touch with their feminine throughout and some were even valued for it.

> *I think that in some of my College experience I have been valued as being a woman who doesn't have to turn into a man to mix it and match it, if you like, in that world and I think that has been quite important both to me, as an individual, because I didn't want to play that game, and as a role model too, because I know that some of the other women in the past who had risen to relatively high levels in the College sort of hierarchy have been considered to have turned into men to do it. So I think that has been important for me. And I mean femininity and womanliness. It's not that I can't drive a hard bargain or have a good argument or stand up for myself, but I can do it in a way that I stay female at the same time. P2*

For most however, the pattern seems to be one of being fully confident as young women entering medicine, grappling with the processes that devalue the feminine, and women, during their training, and then reclaiming their feminine as they mature in their relationship to their profession and gain more control over how they practice. Several of the women describe a time as students and young doctors when they actively sought to identify with the masculine and step away from their female selves in order to be fully integrated into the profession. As a surgeon expressed it, when asked whether she thought of herself primarily as a woman or a doctor, *I didn't know I had a choice so I went for being a doctor. And now I'm, as rapidly as I can, trying to become a woman. P8*. This echoes US surgeon

Frances Conley who describes how women were forced to view themselves as 'doctors first and females second' (Conley 1998 p 28)

This process causes a lot of pain, and the women in this study who had to do that are now reclaiming their female identity. P9 has stepped away from clinical practice for the moment, taking time out to identify a way in which she can reclaim her female ways of knowing and integrate those into her practice as a doctor, instead of abandoning them as she felt forced to do as a medical student and young doctor.

A specialist who had endured years of specialty training that demanded that she think and behave like a man eventually changed specialties. She commented:

> *And I didn't want to change what I was and I think that was a huge conflict. I didn't want to be like the boys, I had no desire to be anything other than what I thought I was. P4*

Another specialist came the same full circle. She too had modelled herself on the masculine, and had become very confused, eventually finding the way back to her female identity:

> *being very, very strong in my sense of being a woman, is good. I have absolutely no wish to be a man except if I could get the best of both worlds and have all the privileges and comfort in the sense of entitlement to be there. I think that I feel pleased to be a woman in medicine. P8*

Reclaiming and revaluing their feminine has been an exhausting journey for these women. It has caused them to think deeply and critically about their profession and their relationship with it, and for each of them it was only possible to do this after they had established their professional identity and competence and a place for themselves as doctors.

Fighting back

Most of the women interviewed were engaged in intermittent skirmishes with medicine, fighting back where they could, breaking the rules, causing a disturbance and making a difference. One of the specialists was determined to hang on to her feminine while in the training programme and one way she kept sane and whole and intact was going out and doing some general practice as well, working in women's health clinics that valued her contribution as a woman. This was breaking all the rules of the hierarchy, in which she was supposed to be learning her place in the ranking of her specialty, as well as technical skills. She kept this strategy to herself because'*That would be seen as rebellious and not toeing the line and she explained that she was no longer afraid to do that.' P3*. A surgeon agreed that she was not prepared to be obedient any more. She described being in the process of throwing off a cloak that she had allowed to cover her '*I think it's being told what to do is what I'm throwing off.' P8*

Perhaps the most powerful way in which these women are challenging and transforming the culture of medicine is by deep thought and reflection, and systematic study of how it works, so they can locate the points of possible transformation, and then act at those points. Asked what she had learned through years of working within medical politics, a surgeon replied:

I learned that my conviction that there was a pattern to women being excluded from medical knowledge and from leadership was correct, that is, that there was a sort of cascade of constructs that were designed to exclude women.

Q: What are they?

Women's opinions don't count. Women don't count in society. Women don't deserve resources. All resources should go to men, including resources for training everybody and for understanding the world. Complete nonsense. And I guess I had long enough to try out every single avenue I could find to see if I was wrong. I'm still looking. P8

This doctor, and others like her, by their presence as embodied females, with untamed instincts, and thought-structures honed by years of medical education and training, with unwavering intention to make a difference, are a potent force for change in the profession. Those women who survive the training system with a sense of their female selves intact have proved their resilience and their capacity to resist surrender, have proved themselves difficult to tame. And some of them have, in the process, developed the leadership skills and authority to require medicine to change instead.

5. Using their authority for change

Several of the women in the interview group were national leaders in their field, and used these positions of influence to argue for and implement changes that made medicine more 'woman friendly'. Others provided leadership at the local level, implementing changes to educational programmes, practice environments and through their individual relationship with patients.

Even the most confused and wounded of the women were working for change, while still trying to work out what was going on and dealing with the consequences of being dismissed, trivialised and trounced.

Specific changes nominated by participants included

Maternity leave of 3 months included as part of post-graduate training

Role model and authorise interweaving of pregnancy, childbirth and specialist training

Authorise leave for childbirth with no adverse affect on training position

Cooperative spirit and teamwork in operating theatre

Refer patients to birth centre, which other obstetricians refuse to do

Listen to patients rather than telling them what to do

Trainee representative on the training programme

Model surgical personality that is co-operative, approachable, female

Encourage young women to consider surgery

Provide good (surgical) service without the crap that comes along with it

Tell female medical students what is going on

Speak with male doctors about the importance of interrupted training

Supervise male medical students exploring medical culture in a gender-competent way

Work for changes to medical culture within their college councils

Seek to implement changes to specialty training programmes to ensure they accommodate women's life-course

Bring non-medical feminist theorists into the medical college process to help elucidate what is going on, name it, and plan for action

Belong to medical women's societies that advocate for change

Network with other medical women in leadership positions to provide support for change

Study outside their discipline to improve their understanding of health and medical culture

Learn how medical college processes work so they can be influenced

Speak in public, with the authority of their medical degree, about the health effects of violence against women

Write policy documents and responses to policy, representing how it will affect women

Set limits to practice to allow time for family

Direct action to protect young female doctors by letting them know who are the sexual predators in the hospital or training programme

Challenge sexual harassment within the hospital

Tell people what is going on within the profession

Challenge the hierarchy

Challenge the structure and content of meetings, men's hierarchy games

Offer to job-share with a pregnant specialist trainee

Identify and name women's pain

Challenge in public college leadership when it misrepresents women's position

Alliance with the Office of the Status of Women, for funding and research

Learning to work the system to get what she wants: pass that knowledge on to other women

Strategic use of feelings to get what she wants

These are concrete examples of actions individual women are taking, sometimes together, sometimes alone, to require medicine to change to include them.

The following vignette demonstrates the power of medical women using their authority to demand change and make a difference. It is a story about protecting the young ones.

Vignette: Protecting the young ones

And this man managed to spread rumours around the hospital … and her reputation was in shreds. And somehow at the same time he was engaging in similar behaviour with me. And the two of us didn't realise this was happening simultaneously. … I mean having two sets of rumours going around would've been very difficult for him to reconcile but she really struggled against that because she had a boyfriend and he heard these rumours and it ended up that I had to call her boyfriend to say 'look this is going on, she's got nothing to do with it', because they were on the brink of breaking up over the whole thing…. Apparently this particular registrar has been doing this for years, and everybody knows about it, but hadn't bothered to tell the junior residents about it, particularly the women who were most at risk. So we dealt with it by instigating the largest public education campaign that this particular hospital's ever seen about this particular man. So he basically discovered that every single person knew exactly what had been going on within about a week and was discovering what had been happening.

We took all the medical students aside and told them what was happening. Male and female. And told them to tell everybody back at their home base what had been happening, so that when more people came in contact with him they would know, particularly female students.

Basically I told them that this guy had been harassing two of the interns, that one of them has had rumours spread about her which were untrue, and if they heard them they were to discount them and tell people that they were wrong, and that he had been doing it previously and was going to do it again. And that they needed to be professional about it because he was a colleague and so they were going to have to work with him at some point in time, but if he made approaches to any of them that they should bear in mind this information before deciding their kind of interactions with him. And we told physiotherapists and like, quite a few ended up going out with him and went through exactly the same thing. But at least they were forewarned about it. So yeah. I was accosted by this man a couple of times in the corridors telling me to keep my f-ing nose out of his business. And I told him that he'd put his f-ing nose into mine and so I was very happy to spread it around. P6

This is Demeter energy, the fierce protection of mother for daughter[46]. Energy that is prepared to lay waste to the ground before them in defence of the feminine. Using their authority as doctors to take care of the young women applies to patients as well. The rural doctors described many different ways in which they protected their female patients from the more brutal aspects of society, particularly the young women and the old ones. They described the difference this made in the lives of their patients:

[46] Demeter is the goddess of fertility, grains and the harvest. Hades stole her daughter, Persephone, and took her to the underworld. In her grief Demeter cast a shadow over the earth and refused to let anything grow for six months (winter) until her daughter was returned to her.

Older cashier at the local supermarket brought in a young recently arrived Indian girl who was working with her. The girl was very vulnerable, living alone and being 'used' by several young men, would only speak to a female about it. Together we were able to work out several strategies which she has subsequently found helpful. – rural doctor

Today: my patient (female) said "It's so nice to come to the doctor and not feel you're being talked down to" – rural doctor

Mother - borderline intelligence. Daughter doing VCE. Tense relationship between them, but both trusted me. Took 2 years to slowly work through the issues but they came back again and again and again. – rural doctor

The women who participated in this study are using their authority to change medicine, on a daily basis, often unwittingly, and sometimes with deliberate intention. As female doctors they interact with patients in ways that reflect their female values and style and women's ways of knowing. As professional colleagues they engage with other doctors in ways that challenge the powerful hierarchies endemic within medicine, challenge the rhetoric about what is valued in professional behaviour, support and back-up female colleagues at risk, and validate their experiences. As consultants they role model ways of being senior in the profession that do not depend on bullying, hierarchy and humiliation and avoid throwing their weight (or surgical instruments) around.

So something happening in me and the reason I'm bringing it up is because you'd asked me, "Have I witnessed a woman surgeon throwing things across the room" but I was thinking of eye instruments. We don't throw eye instruments, I forgot to say that. And I said, "No" and I think what I was trying to say was that I think I feel very comfortable in not throwing instruments in the theatre. I've got no drive to throw instruments in the theatre and because – I think it's come from making links with women in the room, but now I can make the links back with the men in the room a bit better. P8

As senior members of the profession they explore medical culture, advocate for change, and act to make the profession more responsive to the varying life-courses of women. The female doctors who took part in the survey also identified ways in which they were using their authority as doctors to change the profession. The nature of the data-gathering exercise does not allow me to comment on how conscious this is. However I was able to measure what women do in practice that is leading to changes in medical culture and practice.[47]

6. Contesting knowledges

I think my style of thinking is really, really, really annoying to a lot of men and they don't mind showing their irritation and to me they're just out of control. It's them that's out of control and not me because I've got lots of valuable things to say and to do and be. P8

listening to what women say, of course. P3

Working with Sandra Harding's explication of standpoint theory and 'thinking from women's lives', it is possible to explore the ways in which women doctors intuitively develop knowledge based on women's lives, both their own and others, and recognise how

[47] Changes to practice are explored more fully in Chapter 8

conventional epistemological and scientific questions have excluded such knowledge sources (Harding 1991). In their own practice women doctors live the theory that describes the 'positive scientific and epistemic value of marginality' by using either their own marginalised position within medicine, or that of their female patients, to discover new ways of practice and theory (Harding 1996 p 242).

Doctors in the survey were asked to describe an incident in which they had been valued as a female doctor, and details of that have been explored fully in Chapter 4. In addition women described working in ways that are not sanctioned by mainstream medicine. In ways that medicine was developed to suppress. They challenge the ideology of the dispassionate, removed, disembodied, rational, scientific mind described in Chapter 2. The tools these women work with are embodied knowledge, empathy, emotion, engagement, intuition, speaking women's language, spirit, and motherhood.

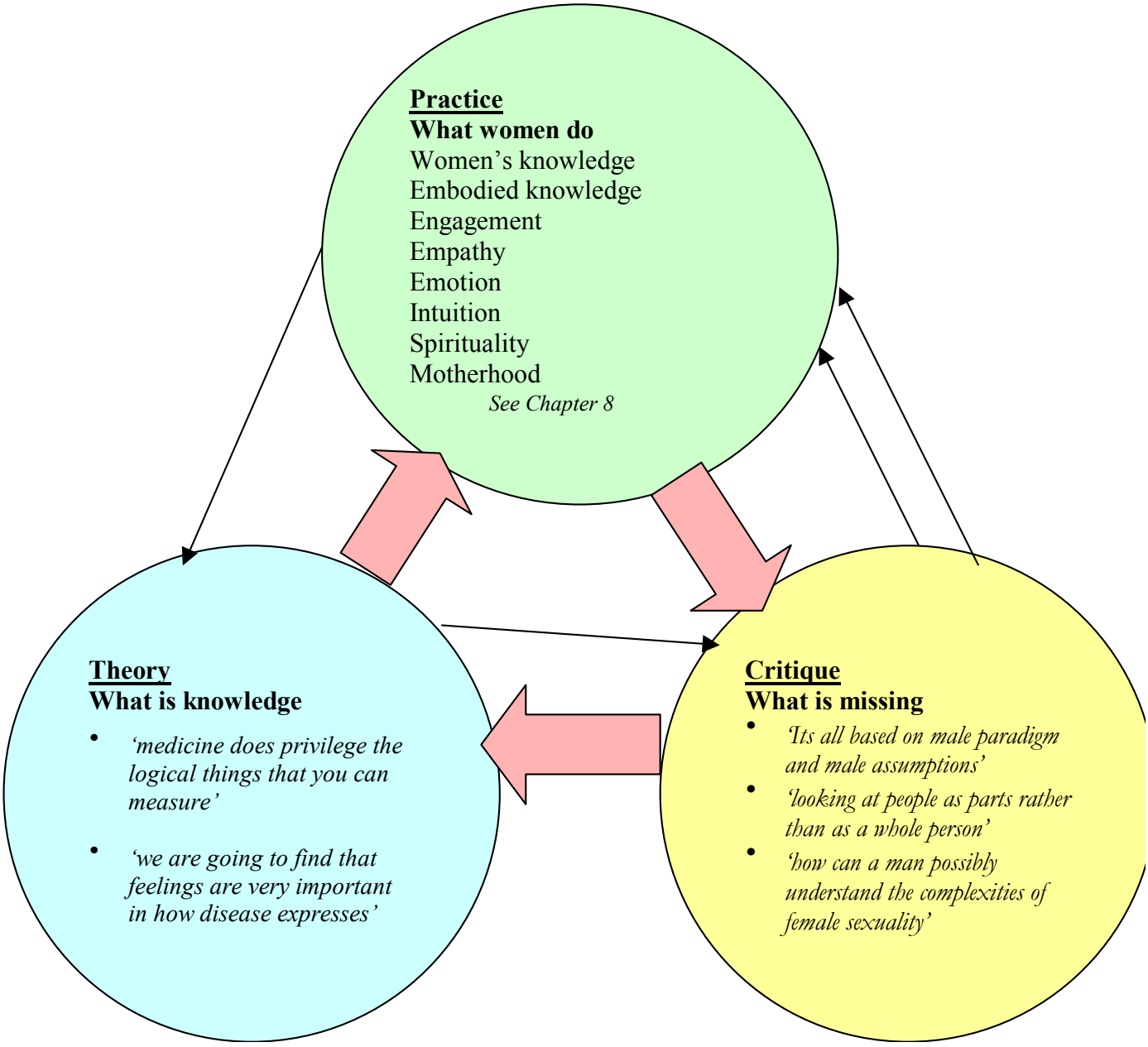
These are ways of knowing that have been systematically beaten out of young doctors during their training, as described in Chapter 5, a process that led to great distress in some of the doctors involved in this research. Yet female rural doctors, free to practice in their own way, in areas of great need and within their own communities as highly valued contributors to community well-being, are breaking through that training and practising like women. Trained as they are in the mainstream paradigm women are most unlikely to speak of this among their colleagues. It is probable that this is new knowledge that has been uncovered because the question was identified in this study as having merit.

A key element of ancient women's mysteries is understanding the cycle of birth, death and rebirth. This is embodied knowledge women have from their experience of being mothers and it is rooted deeply in women's consciousness. It takes away fear of death, it connects with the next generations, it transcends the ego. A rural doctor was expressing this, without consciously knowing that this knowledge was codified by the priestesses at Eleusis thousands of years ago. She described how she was valued as a women doctor *helping with birth and assisting the dying to have a peaceful end has been important. Overall I have an affinity with some of this community as I am a person/mother first and foremost. – rural doctor.*

Similar challenges to accepted scientific medical orthodoxy about what constitutes knowledge and 'scientific' practice were also spoken by women during the interviews. It is likely that the promise of confidentiality was an absolute condition of disclosure of these contested knowledge positions.

Women doctors are challenging the epistemology of medicine as well as its practice. Their practice informs this challenge, mediated by what they identify as missing. The cycle, then, goes from practice, to critique, to theory, and this theory then informs practice. This is not a closed system, and many leakages occur, women travel the cycle only as far as they need to make sense of their lives, some turn back when they see the implications of their destination, but others keep travelling towards the limits of allowable knowledge. This process is illustrated in the following diagram Contesting Medical Knowledge in Theory and Practice:

Contesting medical knowledge in theory and practice



This next section examines how women are critiquing medicine and using theory to understand what is going on.

Identifying what is missing

Most of the women interviewed were able to draw on their experience of learning and practising medicine to identify aspects of medical knowledge, culture and practice that were missing. They challenged the hegemony of established practice and identified some of the absurdities arising from the implicit stance that the doctor has no body, no sex and no life, and that illness is a discreet biological event located in particular body parts. A gynaecologist described how her training had concentrated on surgical interventions and missed out on many of the issues women present with, saying '*you don't get taught about family planning or menopause. You don't get taught about sexual abuse, domestic violence, vulval health'.* And she wondered *'how can a man possibly understand the complexities of female sexuality. .. I mean for them it comes simply down to sore vagina, or sore pelvis, it needs an operation or biopsy or cut it out, or use Canesten cream if you've got thrush.' P3*

P3 is identifying the missing link here, that of women's experience informing medical theory, research, training and practice. She accepts the skills that male-defined medicine has developed, the ability to operate effectively, and deplores the use of this one tool when applied to complex and life-denying problems. And she is determined to incorporate a broader perspective in her own work with women.

> *there's a lot of people on Health Care cards and having all sorts of problems and I don't think its very helpful for them to visit someone who is going to say 'oh well we will do a laparoscopy because you've got pains'. I think that doing what I'm doing now is to help them to come to terms with their own lives and femininity and sexuality because there is a lot of abuse out there, a lot of sexual abuse, and the whole issue about, about female genitals and all this stuff, they don't have the freedom of their sexuality that they should. There are so many miserable women out there. They can't have sex, they use Canesten every week, they scrub and clean it and there's just so much misinformation, and so much misery that I'm seeing. And its something they've got to live with every day. And no one really wants to look after it. And that's part of their sexuality, its part of their whole life. Its really just horrible for them. They are abused in their marriage. Intimately, emotionally and physically, and what sort of a life is that. That's not freedom. You might as well be wearing, what do they call it ? a chador, as do that. P3*

These are the words of a doctor I would trust with my body.

Some doctors are critical of the pressing need to act that is part of the culture of medicine, the need to do something, often surgery, rather than explore what is really going on '*as doctors, we are looking at everything as symptoms, and for a lot of things, the issues are deeper than symptoms.' P9.*

Another of the major critiques that women make of medicine is the concentration on body parts, '*looking at people as parts rather than as a whole person' P9*, and the simple presenting complaint, without taking into account the whole person and their context. The ability to do this is part of the attraction to rural practice for women (Wainer 2001), and the desire to do so underpins the longer and more complex consultations that women often use (Britt, Bhasale et al. 1996).

They also critique the lack of attention to emotion and feeling, both for the doctor and the patient, and describe ways in which they work with these aspects in their own practice (see Chapter 9). The lack of fit between the way many women think and feel, and the way they are required to think and act as doctors, is a challenge to the women, and in turn they use this knowledge to highlight and begin to mend the weaknesses in medicine.

Disbelieving

The cyclical nature of women's bodies helps women monitor their bodies and be conscience of bodily experience. This is heightened by the big transitions of menarche, childbirth and menopause, events that make it increasingly difficult for women to believe that truth lives in the disembodied mind of Descartes and the disembodied science that followed. The confusion that arises in the conflict between embodied knowledge and disembodied science is illustrated by this story of a first year medical student:

> *I can remember one of the senior people in the department of anatomy saying that women who had dysmenorrhoea did not feel pain, they were just too silly to know the difference between muscle pressure and pain and I can remember looking at him and thinking 'he can't know that'. You sat there thinking am I just silly because I interpreted this as pain, or is he just silly because he doesn't know what female experience is. P1*

She goes on to describe the 'constant drip' of these disorienting experiences, how she lost her bearings on herself and her truths, finding that she was talking about things that were quite foreign to the normal construction of medicine. Things such as meaning and experience as well as laboratory tests and diagnoses. This doctor struggled for years to put aside her female ways of knowing, and then decided to work with it and value it, and to believe the women. She is now working to bring forward hidden female experiences of abuse, health and the body.

A surgeon has moved on from the constraints of her surgical training and is now determined to claim her femaleness and her women's ways of knowing:

> *Bringing myself into the knowledge, start counting what I do in my body, what my body can do and what my bodily experiences as a woman and my bodily feelings as a woman bring to me. P8*

All but one of the women interviewed is systematically working to include her feminine in her medical practice. For the three general practitioners this has meant major restructuring of their practice, and for others it has required restructuring of their ontological position, their very understanding of the world. All of these women are making a difference to the practice of medicine in some way, from the individual practice level, through to the national policy level.

Reintegrating

One of the reasons women are so strong in their determination to keep going in medicine, even when they can identify its weaknesses and despite the hardships they have endured, is validation by their patients. This was explored more fully in Chapter 4, and it is relevant here as part of the process of women's resilience. All but one of the women interviewed spoke about their relationships with patients and how valued they felt; '*my time with the patients, what I felt actually resonated with them, so it gave me a chance also for validation and realized that what I was thinking was not so far fetched or different or odd. So that also helped*

hold the things I believed.' P1 The rural doctors who took part in the survey were nearly all able to provide examples of being valued, and with only a few exceptions they talked about patients rather than colleagues. So women use their relationships with patients, and with other women, to keep from being overwhelmed by what they discover about what is missing in their profession.

They also find their own, sometimes unorthodox ways to the knowledge they need to be the sort of doctors they want to be:

The gynaecologist who learnt to put in IUDs from a nurse, and to do terminations from a GP

The GP who learnt from *women's stories*

The obstetrician who listened to what women wanted

The gynaecologist who worked out that medicine was not her whole life

The surgeon who found women outside medicine to be her guides

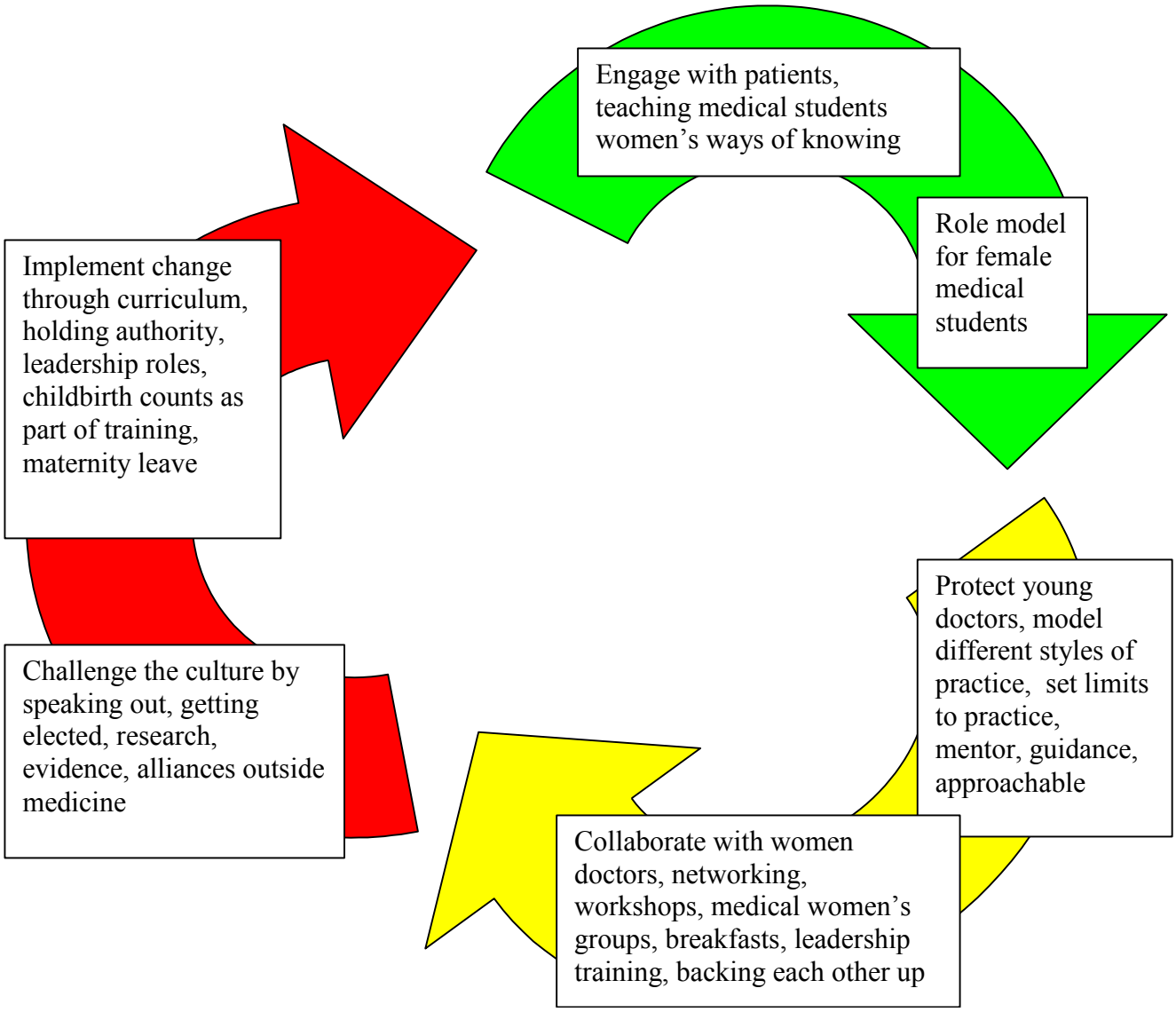
The surgical registrar who has joined a medical women's group to help her keep in touch with the feminine

The psychiatrist who set up a senior medical women's forum in her workplace

This process of diagnosis of the problem between the female doctor/all female doctors and medicine, prescription of a remedy and the implementation of an intervention is a cyclical, continuing process analogous to the quality improvement cycle. It is not a one-off event, and it is one that has an impact on both the individual female doctor and medical culture. Sometimes the women make a radical shift in their practice in order to influence their profession, like the general practitioner who moved from working one-to-one with patients, to working in education because her work with patients, although valued by her patients, made no visible impact on the system.

The Cycle of Change is represented in the following diagram:

Cycle of Change



The rural doctor survey provides an example of women working to be included in the project of medicine. Respondents to the survey were asked how prepared they felt for rural practice and their response was compared to that given in the National Rural General Practice Study (NRGPS) conducted in 1996 (Strasser, Kamien et al. 1997). The rural doctor survey found that two thirds of women feel prepared for practice, (see Table 11) which is a statistically significant improvement on that of the NRGPS, and may reflect the intervening six years of developmental programmes to support rural doctors, as well as women's insistence that they be heard. It appears that the needs of women are being attended to a little more effectively in 2002 than they were in 1996. A higher but not statistically significant percentage of men also report being prepared for practice compared with 1996.

Table 11 Preparation for practice, compared with NRGPS

	Sustainable Models 2002*		**NRGPS 1996**	
	Women	Men	Women	Men
Prepared	66%	72%	51%	68%
Unprepared	34%	28%	49%	32%
Total N	564	448	319	1080

*Doctors who were neither prepared nor unprepared are not included in this table.

Women: Chi-sq = 33.6, $p<0.001$, Men: Chi-sq = 1.48, p=0.223

The change for women is likely to reflect the dedicated work of women rural doctors (and academics) over the past eight years to ensure that their training needs and professional support requirements are included in rural practice (Tolhurst, Bell et al. 1997; McEwin 2001; Wainer, Bryant et al. 2001; ACRRM 2003; Wainer and Doty 2003). This is a concrete example of women cooperating to diagnose the problem, define appropriate interventions, and work politically to secure resources.

When they experience a disturbing encounter within their profession the women in this study have learnt from it and have become wiser in their understanding of themselves and their profession. They turn this wisdom into requirements for change, and make it available to other women, particularly the younger ones, so that they can stand on the shoulders of the women who go before them. For a few of the women, this process of understanding leads them to theories about knowledge creation, social construction, professional development and feminism that give them deep insights into what is going on. Their struggle then becomes finding points of insertion into the profession. Who wants to know ?

7. Epistemology

Half of the women interviewed are challenging the construction of medical knowledge and the effects of the exclusion of women from that process. Two are doing this in radical

practice and conversation with colleagues, and two are undertaking doctoral studies and working in medical education so that they can have a system-wide impact. They are at the leading edge of the international critique of medicine being undertaken by women throughout the world. Organisations such as the Medical Women's International Association, the National Institutes of Health in the USA, and the Wonca women's group, are documenting the effects of the absence of women from the development of medical knowledge in the existing medical paradigm, on both doctors and patients, and engaging in a dialogue for change. These are some of the challenges being made by women in my study:

> *But what's knowledge, what's history ? Its all been based on male paradigm and male assumptions, so anything that is not in that paradigm is not respected, its not acknowledged in books and it is only very recently that things are starting to be written the female way but they're not respected in that way. P3*

> *take healing modalities if you like, to actually gather the information but having an experience of them and then if you are actually translating it back, … the slant I put on it will be different from the slant you put on it, having got the same bit of information. So for me … what you get is that information but when you translate it back it's knowledge because it's got your little stamp on it. Your knowledge and my knowledge and everyone else's knowledge then becomes this… pool of wisdom, if you like, because it's a soup that's flavoured with different bits because it's all interpreted and fed in differently. P9*

> *I have a very strong feeling that the silence that I was taught was premised on women's views or women's understandings being absent or not worthy of even contemplation. I guess that's why I'm now interested in the social construction of what counts as knowledge, what counts as science and I've got an absolute conviction that most of the scientific knowledge that I was taught, so called science, was premised on that, was premised on excluding a whole lot of things that are just as important, if not more, but that didn't seem to count as knowledge, from one perspective. And I think it is very much gendered …understanding and language relies on being able to separate those things (socially constructed knowledge and physical things). But it's their inseparability that's the knowledge. Like the fact that we can talk about neural pathways about why and how children hold their eyes straight and I can now think that, together with the moral judgements about someone looking bad if their eyes look crooked. In my medical training I don't think I gleaned that they're both knowledge; attitudes and values are knowledge too… I see knowledge as constantly dynamic, constantly contested, constantly contestable and that's where I'm up to, where I'm up to with my thinking about knowledge construction. P8*

> *I'm someone who's very comfortable with the idea of quagmires and mixes…I see so many men who naturally feel like saying, "Well, of course, if you can't break things up into pieces I can't even talk to you, we can't engage". But what I know that they don't know is that there's very good codification that that capacity is cultural. P8*

These women are wrestling with knowledge paradigms that are outside their profession and it poses serious problems for them, but they exist and they are not going to go away and they are determined to be heard. Other medical women can find them a challenge because in effect these women are saying 'we know the medical culture, the professional secrets, the tools of the trade. And we also know other things that are important, may even be as important, or more important. We are inside the tent and we are wondering what we have walked in on'. Women who are comfortable with or delighted by medicine as it is presently constructed will not rejoice in the existence of these challenging, transgressive women, but they will have to engage with them.

At this point it is likely that the power and authority within medicine is so weighted in favour of existing paradigms that these voices from the margin can go unheeded by those who exist in the controlling stratum, yet, as predicted by standpoint theory, they are identifying critical soft spots in the fabric of medical knowledge and a wise profession would ask them to tell what they know, what they can see and what is really going on. Like a canary down a mine, these untamed minds can identify problems in the making before they become evident to the mainstream. As Gilligan puts it 'women medical students (and doctors) in their heightened sensitivity to detachment and isolation often reveal the places in medical training and practice where human connection has become dangerously thin' (Gilligan and Pollak 1988 p 262).

8. Claiming medicine for women

Women like to see women about women's business. P3

The women interviewed for this study have struggled with their sense of entitlement to be both doctors and women. When they entered the profession as medical students it had not occurred to them they may not be entitled to be there, and for one of the women that has been her experience throughout her professional life. The others have been confronted, challenged, ignored, silenced and side-lined often enough that their sense of belonging was seriously and painfully challenged. Most of them have taken on the challenge and arrived at the understanding that the problem is a problem for medicine, not for them. They are actively working to make space for themselves as women, and for other women, and thinking and acting strategically to find ways to be women as well as doctors. They want medicine to belong to women too.

Many of the women in the survey are working toward the same end. They challenge the rhetoric that 'super doc' is the only way to be a rural doctor, they describe medical encounters where their female ways of practice have led to positive outcomes for the patient, and they have changed the way rural medicine is practised so that they can be women as well as doctors, and have lives too.

Women from both arms of the study describe how they network with other women doctors as part of the strategy of claiming medicine for women. The importance of female mentors and role models is mentioned again and again, and the existence of hospitals established by women for women, such as the Queen Victoria hospital in Melbourne and the Rachel Foster hospital in Sydney, holds iconic value for women who have experienced female-controlled medical space. Women's health clinics controlled and staffed by women, and Family Planning practices controlled and staffed by women also provide experiences that confirm the value of the critical contributions women make to medicine, and highlight the cultural differences between how women work and what medicine currently requires of doctors.

Women are beginning to hold office in their medical colleges in Australia and young women can now see portraits of women councillors and presidents in the colleges of Surgery, General Practice, Physicians, Rural and Remote Medicine, Psychiatrists and Obstetricians and Gynaecologists. One other place women turn to find the mother-line in medicine is medical history.

Claiming history

Most of the women interviewed knew something of the history of women as healers and in medicine, and even of the witch burnings, even though the official current version of the history of medicine valourises medical men and sets medicine against non-medical healers. The feminist consciousness raising of the 1970s has infiltrated these women's world view and encouraged them to challenge accepted versions of history that write women out. Some have even taken the time to search out their fore-mothers, and are excited by what they have found:

Vignette: Knowing your own history

Well its mostly recently, I've been doing a lot of reading around medical theory of women and women's bodies and part of that has been reading about (the) history of women in medicine and there are a couple of really good books that I've found. I think you say it as, 'Hypatia's Heritage', and that's all about women scientists. There was another one I read on timelines of women in science, and stuff like 3000 years ago there was a medical school in Egypt, two medical schools which accepted women. Italy had a long history of female medical practitioners, I found a bit for a friend, about there being four female ophthalmologists in the 16th Century in Frankfurt, and one of the women was the first person to ever use a magnet to extract a foreign body from somebody's eye. So that was pretty exciting for us. Pictures of female professors of anatomy and things that, as a student the history was all about men in medicine and there was nothing about women and to find there is a female history of women in medicine is really exciting. Just if I know it and then when I teach its something that can be brought in. Even for the students when they get the comment, 'oh they're still letting women into medicine', well they've been letting women into medicine for 3,000 years. I mean who's the one who's behind the times ? It just opens the world. You think, wow we've always been there. And what's happened is, probably in the last couple of hundred years the story has been re-written so we're not there. But actually women have always been there, and its something that, at a deep level, I have always felt, but I've never been able to justify. Suddenly you think, Hah ! here I have the info that says I am not imagining this, that this is real. ... I always knew that women were healers, certainly the non medical tradition of women healers. I always knew that was there, but that's very devalued in conventional Western medicine. I think what they did was very valuable and they were the initial pharmacists, and that was the work they were doing as women. I don't think it should devalued at all but its also exciting to see that in more conventional medical terms that women were there right from the beginning as well.. (pause) Yeah I think it gives you this sense of belonging which is something which was never there, I never felt through medical school that I belonged. I felt I belonged in my practice and I've felt that I've belonged in my current academic community but I never felt through medical school that I belonged, that somehow there was something about me that shouldn't be there. P1

Knowing their own history can ground women in their knowledge of who they are, what it is possible for them to be, and particularly, their right to be there. When women discover that their absence from the annals of their profession is a political act rather than a result of the inadequacy of women or because women's 'natural' domain is the family rather than the professions, then they can begin to understand the political nature of all knowledge-

making, and some will begin to wonder why and how women came to be written out of history, how women came to lose the keys to the kingdom. The women in this study who have done that take the next step. They want it to be different, for themselves, for their patients, for the next generation of women in medicine, and they are working toward that goal.

Claiming women's ways

Women in this study made a link between women's unique skills and history and the skills needed to be a doctor. A surgical registrar claimed that *from a technical perspective I mean given that for years when they had been seamstresses and fine motor work with their hands, there's no technical barrier to us being good surgeons P6.* This is not an analogy likely to be heard in the corridor of the College of Surgeons although US neurosurgeon Frances Conley makes the same comparison when she describes learning surgery as 'such fun, and so very natural, perhaps from having learned needlework as a child' (Conley 1998 p 25). A rural doctor wrote of her skills as a seamstress and how it forged bonds with women in the towns she worked in *the fibres and fabrics which we love so much create an instant connection between us sewers… and after recent gynaecological surgery a bunch of fabric flowers in luscious orange, red, pink and purple silks representing female fertility* (Tolhurst in press).

Another surgeon realised how her life as a surgeon had left her bereaved of her life as a woman and knew she wanted to bring that into medicine, and that after years of looking for it inside medicine, decided women's ways lay outside, so she would go and find them and bring them in, breaking one of the most potent of the unwritten rules of medicine, that only doctors have anything of value to say to doctors. She was determined:

> *to bring real women into the culture. Women who had the sort of perspective that I knew I wanted to get and knew I didn't have. I didn't have the intellectual and conceptual tools, the emotional experience, nothing, the life experience of testing out and understanding. P8*

She describes further the process of bringing women into the culture and the transformative quality of that for a young doctor:

> *I'm sure I'm connected by a strength of spirit with other women doctors and the connection is the spirit of not being frightened. It's something I wasn't aware that I had tapped into in medicine as a young woman. I didn't know it, I was frightened of it, frightened of powerful women and I didn't see the power in me…And you get high on challenging power. Challenging power gives you power. P8*

Two of the women interviewed were bringing experiences of being female healers in past lives into their current experience of medicine, and a majority were bringing through the mother-line in their family. By this I mean they could identify a heritage through mothers, grandmothers and great grandmothers of strong women, professional women, smart women, pioneer women, feminist women. Some were quite surprised to find this as they had thought their determination came from their fathers and certainly fathers were important. Authorising fathers who encouraged their daughters to dream and strive, who approved of what they were up to, were strongly validating to these women.

Claiming connection with women

> *To tell their story, to teach, to talk to their grand children, talk to other young women, I think there are lots to do, in my medical woman hat I keep trying to get some of our*

> *older members to actually tell their stories, because we don't know them, about what it was like to mother and work like a lot of them did in the 30's. It would be nice to hear their story and it would be nice to be able to hand their story on as well. P1*

Again and again women in both the survey and the interviews spoke of their connection with women, particularly medical women. They claimed their family heritage, their relationship with their sisters and mothers, and told of pioneering and strong-willed grandmothers. Medical women come from a line of women who will not be trampled on. In the survey the doctors spoke of their relationship with female patients and colleagues, and the study showed that these relationships play an important part in their satisfaction with their practice and their lives as rural doctors. Fighting back against innuendo about being 'not real doctors' women are claiming connection with other women as a strength and a resource in their medical practice.

Women who are able to network with female colleagues intend to stay longer in their existing practice, and women who refuse to be intimidated by discrimination from their colleagues are twice as likely to be contented with their life as a rural doctor. These sex-specific behaviours are consistent with the finding that women are more likely to work in towns that have other female doctors. There is a culture in some parts of rural practice that is dismissive of female doctors. Women respond to this by gaining support from each other, and this works to make them more contented and more likely to stay. Women are claiming their relationship with other women as part of claiming medicine for women.

9. Including women in the project of medicine

This chapter focuses on the actions women are taking to transform medicine to include women. Many of these actions are private behaviours or interactions with individual patients. Others are more explicitly aimed at changing the culture of medicine, and the most radical intend to extend the epistemology of medicine to include other ways of knowing. Each intervention causes ripples on the surface calm of a tightly patrolled homogeneous profession. Its long and proud history of healing is being examined critically by the new kids on the block, and gaps and distortions are being identified and quietly rectified.

Known to some and unknown to others, the women in this study are likely to be contributing to what Foucault termed 'epistemic' change, a time in human affairs when the structure of knowledge changes to reflect changes in the balance of power and authority within a culture (Danaher, Schirato et al. 2000).

As one doctor said, describing her need for flexibility in her training experience, *I didn't know how to negotiate it so I just did it. P8.* Women are 'just doing it' on a daily basis and the cumulative effect is rippling through the profession, building a wave of change that will transform practice structures, training programmes, doctor/patient interactions, and the very knowledge base of medicine. Some time soon we will look back and wonder how such a magnificent profession could build itself on such a narrow base and trumpet the achievements of its science, when that science and that profession excluded the experience and wisdom of half the human race.

Gilligan has noted from her research with doctors the transformative potential of women's ways of knowing. She finds that:

> the division between nurturance and achievement, especially in a healing profession, may be of particular consequence for women….Women's perceptions about the healing power of relationships and their vigilance to the dangers of detachment may both explain greater stress among women doctors and may provide a new understanding of physician vulnerability and success…The inclusion of women in psychological theory and research has brought about a change in the understanding of human motivation' (Gilligan and Pollak 1988 p 261).

Kuhn has described how 'high levels of agreement in perception, practice and judgement .. makes normal science possible' (Barnes 1985 p 89). This agreement depends upon homogeneity in the project of science, and the presence of women is essentially disruptive unless they can be coerced to adopt the 'perception, practice and judgement' of their male colleagues. The women described in this chapter at first accept and then resist this requirement and in the process have the potential to disrupt 'normal science'. Transformative indeed.

Like Gilligan's work, this chapter has identified ways in which women are transforming medicine through practice and through relationships, and from the stories women tell it seems patients cannot get enough of it.

8

Changing the Very Frame in Which They Work

If we were a group of women practising, we would get that practice right and would make lots of assumptions that we can't change the outside world whereas I think men tend to make the assumption, which is true, that they have much more power in changing the very frame in which they work. And I think part of this is that one of the reasons why women are locally focused is that that's all they can change. They don't have the systemic links to how society's organised and so part of the essential difference between men and women, which is talked about in even education for example, is that women are more practice based or more focused on the local and the actual practice rather than the abstract. It's partly because women can't change the abstract in a way that they might if abstract was constructed as what they know and what they think is important. P8

When I worked with Fred, I saw fewer people than him for which I got a lot of crap, but he was always playing computer games, always. So everyone'd go and see him for quick and easy things, but if it was anything difficult or needed a bit of, you know, sorting out or discussion, they would come and see me. P5

This chapter primarily draws on qualitative data from the national survey of rural doctors to extend the examination of the impact of women on medicine. In Chapters 6 and 7 we have seen how women are resisting the requirement that they behave like men, and are working in many ways to change the culture and content of medicine. In Chapter 8 I concentrate on how women are changing the practice of medicine.

Rural medicine is the place where women have the most leverage, and change is happening most visibly, for two compelling reasons. There is a shortage of rural doctors; and rural constituencies have political clout. As a result the Australian government has funded research to identify what is going on with female rural doctors, including the national survey that was conducted as part of the research for this doctorate.

In Chapter 2 I briefly described the methodology for developing the survey, including the use of the Delphi technique to generate new information about what women are doing in rural practice. This new information provided the innovative strategies that formed the central part of the national survey.

Throughout the conduct of this research, and the writing of the thesis, I have been clear in my purpose to uncover and describe the feminine, without reference to the masculine and what men are doing. This reflects my intention to avoid the common practice of assuming

that men and their activities are the norm, and that women can only be understood by reference to that norm. In this chapter I make an exception and I will include comparison between women and men, using women's activities as the norm and testing to see whether they apply to men as well. This is necessary in order to quantify how women are changing practice. Data from the survey identified ways in which female doctors are changing medical practice, ways that are generalisable to the rural doctor workforce, and that provide models of best practice for including women in the project of medicine. Data from the interviews will be included in the analysis to provide further insight into what is going on.

1. Survey – 'constructing my workplace'

Standpoint theory, working from women's lives, makes problematic many things that are constituted as 'natural' and, in their 'naturalness', underpin existing social and professional structures. One example is that women's work in childbearing and rearing and in the general care of bodies is invisible from the dominant perspective, even though it is such invisible work that makes it possible for others to dedicate themselves to socially recognised work (Tanesini 1999 p 151). So also professional structures are built that depend on, and yet do not recognise, the body work that women in our society do. Training programmes and practice environments in medicine are just such structures.

As we saw in Chapter 7, one of the major ways in which women are transforming medical practice is by making their families visible, and taking their family work into account in determining their approach to professional work.

Family life

> *a lot of it is to do with having children, which is the most powerful life-changing forces that there are. And I spend quite a lot of time talking to my younger colleagues about giving themselves enough space to allow that to be available and not trying to compartmentalise having kids into a neat little corner. Fit it into the weekend sort of thing. So that biological fact has got tremendous power and tremendous release and gives you tremendous capacity to understand more about yourself than almost anything else I think. P2*

It is increasingly being recognised in rural practice that doctors have families, and that this matters (Bond 2003). As part of the process of making the family visible, the survey sought to document how work in the family interacts with professional work. Questions concentrated on children and other family members who need care, such as the doctor's own children, step-children, other children living with them, or parents or parents-in-law, for example. If the doctor had children who were living independently, they were asked to leave them out of their answers.

Nearly all the doctors in the national survey are in a marriage like relationship and have dependent children (see Table 12). An important minority do not fit this description.

Table 12 Family status of rural general practitioners

Variable	Value	Female		Male		Missing	
Relationship		N	%	N	%	Female	Male
	Marriage or de-facto	506	84%	461	91%	8	5
	No partner	74	12%	37	7%		
	Friend	10	2%	6	1%		
	Other family	7	1%	0	0%		
	Other	7	1%	4	1%		
Have dependent children		377	62%	327	64%	4	1
Responsibility for care of children							
	All	52	14%	17	5%	230	181
	Most	166	44%	10	3%		
	Shared	154	40%	249	75%		
	Little	9	2%	54	16%		
	No	1	0%	2	1%		
Care of other family member		105	17%	58	12%	10	15
Mean hours of care for family members during 6 day working week		4.7 day	28.2 week	2.5 day	15 week	29	33

Twelve percent of women and 7% of the men are living on their own (with or without children) and the remainder are sharing their lives with partners, friends or other family.

Sixty two percent of women and 64% of men have dependent children living with them who require daily support. Fifty eight percent of these women have all or most of the responsibility for their care (8% of men).

It is clear that women are much more likely than men to carry most or all of the responsibility for caring for dependent children. Men are nearly twice as likely to say they share in the care of the children than women are, indicating a substantial difference in world-view about who is doing the work. This is consistent with Quadrio's finding that doctors' wives, whether themselves doctors or not, carry most domestic responsibility (Quadrio 2001 p 253).

It has been well-established (H.ofR. 1992) that women do a 'second shift' in addition to their paid work, and that the amount of work involved in this second shift does not alter significantly whether they are in the paid workforce or not. This family work has a substantial impact on the availability of women for clinical and other professional work. The doctors were asked to estimate how many hours they spent caring for a family member in the previous normal working day.

The mean number of hours for those women caring for children or other family members is 4.7 hours on a normal working day, or 28.5 hours per 6 day working week. The mean number of hours for those men caring for children or other family members is 2.5 hours on a normal working day, or fifteen hours per 6 day week. Thirty nine percent of men and 22% of women spend no time on family care.

Family work is a key difference between male and female doctors and permeates many of the challenges women face working within a system that ignores their family responsibilities or assumes there is someone at home providing family care. Yateman talks about rural paradigms that arbitrarily privilege public work and that have the 'effect of making the public domain falsely appear as self-sustaining' (Yateman 1986 p 159) and it quickly becomes clear to rural medical women that 'self-sustaining' means they will do the work.

In Chapter 5 we saw how medical culture requires female doctors to ignore or hide their families, and Chapters 6 and 7 identified strategies of resistance and inclusion that involved making families visible and drawing professional skills from experience within the family. The intersection of women, families and medicine is an enduring theme of this research.

Professional practice

Hours of work

> *Well job sharing for a start, is becoming more acceptable. Pregnancy, you know they are being pregnant during the training program now and I think I heard of someone who took three months off and I think she was even accredited for that time. P3*

This study drew on previous research (Tolhurst, Bell et al. 1997; McEwin 2001; Wainer 2001; White and Ferguson 2001; Tolhurst and Lippert 2003) to explore just what work rural doctors do, and how best to measure it. Work, especially work that women do, is much more complicated than the individual patient encounter, or even the booked session. I broke down work into face-to-face clinical work, other professional work, and community work, reflecting the intellectual and leadership skills that doctors bring to rural communities. Then I added family work.

As predicted, doctors work substantially longer hours in clinical practice than they are booked to work. Previous research has established that female doctors often have longer and more complex consultations than their male peers (Britt, Bhasale et al. 1996). One consequence of this can be that they work beyond their scheduled time as a way of completing their workload, rather than see patients for less time.

The mean of scheduled working hours for women is 26, and the mean of actual hours worked is 33 (see Chart 1). Eighty one percent of women were scheduled to work the 35 hours or less that constitutes part-time in general practice, but only 54% actually did so. Two percent of the women were scheduled to work 45 hours or more in the week prior to the survey, and 16% actually worked this long.

Chart 1 Hours booked by hours worked, women

The male doctors also worked more hours than they were scheduled to work, and worked longer hours than the women in clinical practice. The mean number of hours booked for men is 35, and the mean of hours worked is 47 hours.

When the hours of work are aggregated, including caring for family, clinical hours, other professional work and community based work, the men work a mean of 62 hours and the women work a mean of 58 hours (assuming a six day working week for hours of family care, as the variable asked about 'hours on the last normal working day'). This does not include on call. For those doctors who are caring for family members, the mean hours worked per week is 68 hours for the men, and 62 hours per week for the women (see Table 13).

The accuracy of this figure is affected by the non-response bias among women. Women working full-time were under-represented among respondents. Information about the workforce status of men in the survey sample was not available.

Table 13 Mean of hours of work per week

	Women			Men		
	Mean hours	Median hours	N	Mean hours	Median hours	N
Family work						
All doctors	22	18	583	9	6	480
Care for dependents	28	24	452	15	12	295
Professional work not including on call						
All doctors	37	37	480	54	52	439
Care for dependents	35	35	351	53	52	251
Total hours of work not including on call						
All doctors	59	55	462	63	60	421
Care for dependents	63	60	351	68	65	251
Total hours of on call						
All doctors	30	14	531	50	18	496
Care for dependents	28	11	392	22	19	287
Total hours of work including family work and on call						
All doctors	89	74	428	113	81	413
Care for dependents	91	75	324	90	86	247

Men who are not caring for family members have the highest workload, working a mean of 113 hours per week. Women caring for dependent children have the second highest workload of all rural doctors. They work an average of 91 hours per week, including family work, professional work and on call. Men with dependent children work 90 hours per week.

The mean for hours worked, excluding family care, for those doctors who are caring for family members is 35 hours for the women and 53 hours for the men. For those doctors who are not caring for family members their mean number of professional hours worked per week is 44 for the women and 54 for the men. These work hours do not include on call. Caring for family members leads to a reduction in clinical working hours of 20% for women, but makes no apparent difference for men.

This is a clear example of women changing practice. Women have complicated lives, with multiple sources of enjoyment and respect, and they are not as easily persuaded as men are to forgo the pleasures of engaging with their family. Unlike men, women decrease clinical hours of work when they have dependent children.

Women seem to be more able than men to set limits to their practice. One of the successful strategies identified by the Delphi Expert Panel was to establish professional and personal boundaries. The details are explored in the section on Strategies below. Setting limits to practice is a radical shift for doctors, a major change in medical practice. Traditionally medicine has been deemed a vocation, in which caring for patients (or climbing the professional ladder or making a very large income) is prioritised over all other aspects of life. Doctors have been, and in many areas of medicine still are, required to give all their energy to the practice of medicine, and to not have competing priorities, if they are to gain access to the high prestige, high income areas of the profession. Rural doctors of both sexes are challenging this, but particularly the women. As suggested in Chapter 7, women are perhaps harder to tame than men, less easily lured by promises of money and status to do the work of two when they are only one.

Medical workforce planning in Australia and similar countries has been caught short by the impact of women's determination to contain their hours of clinical practice. No amount of cajoling and threats has persuaded any but a few of the women in this study to give up their relational life in order to work themselves to exhaustion as doctors. Women want medicine and a life, and increasingly young men are saying they want that too. Medicine may never be the same.

On call

On call is an aspect of general practice that differentiates rural and urban practice, and which is highly problematic for women, most of whom are on call for their families. Rural doctors who are on call get called (Strasser 1992). Like hours of work, on call is complex to define. The definition used in this study excludes time spent in face-to-face clinical work.

Most female rural doctors provide on call cover for their communities, however they provide less call than male doctors. The shortage of rural doctors and the importance of after hours medical cover has led to various innovations, such as triage services, after hours clinics and nurse-led 'first call' practice, to lift the burden from rural doctors. Women in this study identified the strategy of taking time off to compensate for weekends on call for example. Women are saying they cannot provide after hours care unless childcare is provided. This is a change that is being resisted so far, but as more women, without wives at home caring for children and family life, become rural doctors, there will be increasing pressure for systems change in the provision of after hours medical care for rural communities. These changes could provide models of best practice for many other areas of medicine.

Domains of practice

> *It is very apparent and well documented in general practice, but I think it happens in other (specialties as well). I mean the surgeons tell me that there is patterns there too, they say 'oh you're a female surgeon, you will see the women with breast lumps' or the women with ill-defined symptoms who are a little bit uncertain about what's going on and want to spend a bit of time discussing things, whereas not so much the 'right you've got a gallstone you need to have this, this this' and out the door sort of thing. I am sure it happens in a lot of areas of practice. P2.*

In the mid nineteen nineties the changing sex ratio of graduating doctors prompted several researchers to began investigating the way women practice medicine in Australia (Redman, Saltman et al. 1994; AMWAC and AIHW 1996; Britt, Bhasale et al. 1996; Tolhurst, Bell et al. 1997; AMWAC 1998; Britt 2002). A consistent finding since then has been that women practice the core aspects of medicine like their male peers, and yet they have key differences in approach. These key differences are partly a response to patient presentations, and partly a reflection of what constitutes professional satisfaction for women. The differences that have been identified are that women take more time in their consultations, address multiple problems in the one consultation, and deal more with women's health and mental health issues than male doctors. And they listen.

The recent BEACH study identified a number of domains of general practice in which women were more likely to be engaged than men (Britt 2002). Building on this finding, the doctors in my study were asked "Taking into account that these domains overlap, please estimate how much of your practice is made up of mental health, preventative health, women's health, counselling, family violence, men's health, public health and other general practice." This question also sought to gather information on styles and content of practice that are not yet part of the national debate about the value of rural doctors. The national debate has concentrated on the procedural and interventionist skills of doctors, such as obstetrics, surgery, anaesthetics and emergency management (ACRRM 1997) which are more highly valued by representative groups of rural doctors, and of course more highly paid, than are the management of low-interventionist presentations such as counselling and mental health.

Female rural doctors suggest that they are often challenged by their peers as being 'not proper doctors', or 'hobby doctors', because they see fewer patients for longer consultations and work restricted hours, and thus attract less income to the practice (Tolhurst, Bell et al. 1997; Wainer 2001). One reason for this may be that they see a higher proportion of female patients, and women present with complex problems. Evidence from the BEACH study, for example, shows that significantly higher rates of RFEs (Reasons For Encounter) were recorded at encounters with female patients than at encounters with male patients (Britt 2002). The question about domains of general practice was designed to contribute some data to this hotly contested field.

On their own estimation female rural general practitioners spend nearly two thirds of their time providing women's health, mental health, men's health and counselling services to their patients, and male doctors spend half of their time (see Table 14). This is consistent with qualitative research findings and provides quantitative and statistical underpinning to the story women have been telling for some time; that they provide time-consuming and complex interventions in response to the needs of their patients, that this is a form of rural practice that has a low profile in rural medical politics, it is poorly paid, and highly valued by patients.

Table 14 Mean Percentage of clinical time in different domains of practice

Domain of practice	Mean % of clinical time		Mean Difference
	Women	**Men**	
Mental health*	15.6%	12.6%	3.0%
Preventative health	14.3%	15.0%	-0.7%
Women's health*	29.9%	12.7%	17.2%
Counselling*	12.1%	9.6%	2.5%
Family violence	2.5%	2.3%	0.2%
Men's health*	5.0%	11.5%	-6.5%
Public health*	2.8%	4.4%	-1.6%
Other general practice*	18.0%	32.0%	-14.0%
Total	100%	100%	

*difference between women and men significant at $p<0.000$

The difference between the percentage of time spent by women and men in all domains is statistically significant ($p<0.000$) except for Preventative Health and Family Violence.

The data thus confirm anecdotal evidence from women that they are changing rural practice by spending a much higher portion of their consulting time managing women's health consultations than men do. The other differences might be statistically significant, but are trivial in practice. So the domains of practice do vary between male and female doctors in ways that are quantifiable and female doctors are changing medical practice by meeting the previously unexpressed demand for women's health and mental health consultations.

Hospital practice

The hospital-based work of rural general practice is one of the distinguishing features of rural medicine. Rural general practitioners provide the clinical care in many rural hospitals and prior research had suggested that the way women and men relate to this aspect of practice differs in ways that matter (Campbell, Strasser et al. 1996).

My study showed that two thirds (66%, n=383) of women and 85% (n=429) of men provide hospital based care. Forty five percent of women and 41% of men provide general practice services only, and 21% of the women and 44% of the men provide general practice care plus specialist care (see Table 15). There is a statistically significant difference in hospital work between women and men.

Table 15 Clinical privileges at local hospital

	Women		**Men**	
	No.	%	No.	%
GP plus specialisation	122	21%	224	44%
GP services	261	45%	205	41%
No hospital based care	201	34%	74	15%
Missing data	28		10	
Total	612	100%	513	100%

(chi-sq=89, p<0.001, df=2)

Most of the women who do not provide hospital based services do not want to do so, while for others the hospital is too far away. Seventeen women and nine men said they are unable to gain access to the hospital.

The majority of general practitioners of both sexes, two thirds (66%) of women and 85% of men, provide hospital based care, including emergency care, anaesthetics, obstetrics, geriatrics and psychiatry. Men are twice as likely as women to provide most types of hospital care (see Table 15).

Table 16 Risk Ratio of types of hospital care provided by men compared with women

	RR	95% CI
Accident and Emergency	1.96	1.72-2.22
Admit and manage own patients	1.41	1.29-1.54
Aged care/Geriatrics	1.85	1.63-2.08
Anaesthetics	4.58	3.11-6.83
Gynaecology	2.17	1.70-2.79
Hospice care	2.03	1.72-2.41
Obstetrics	2.33	1.81-3.00
Paediatrics	2.03	1.73-2.37
Psychiatry	2.74	2.10-3.56
Rehabilitation	2.19	1.76-2.72
Surgery under general anaesthetic	4.42	2.90-6.82
Surgery under local anaesthetic	2.56	2.09-3.14
Other	1.08	0.73-1.60

The highest relative risk that men are more likely to provide a particular type of care than women is with anaesthetics, and surgery under general anaesthetic, and the lowest risk is for admitting and managing patients, and providing other types of care (see Table 16).

The pattern of involvement in hospital care for male and female doctors is similar to that of their engagement with emergency medicine. More men do more of this work than women. The reason is likely to be a combination of the preference of the doctor and the work practices and culture of the hospitals, combined with differing responsibility for family care.

Women, then, are changing rural practice by establishing a changed relationship with the local hospital. Some women are waiting for the hospital to change its culture, and to provide child-care for the management of after-hours presentations, before they will join the hospital workforce.

Confidence in managing the emergency care that distinguishes rural practice

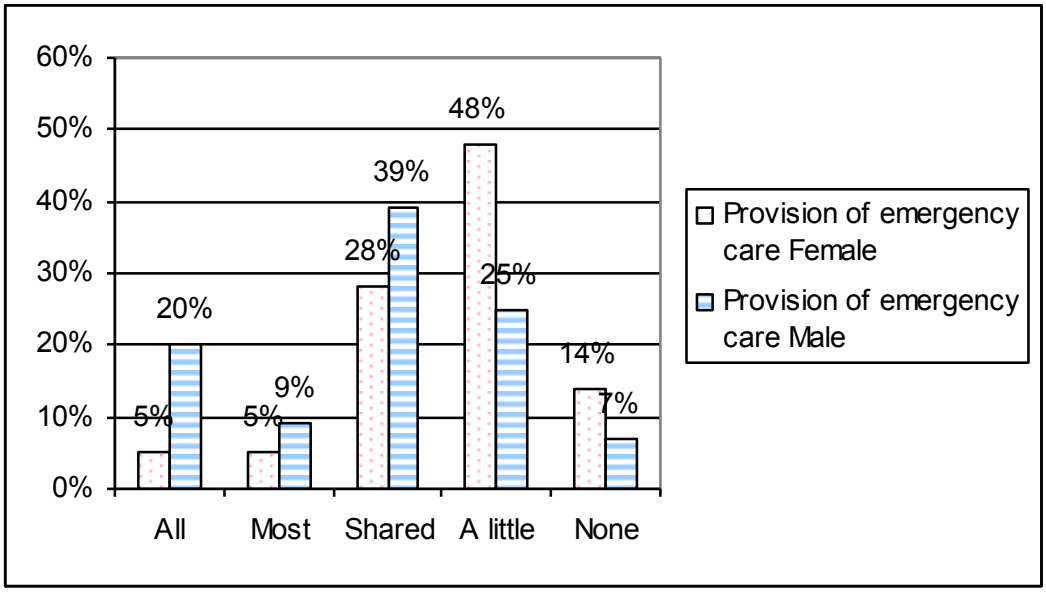
This section concentrates on the doctors' experiences with that aspect of medical care in which immediate treatment by a doctor improves the outcome for the patient. One of the

defining features of rural practice, in addition to providing hospital-based care, is the management of medical emergencies and trauma. The survey asked how much emergency care doctors provide to their communities, how confident they are to carry out a sentinel emergency procedure (intubate an unconscious patient), and whether the sex of the trainer makes any difference to whether they would attend a course in emergency management.

Emergency medical care

Eighty six percent of female doctors and 93% of male doctors provide at least some emergency care, with 38% of women and 69% of men sharing or providing most or all of the emergency care to their communities, see Chart 2.

Chart 2 Provision of emergency care to local community



The difference between the sexes in the provision of emergency care is statistically significant (p=.000) (2 tailed, Pearson coefficient 124.051, df 4).

Five separate types of emergency care were described, covering the range of emergency medical care rural doctors are routinely required to respond to. These are:

- responding to trauma
- dealing with an acute medical or psychiatric illness
- providing initial assessment in a life-threatening situation
- resuscitating a critically ill patient
- stabilising a critically ill patient for transfer

The doctors were asked how many times they had performed each of these tasks over the past year. The timeframe was chosen to allow for meaningful responses by doctors whose main work did not include emergency medicine, but who would be required to manage a medical emergency as part of their role as a rural doctor. The findings are reported in Table 17.

Table 17 Episodes of emergency medical care over the past year

N Valid F 583 M 490 N Missing F 29 M 23	Times attend roadside or trauma in past year		Times attend acute medical or psychiatric in past year		Times assess life threatening situation in past year		Times resuscitated critically ill patient in past year		Times stabilised patient for transfer in past year	
	F	M	F	M	F	M	F	M	F	M
Mean including 0	3.43	8.2	18.01	44.08	3.83	10.92	1.83	4.44	2.45	5.31
Mean excluding 0	11.69	14.83	19.55	47.26	6.08	13.08	4.49	6.27	5.19	7.01

Twenty nine women and 23 men have missing values for all five variables. For those cases with intermittent missing data, where there was data in at least one of the variables, missing values were assigned the value of 0 on the assumption that if doctors had provided this type of care they would both remember and report it, given that for most of them it would be an occasional and challenging experience. This is likely to result in an underestimate of the mean. The mean for those doctors who reported having provided episodes of emergency care are reported in addition to the mean for all women and all men.

Men provide more episodes of emergency care than women, for each type of care, particularly attending acute medical or psychiatric illness. Resuscitating a critically ill patient, and stabilising a patient for transfer are rare events for doctors of both sexes. The difference between women and men in provision of emergency services is statistically significant for each type of emergency care.

Female rural doctors are changing rural practice by being less engaged than male doctors with the provision of emergency medical care and systems will have to adjust to take this into account. There is likely to be more to this than a lower exposure to medical emergencies because of fewer hours of clinical practice, as we shall see.

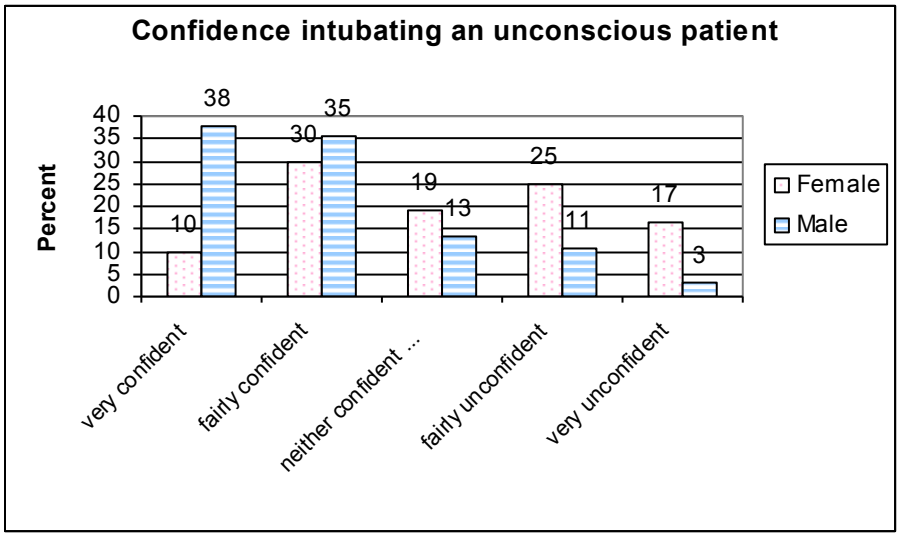
Confidence to intubate unconscious patient

> *I certainly see a lot of men who have fundamentally more confidence in their capacities than women, who often question their capacities and think of themselves as sort of lucky rather than good, whereas I think it is usually the opposite way around for men… So I am sure it is more complicated than that, but I think it is very true. P2*

A question was included in the survey that followed up on a question used by Campbell (Campbell, Strasser et al. 1996) in his survey of rural doctors working in towns with and without hospitals. Campbell found that women were much less confident than men in a sentinel emergency procedure, that of intubating an unconscious patient. This important finding has implications for the type of practice women are likely to undertake. If they do not feel confident to manage medical emergencies, then we can expect them to structure their practice to avoid responsibility for emergency medicine.

The women in this survey were nearly equally divided in their confidence. Forty percent (n = 242) were very or fairly confident, 19% (n = 116) were neither confident nor unconfident, and 41% (n = 251) were either unconfident or very unconfident (see Chart 3). Nearly three quarters of the men (73%, n = 373) were very or fairly confident to intubate an unconscious patient, 13% (n = 68) were neither confident nor unconfident, and 13% (n = 69) were either unconfident or very unconfident.

Chart 3 Confidence in intubating an unconscious patient, by sex



There is a statistically significant difference in confidence to intubate an unconscious patient for women and men (Mann Whitney U test z=-13.40, p=.000).

Whether confidence equates with competence has not been explored in this study, however the sustained attempts to impose masculine culture on women doctors explored in Chapter 5, combined with a long history of extreme misogyny outlined in Chapter 3, are likely to be major factors in undermining the confidence of women doctors. Quadrio has identified that at similar levels of competence 'women consistently rate themselves lower than do their male peers' (Quadrio 2001 p 218). Data from my study suggest that women are responding by reducing their participation in the provision of emergency care, with potentially serious consequences for rural communities.

There is anecdotal evidence that some women are put off training in emergency medicine by the culture of the training environment. Very few women are selected to train as teachers in the emergency medicine training courses such as the Early Management of Severe Trauma (EMST) course run by the Royal Australasian College of Surgeons. I wanted to test whether women would be more attracted to emergency training if it were presented differently, for example, by women trainers. Participants in the survey were asked 'whether you would be more or less likely to attend a short course in emergency management if the trainers were women rather than men".

The great majority of doctors said it made no difference to them, see Table 18.

Table 18 Women more or less likely to attend A and E training with female trainers

	Women	
	Number	**Percent**
Much more likely	41	7%
A little more	85	14%
No difference	480	79%
A little less	0	0%
Much less	1	0%
Missing data	5	
Total N	612	100%

Twenty one percent of women and 3% of men said they would be more likely to attend such a course. There is a statistically significant difference in intention to attend for women and men (Mann Whitney U test z=-9.87, p=.000). This finding provides additional support and incentive to groups such as the Rural Workforce Agency of Victoria (RWAV) and the Australian College of Rural and Remote Medicine (ACRRM) to ensure that such courses are established and made accessible to these doctors. Driven by the expressed need of its members, the Women in Rural Practice committee of ACRRM held its first 'by women for women' professional development weekend in 2002 in the state of Victoria. The weekend was attended by more than thirty female doctors and their families, and included training sessions in emergency medicine provided by female doctors.

It is a particularly important finding that women who are less confident in a specified emergency management skill (intubation) are more likely to prefer an educational programme run by women, see Table 19.

Table 19 Confident and unconfident women likely to attend training by women*

	Unconfident women		Confident women	
	Number	**Percent**	**Number**	**Percent**
Much more likely	20	8%	14	6%
A little more	48	19%	20	8%
No difference	183	73%	206	86%
A little less	0		0	0%
Much less	0		1	0%
Missing data			1	
Total N	251	100%	242	100%

** women for whom it would make no difference have not been included in this table.*

Responding to anecdotal evidence about the culture of emergency medicine training, RWAV worked with fourteen women to develop Flexible Learning and Management of Emergencies (FLAME), a continuing medical education programme in emergency medicine designed for and delivered by female general practitioners, and first implemented in 2003. Female doctors are changing medical practice by identifying their training needs and then implementing innovative programmes to meet those needs.

Women have articulated the issues, leveraged the demand for rural doctors to support their requirement for resources, and used their professional skills to develop an approach to training and practice that is female-specific. In this way they are changing medical practice.

The purpose of medical education and training is to produce confident, competent doctors. All areas of medical education could benefit from acting on the finding that educational models in which women are absent are clearly no longer best practice.

2. Strategies

Women are trained in caring from birth. They understand its demands and its nature, the constancy of it. Perhaps this is why medical women learn quickly to set limits, and avoid taking on superhuman tasks and roles, which intuitively they know cannot be done from a caring perspective (Gilligan and Pollak 1988 p 259). Setting limits is one of the strategies rural medical women identified as contributing to their contentment with life as a rural doctor.

Defined by Delphi Expert Panel

Chapter 2 outlined how the work with the women who comprised the Delphi Expert Panel led to the identification of innovative strategies women were using to make rural practice work for them. These strategies are detailed in Table 20.

Table 20 Innovative strategies for sustainable practice

Strategy	Examples		
Obtain and update professional skills	Prepare for what you want to do – you can't go out half hearted and expect people to accept that you are capable. You have to show them	Prepare for rural practice by upgrading skills eg radiology skills, emergency medicine, which enhance confidence with after hour/on call work	Extra courses in counselling, women's health, family planning
Structure medical practice to work for you	3 days a week & on call 1 weekend in 5. This gives continuity of care for patients, a great sense of ownership of work and some acute care to keep on the ball	Chose a practice that will give flexibility in a) working hours/days, b) responsibility, c) work agreement - no pressure to elevate from assistant to associate or partner.	Practice from home - to accommodate needs of young children ie. after school care, sickness and to allow flexibility of hours
Establish professional an personal boundaries	Take 4 – 6 weeks holiday per year leave the community and spend time as a family	Be really firm about limits of availability – in time and personal space	Develop interest in farming, wine grape growing and make friends in these industries as a diversion from the medicine
Engage with community	Join in local community events/groups eg Rotary, children's soccer, basketball club doctor, local acting group.	Find other families with small children. This helps feel involved & committed	Participate in education including public talks, school talks & Division
Engage with women	Start a book club reading women authors only –the women in the group will make a satisfying social life when first arrive in town	Work to change the rhetoric that 'super doc' is the only valued rural doctor	Bring up gender issues in as many fora as possible
Implement professional strategies	Have your kids in the waiting room a lot – this tells everyone your priorities and helps them understand when you are not available	Accept the significant help offered by Division phone calls, visits from senior members, lots of information	Increase professional supports by attending women in GP activities run by RACGP and becoming involved with Women in Rural Practice Committee of ACRRM
Implement personal strategies	Marry a rural GP	Husband manages all of the domestic affairs and child care	Keeping fit and time out is essential
Gain exposure to rural	GP training time in rural placements	Bush experience for a taste of remote medicine	Train in Rural/ Remote Base Hospital in for first 2 years after graduation, gaining experience in anaesthetics and emergency medicine

A more complete documentation of the ways in which women are implementing innovative strategies in rural practice is reported in the published article in Appendix 2 (Wainer, Bryant et al. 2001).

Strategies in the survey

The survey was designed to generalise the strategies identified by the Expert Panel. The hypothesis being tested was that women had already developed successful and innovative strategies for sustainable rural practice, and that their muted voice in rural medical research had prevented these strategies from surfacing. The survey was designed deliberately to provide a vehicle through which this muted voice might be heard.

A secondary purpose of the study was to identify to what extent men were using the strategies identified by women. The 1997 NRGPS identified a gap between the older and younger doctors (<40> years) that reflected in some ways the gap between the experience and preferences of men compared with women. One prediction from that research was that the younger men would increasingly report experiences and preferences that reflected those identified by women, rather than by older men (Strasser, Kamien et al. 1997; Wonca 2003). If this is the case, then women are changing not only their own medical practice, but that of their younger male colleagues.

The survey worked with the strategies identified by the Expert Panel in two ways. The first question for each of the eight strategies was an overall question, asking whether they had used this strategy, or a similar one, in their practice or their life. The second part of the

question detailed each specific strategy that made up the general strategy, and asked the doctors to indicate whether they had used the specific strategy. The purpose was to be able to identify those strategies that were used most often, and to determine their impact on the dependent variables: satisfaction with rural practice, contentment with life as a rural doctor, and intended length of stay in rural practice. Responses to three of the eight strategies will be reported on in this thesis because they provide data about the way in which women are changing medical practice.

Structure rural practice to reflect they way you want to work

> *Have books for intelligent reading and it's restful and we play nice music and we're friendly and people sit and like, really talk, if they sit around and talk. And all of those things, I think the experience of going to see a doctor is different. I try and make it different. P5*

The first general strategy the doctors were asked about was whether they had been able to "*structure your medical practice to reflect the way you want to work*". Seventy nine percent of the women (n = 477) and 68% of the men (n = 344) said they had been able to do this (see Table 21).

Table 21 Able to structure medical practice to reflect the way you want to work

Strategy	Female		Male	
	N	%	N	%
Structure practice the way you work	477	79%	344	68%
Specific strategy				
1. Flexible work practice	411	67%	250	49%
2. Partner with similar aims	206	34%	220	43%
3. Partner treats you as an equal	274	45%	231	45%
4. Work 5 sessions + on call	204	33%	156	30%
5. Three day weekend after on call	81	13%	100	19%

This table demonstrates that women are more able than men to structure their practice to reflect the way they want to work, and one of the main ways they do this is to choose a practice that provides flexible work environments. These women are directly challenging and subverting established methods of medical practice that require the doctor to fit into existing structures, and instead are requiring the structures to adjust to accommodate their complex and multi-faceted lives. Rural women are able to require this, in a way that surgical trainees, for example, are not, because of the shortage of rural doctors, and particularly of female doctors, who, as we have seen in Chapter 4, are highly valued by their communities.

Establish professional and personal boundaries

> *And I also think that the balance that one can strike… as a strong professional, balancing the knowledge and the independence and the capacity versus the traditional female side of one's nature of being nurturing, being a bit needy, and wanting to be with people and wanting to be a partnership. I … like striking that balance as a woman, although I can't judge what it would be like to strike that balance as a man, but I suspect that we might have a little bit more of an opportunity to find a balance in that and not to have to be a certain way to show the world, so to speak. P2*

Another strategy identified by the Expert Panel was to *establish professional and personal boundaries*. Eighty percent of the women (n = 472) and 72% of the men (n = 361) said they had been able to do this (see Table 22).

Two examples were given of specific strategies doctors have used to implement this. The first was that of 'being really firm about limits of availability in time and personal space'. The text that accompanied this read *'This is vital. I have learnt to become firmer with time and over time. Assertiveness training helps.'* Doctors struggled with this a little. Only 57% (n = 350) of women and 48% (n=244) of men said they had been able to put this into effect. There were many comments that this was difficult to do in a small town, or where there were only one or two doctors.

The second specific strategy is that of having 'balanced work with other goals outside medicine', with the comment that *It helps avoid the god complex.* More women are able to do this (61%).

Table 22 Establish professional and personal boundaries

Strategy	Female		Male	
	N	%	N	%
Establish professional and personal boundaries	472	80%	361	72%
Specific strategy				
1. really firm about limits of availability in time and personal space	350	57%	244	48%
2. balanced work with other goals outside medicine	376	61%	258	50%

Anecdotal and workshop evidence (Wainer, Bryant et al. 1998) suggests that women are better at setting limits to their practice than men are, and this is a crucial strategy for long-term sustainability. An important cultural change that rural women doctors have implemented is that of putting limits to their practice, and establishing clear boundaries between their professional and personal lives. This is hard to do for a rural doctor. The men who preceded them and established the culture of rural practice have left a legacy of the rural doctor always at the service of his community, prepared to die with his boots on – and many of them did – with a wife providing all the invisible family services that support this type of engagement with profession and community. Women found that this cultural

practice does not take into account the complexity of their lives and they needed to do something about that. So first they made their families visible instead of invisible, secondly they put limits to their practice, and thirdly they challenged the definition of what is valued in a rural doctor.

One woman from the survey challenged the cultural belief that medicine is a vocation:

> *I am a person/mother first and foremost. I have always regarded this as an occupation not a life. – rural doctor*

Women pay a price for this strategy, yet they seem determined to implement it against considerable pressure to work longer hours in clinical practice. The Viable models study quantified the reduced income that women receive as a result of this, yet the study of female doctors conducted by the author in Victoria in 2001, and the Access Economics study conducted for the Australian Medical Association, found that very few doctors, men or women, want more hours of clinical work (AccessEconomics 2001; Wainer 2001; Mildenhall and Humphreys 2003). Female doctors exercise great skill and determination in putting limits on their professional practice and quarantining time for family and non-medical activities.

This strategy has the highest marginal effect of all the measured variables on satisfaction with rural practice, which perhaps explains why women are so ingenious and persistent in finding ways to put limits on their practice[48].

Network with female colleagues

The third relevant strategy identified by the Delphi Expert Panel was that of having *networked with female colleagues* as a way of making rural practice work for them. This question was omitted from the survey the male doctors completed. Sixty three percent (n = 374) of the women said they had done this and only 3% did not respond to this question. Five different ways of doing this were listed, see Table 23.

Each of these strategies is used by about a third of the women. Only one specific strategy, that of talking with other women, is used by more than that.

Table 23 Network with female colleagues

Strategy	**Female**	
	N	%
Network with female colleagues	374	61%
Specific strategy		
1. Changed rhetoric re 'superdoc'	179	29%
2. Talked with other women	321	53%
3. Avoided being a victim	159	26%

[48] Marginal effect is derived from the Probit modelling, described in section 3 of this chapter.

Strategy	Female	
4. Learnt to be more assertive	182	30%
5. Operated outside comfort zone	198	32%

Talking with other women involved in similar work is the clear favourite of these techniques. This reflects the consistent request by female rural doctors for networking and mentoring relationships to strengthen their rural practice. The General Practice Partnership Advisory Council (GPPAC) national qualitative study of female rural doctors (Tolhurst and Lippert 2003) found that the most important action that GPPAC could take to support female rural doctors was to establish a national female rural general practitioner network, and made this the first of more than twenty recommendations to the Commonwealth Government[49]. Many rural divisions of general practice arrange dinners and other activities to put their female members in touch with each other. Women are changing rural practice, and providing the evidence to change national health policy in the process.

Challenge rhetoric about valued doctor

Female rural doctors identified that they 'worked to change the rhetoric that 'super doc' is the only valued rural doctor', with the commentary that *we ourselves value the 'superdoc' but we also recognise the cost to the family.* Twenty nine percent of women surveyed (n = 179) had tried this and a number of their comments suggested it was a difficult strategy to maintain.

The doctors identified many innovative ways in which they contribute to their communities by bringing in additional skills, particularly in mental and women's health, and by working with Divisions of General Practice to develop self-care and trauma programmes for doctors, and public health initiatives. There is a sense of quiet pride in these achievements and in the skills and attitudes they bring to rural medicine.

This study has demonstrated that women and men work as hard as each other, but that women distribute their work more evenly between professional tasks and family and community than men do. The expectation that the rural doctor be available at all times no longer fits the incoming rural general practice workforce. Women are requiring that alternative ways to meet community need must be devised, for the wellbeing of both the community and the doctor.

3. Modelling satisfaction and contentment

The rural doctor survey was designed to determine some of the influences on satisfaction with rural practice, and contentment with life as a rural doctor. It was carefully constructed so that influences that affected women and men differently could be identified.

[49] The National Female Rural GP Network Steering Committee has since been established under the auspices of the Australian Rural and Remote Workforce Agency Group, and funded by the Commonwealth Department of Health and Ageing, in part to address this need. Findings from my study are being used by female rural doctors to lobby for continued funding of the Network.

Probit modelling was used test for the marginal effect of variables in the survey on the two dependent variables. LIMDEP was used to estimate the Probit model (LIMDEP 1995)[50].

The model predicts the relationship between the dependent variable and the explanatory variables, in both the direction and the amount of marginal effect.

The two dependent variables are:

- Satisfaction with rural medical practice
- Contentment with life as a rural doctor

The underlying, latent satisfaction and contentment could not be quantified, but the model is able to measure the effect on satisfaction and contentment of the variables in the model.

Female and male populations were run through the same model, but separately, because the original sample frame comprised a stratified random sample of female rural doctors, and a matched sample of male doctors, rather than a random sample of rural doctors. The combined data were used only to test whether non-significance was a result of sample size, after it had been established that the variable had a similar effect for women and men.

Details of construction of the model are in the *Sustainable Rural Practice: successful strategies by male and female rural doctors* report on the CD at the end of this thesis.

In the end the model included the twenty one variables listed in Table 24.

[50] Development of the model was done in conjunction with Mr Alastair Boast, statistician at Monash University. He undertook the work of converting the data to an acceptable format, and ran the LIMDEP programme.

Table 24 Variables in the Probit Model

Variable	Comparative variable/Binary variable
General practitioner	GP Trainee
In a marriage like relationship	Any other arrangement
Years of rural practice	Continuous variable
Hours of work	Continuous variable
Provide hospital-based general practice and specialist services	Do not provide hospital based care
Provide hospital-based general practice only services	Do not provide hospital based care
Provide emergency care (1-3)	Do not provide emergency care (4-5)
Confident to intubate an unconscious patient (1-3)	Unconfident or very unconfident to intubate (4-5)
Formal training prepared you for the type of medicine you now practice (1-3)	Unprepared (4-5)
Structure your medical practice to reflect the way you want to work	Do not structure medical practice to reflect the way you want to work
Implement personal strategies	Do not implement personal strategies
Establish professional and personal boundaries	Do not establish professional and personal boundaries
Gain exposure to rural practice before becoming a rural doctor	Do not gain exposure to rural practice before becoming a rural doctor
Make the community your own	Do not make the community your own
Obtain and updated professional skills	Do not obtain and update professional skills
Think of yourself as a healer as student, as doctor, as student and doctor	Do not think of yourself as a healer
Age less than 40	Age equal to or greater than 40
Have children	Do not have children
RRMA 4	RRMA 1
RRMA 5	RRMA 1
RRMA 6 & 7	RRMA 1

The model demonstrates that there are both significant overlaps and important differences between women and men in the variables that influence satisfaction with rural practice and contentment with life as a rural doctor.

Women and men

Probit modelling has identified those variables in the model that are statistically significantly associated with satisfaction with rural practice and contentment with life as a rural doctor for general practitioners. An important finding is the difference that is apparent between women and men. Only four out of 11 variables related to satisfaction and two out of nine related to contentment are significant for both sexes. Six variables have opposite effects on satisfaction and six variables have opposite effects on contentment for women and men. Two of these are statistically significant and two others almost so.

The variables, **Structure your medical practice to reflect the way you want to work**, **Hours of practice, Provide hospital-based general practice and specialist** services and **Formal training prepared you for the type of medicine now practiced**, are strongly and positively associated with satisfaction with rural practice for both female and male doctors. The variable **Structure your medical practice to reflect the way you want to work** is also strongly and positively associated with contentment with life as a rural doctor for both women and men. **Number of years spent in rural practice** is strongly and negatively associated with contentment for women and men.

Table 25 lists the variables that are statistically significantly associated with satisfaction with rural practice, (p value < 0.1), ordered by their Marginal Effect (M/E) on satisfaction. Table 26 lists the variables associated with contentment.

Table 25 Significant relationship with Satisfaction with Rural Practice

Satisfaction with Rural Practice Statistically significant variables	**Women** **n = 453**		**Men** **n = 400**	
Variable	M/E	p-value	M/E	p-value
Strategies				
Establish professional and personal boundaries	19.05%	0.001		
Implement personal strategies	15.45%	0.030		
Structure your medical practice to reflect the way you want to work	18.95%	0.002	12.81%	0.012
Implement professional strategies			19.72%	0.000
Professional practice				
Number of hours of clinical work	16.96%	0.005	26.95%	0.000
Provide hospital-based general practice and specialist services	10.56%	0.088	12.71%	0.074
Provide hospital-based general practice only services	8.54%	0.073		
Formal training prepared you for type of medicine now practiced	8.09%	0.089	9.47%	0.081
Provide emergency care			9.12%	0.108*
Personal qualities				
Thinks of self as a healer	8.71%	0.044		
Has children	10.57%	0.037		

* nearly significant

The striking finding is the difference between women and men. It was anticipated that there would be an overlap between variables that influence satisfaction with rural practice, and contentment with life as a rural doctor, and there is. However there are also important differences in both the variables and the amount of the impact of variables on contentment with life as a rural doctor, compared with satisfaction.

Table 26 Significant relationship with Contentment with life as a rural doctor

Contentment with life as a rural doctor Statistically Significant Variables	**Women n=453**		**Men n = 400**	
Variable	M/E	p-value	M/E	p-value
Strategies				
Structure your medical practice to reflect the way you want to work	26.04%	0.0000	21.82%	0.0000
Make the community your own			14.89%	0.0173
Implement personal strategies	11.07%	0.0813		
Professional practice				
General practitioner			29.64%	0.0858
Number of years spent in rural practice	-18.72%	0.0819	-19.89%	0.0899
Provide hospital-based general practice only services			10.97%	0.0836
Formal training prepared you for type of medicine now practiced	8.63%	0.0426		
Provide emergency care	-8.41%	0.0650		
Personal qualities				
Thinks of self as a healer	11.44%	0.0030		

*p<0.05 **p<0.01

The standout variable, the one that has maximum marginal effect on contentment and the second highest effect on satisfaction for both sexes, is one of the strategies that was developed through the Delphi work with the Expert Panel of female rural and remote doctors. **Structure your medical practice to reflect the way you want to work** reflects the individualistic character of rural doctors, that 'one size does not fit all', and the importance of changing practice structures to reflect the way doctors want to work, rather than trying to change the doctors to fit into existing structures. This is particularly important for doctors who do not want to work within frameworks established by the older cohort of (mostly) male doctors with full-time wives, extended hours of work and on call availability.

This finding reinforces previous research that has identified flexibility as a key issue for female rural doctors (Tolhurst, Bell et al. 1997; RACGP 2000; McEwin 2001; Wonca 2003). In addition, women with families have a readily recognisable reason for requesting flexibility that is not as obvious for men and men may find themselves less likely to be

able to structure their practice to reflect the way they want to work because of the universal expectation that existing work structures suit them, and this may be reflected in the lower marginal effect on satisfaction the strategy has for men.

Providing **hospital-based care** contributes to satisfaction and contentment for women and men. Doctors of both sexes are more satisfied when they are able to provide specialist-type services as well as general practice care. Women also experience a significant increase in satisfaction with rural practice when they provide general practice only hospital- based care and this contributes significantly to contentment for men.

Having undertaken **Formal training that prepared you for the type of medicine now practised** has a positive and significant marginal effect on satisfaction for women and men. It also had a positive and significant effect on contentment for women, but not for men.

Women

Two of the strategies developed by the Delphi Expert Panel contribute significantly to satisfaction and contentment for women but not for men. The strategy with the highest marginal effect on satisfaction is that of **Establish professional and personal boundaries.** It has a positive but not significant effect on contentment for women and men, and satisfaction for men. It is statistically significant in the combined data, suggesting that the lack of significance is a factor reflecting sample size rather than lack of impact. This strategy is likely to be a reflection of the capacity women have to put limits on their hours of practice.

Establishing professional and personal boundaries is the solution female rural doctors have developed to the most pressing of their dilemmas, how to be a doctor to their community while providing most of the family care, and also perhaps how to manage the question of privacy in a working environment where the doctor is highly visible to their community. It reflects one of the core differences between the experience of rural practice for women and men, that women use their authority to set boundaries around their professional practice, and men do not seem able to do this, or are not attracted to it as a way of increasing satisfaction.

The personal quality of **Thinks of self as healer** is positively and significantly associated with satisfaction and contentment for women. It is positively associated with both for men too, but not significantly. Thinking of yourself as a healer is significantly associated with satisfaction and contentment in the combined data, suggesting that the lack of significance for the men is a result of small sample size. **Having dependent children** is the last of the variables that is significant for women only, and only for satisfaction. Having dependent children has a negative impact on men's satisfaction. Children make a positive, but not significant, contribution to contentment for both women and men, but this is not significant even in the combined data. It is possible that women with dependent children are able to insist on flexible and limited practice in a way that increases their satisfaction with practice, and that this is not available to men. Men may experience the stress of the dual role of parent and doctor, without the sanctioned opportunity to limit hours and availability to enable them to carry out both roles without conflict.

Women and men differently

The provision of emergency care increases satisfaction for men and decreases it for women, and is not quite statistically significant. It significantly and negatively affects contentment for women and positively but not significantly affects contentment for men (see Table 27). The contradictory impact on satisfaction and contentment for women and men of providing emergency care is likely to be a reflection of the intrusive and chaotic impact that the provision of emergency care has on family life. Women are less likely than men to have the family backup that allows them to step out of their family at a moment's notice, which is incompatible with provision of emergency care unless carefully designed support systems are in place.

Table 27 Variables with opposite effect on Contentment for women and men

Variable	Coefficient		p-value		Marginal Effect	
	Women	Men	Women	Men	Women	Men
In a marriage like relationship	0.10465	-0.10654	0.6154	0.7057	2.73%	-2.96%
Provide emergency care	-0.32169	0.25899	0.0650 *	0.1831	-8.41%	7.75%
Confidence to intubate	-0.03686	0.04308	0.8197	0.8544	-0.93%	1.26%
Obtain professional skills	0.27525	-0.01163	0.2845	0.9620	7.68%	-0.33%
Make the community your own	-0.02525	0.46370	0.8950	0.0173 **	-0.63%	14.89%
RRMA 6 & 7	-0.22511	0.42784	0.3430	0.3158	-6.13%	10.44%

* p< 0.10 ** p< 0.05

There is a high underlying level of satisfaction with rural practice and contentment with life as a rural doctor among general practitioners. However satisfaction and contentment are based on different factors for female and male doctors. As hypothesised at the beginning of this research, women have already implemented strategies that contribute significantly to satisfaction with rural practice, and are changing rural medical practice by doing so.

4. Changing practice

Women just have to do it the best they can. A lot of people do job share during the year they are having their baby. Its becoming more and more acceptable, we were the first to do it, back then, 1997 I think. It was very difficult for our training consultants to do it at the time, but its becoming much more acceptable, well they are getting used to it I guess. So to have their babies, I mean we are talking about women who start their training program at the age of 25 or 26, it is a 6 year training program so as they get towards the end of it, you're

talking 30. Its time for them to have their babies. So they job share or they do a research year. P3.

The future trend will be for an increasing proportion of female rural doctors and they will require professional and practice structures that allow them to be women as well as doctors. The Expert Panel and the doctors who took part in the survey have identified flexible practice structures as the place to start. They have implemented flexible hours, changed waiting rooms and patient information practices, structured communication with practice staff, established co-operative working arrangements with male colleagues, shared on-call and time off after being on call, set limits, built in time for paperwork, accepted help from Divisions and colleagues, worked in salaried positions, scheduled appointments to leave time for emergencies, and found supportive professional and life partners. These women are transforming rural practice. And it is not only rural practice.

Interviews – do men and women practice differently

I don't know. I am sure they do but if you're asking me to characterise the differences, I don't know how I'd talk about it. To me it's getting so close to what I am calling the difference paradox or the essentialism problem, the problem of essentialism, that generalisations about gender are both necessary and problematic. P8

Quadrio concluded from her study that 'gender was a significant factor in distinguishing between the practices of women and men psychiatrists' (Quadrio 2001 p 121). In pursuit of further evidence about the way women and medicine interact and the impact this might have on the profession and on patients I asked doctors who took part in the interviews whether they thought that women and men practised differently. Some struggled with the essentialism behind the question – the idea that men or women are in some way homogeneous groups or share common and distinguishing experiences – and most agreed that they did. This is what they said:

Q: Do you think men and women practice differently ?

There is no doubt in my mind that I have seen that men practice medicine in a more business-like sort of way, and whether that is from a natural tendency to be like that, whether a lot of it is socialised into because of those sort of male responsibilities, the breadwinner sort of responsibilities if you like. So I think that men practice medicine in a more business like sort of way and I think that women are much more likely to be less business proficient because they allow the interpersonal things to come to the fore and be a part of their medical practice rather than a more cool appraisal of what needs to be done and you get on and do it and move to the next thing. P2

Well males are more task oriented and they want to go and do a procedure. P3

Yes, yeah. In the way they approach the patient. Again its mostly because I've worked with surgeons and male obstetricians, even the good male obstetricians seem to be a little bit more' telling people what to do' rather than asking or rather than working out what options there are and giving options to the patient; or paternalistic. P4

Yeah, I think women are usually more holistic. They … are willing to address in a meaningful way other issues than what people present with. I think a lot of men are very concrete and they're just like really happy just to you know 'this is the presenting complaint and this is what we're going to do' and they also seem to be quite critical of people's… humanity or their foibles or something. P5

Yes I do. Partly because men and women are in different areas of the profession, so that's just a structural thing. But also within the different areas of within surgery for example, if you look at my area, there are some women who practice surgery in the same way as the men, but they are to some extent, although they are seen as being the standard female model of a surgeon, being a pseudo man, they're still viewed differently to men and they're not seen as really performing a female role, and that there's a dual role there that people recognise. That the only surgeons that I know who work quote, unquote,' part time', 40 hours a week surgery or the like or who take their family commitment seriously in terms of actually devoting blocks of time that could be otherwise devoted to other professional activities or who allow their personal life to impact upon their professional activities such as my female surgical boss who cancelled a list because her daughter had been unwell over night. The only people I know who do that are women. I've only worked with one female boss, so I can't comment on general patterns. That in itself I guess is worth commenting on. P6

I certainly believe the evidence that if you ask young women about their intent as doctors, how do you think they might differ, then I believe that women might articulate that they would spend more time with patients because that, to women, is more important as far as their identity as doctors than for men it is. P8

Yes. I don't think a lot of men are comfortable with their emotion. So consequently they cannot hear beyond the words. Not because they can't hear, but because to go beyond it sets up a level of discomfort. I think women tend to give more time. I think women tend to listen. I think women tend to hold a space better for people to speak into. P9

If these women, with life times of practice and reflection between them, are right, then women not only will, but are transforming medical practice. In Chapter 9 I will explore what a gift this is to both patients and the profession.

This chapter has focussed on the experience of rural doctors. Doctors go into rural practice for a variety of reasons, yet it is highly likely that they are an adventurous and self-managing group of the profession, with little liking for formal hierarchies and rigid work environments. The extended generalist nature of rural practice, the professional isolation and the relative paucity of back-up and support make rural practice appropriate for doctors who are independent and confident of their skills. It is a key finding of this research that the ability to practice medicine in a way that reflects the doctor's practice style, in a flexible environment based on common aims and mutual respect, is critical to keeping rural doctors happy. This applies to women and men alike. The key to this is flexibility, common purpose and mutual respect among professional colleagues, which sounds like best practice to me.

Flexible practice structures that allow female rural doctors to be women as well as doctors are being implemented by women. The shortage of rural doctors gives them leverage to require that their complex lives be taken into account when structuring rural practice and they resist considerable pressure to overwork and to be constantly on call. Women are leading the way in implementing flexible practice models, and changing rural practice as they go; they are changing the very frame in which doctors work, and perhaps healing the profession as they do so.

Section 4
WOMEN AS HEALERS

Chapeau 4

Women, of course, have always been healers, creating the conditions in daily life where bodies, minds and souls can be sufficiently healthy and resilient to heal themselves. They are the original anatomists, obstetricians, pharmacologists and chemists. Working in the fields, the kitchen and the bedroom women have always had responsibility for the bodies of those around them. For feeding them, bathing them, clothing them, comforting, binding wounds, soothing hurts, cooling fevers. All around the world and throughout time women have planted, harvested, prepared and cooked the food that provides the fundamental building blocks of a healthy life. Alchemy in the kitchen. They spin and weave the cloth that keeps bodies warm, safe. They create the crafts that adorn bodies in display and enjoyment and sexual attraction. They light and tend the fires that makes the hearth a welcoming place, they cuddle and soothe the fretful infant, bathe and tend their wounded menfolk and layout the bodies of the dying.

Throughout the world and throughout history women also attend to women's business. They teach their daughters about sex and family life, about menarche and contraception. They do the abortions, as well as the rituals for encouraging conception. They attend the births and deliver mother while welcoming the new soul into the world. They swap information about relieving menstrual cramps, enhancing their libido and using it for their own joy, experiences of pregnancy and childbirth, about engaging with the demanding task of menopause. Women share information about men, their own men, their sons and husbands and partners and how to be in relationship. Mothers instruct their daughters on the skills necessary to run a household, attract a mate, care for baby and infant. Women care for the emotional lives of their families and friends and in so doing create healing environments for those they love and cherish.

In our society today generations of women come together at special times recognised and sanctioned by society, and at other times that are marked within their families or among friends. Grandmother, mother and daughter/son will gather in the kitchen to transfer the skills of knowing, recognising and transforming ingredients into food, creating festive delights for palate and soul. Grandmother may bring her special cooking pans and cake tins and conspire with her grandchildren. In this and many other ways women enact nurturing rituals that hold together community, family and friendships. They establish the preconditions for health and healing.

Many women know how to call in the spirits of the grandmothers and grandfathers for guidance and protection; know of rituals that nourish the earth and ensure her plenty; know how to work with the elements; how to address the gods. The goddess for these women is Hygeia, the god of healing.

Women then, are and always have been the deliverers of most of the care that underpins health. They provide the healing environment that supports bodies and souls and psyches to heal themselves. Doctors and scientists know at some level that bodies heal themselves, even if they focus on interventions and activity that make the doctor the central player.

Medical students are taught in pathology, for example, how a cut or burn will heal itself. But if the feminine is 'being' rather than doing, then healing takes on an additional aspect. The power of presence, of attending to, of listening as well as acting, of empathy and compassion, of the gender of the doctor as a therapeutic tool.

The following chapter explores the ways in which women say they heal. It identifies how women work to heal their patients, to gain healing for themselves from their encounters with patients, how they use their embodied female experiences as therapeutic tools, and how this gendered approach is contributing to healing the profession of medicine.

9

Healing is my Trade

healing is my trade – rural doctor

'We cannot be comfortable with the mechanical metaphor which dominates medicine, or with the mind/body dualism derived from it… the value we place on relationships influences our valuation of knowledge. Those who value relationships tend to know the world by experience rather than what Charles Taylor calls 'instrumental' and 'disengaged' reason. Experience engages our feelings as well as our intellect. The emotions play a very significant part in general practice, and .. are seriously neglected in medicine as a whole." McWhinny 1996

'Thinking from women's lives provides the crucial resources for the reinvention of sciences for the many to replace sciences that are often only for the elite few' (Harding 1991 p 312).

medicine does privilege the logical things that you can measure over the things that you feel, but I think we are going to find with time that the feelings are very important in how disease expresses and who gets sick and why they get that particular sickness, which conventional medicine has no room for. P1

The healing power is the love, the intensity of your listening, the joy in hearing the stories and seeing people change with encouragement. Nothing magic, just the passion and the warmth we contribute when we share ourselves generously as human beings. – rural doctor

I think it is about connecting very honestly with people - not playing the doctor persona - working with your own emotional response to them and giving to them of your love - your love for them just as they are and giving them hope that whatever is happening in their body and life they can find a new path through that. This is the emotional substrate on which I place my scientific, rational knowledge and methodology. – rural doctor

This chapter builds on the findings detailed in Chapters 4 - 8 to examine the question, how do women, healing and medicine come together, and consider whether women might be healing medicine from some of its excesses, such as those described by McWhinney:

> By living in a world of abstractions and neglecting our own emotional development we have erected an invisible barrier between ourselves and our patients. We protect ourselves by growing a hard shell which makes openness difficult, and our patients interpret this as cold indifference or rejection. (McWhinney 1996)

Data were collected from the survey and the interviews to explore whether women doctors think of themselves as healers and if so how they integrate this into their medical practice. Participants in the survey were asked to write a paragraph that commented on their work as a healer. Women who took part in the interviews were also questioned about whether they think of themselves as a healer. This provides both quantitative and qualitative data to shed light on the suggestion made by Carol Gilligan, that women may be contributing to healing the medical profession of its loss of humanity. Gilligan speculates that 'women physicians may help to heal the breach in medicine between patient care and scientific success.' (Gilligan and Pollak 1988 p 262).

Keller and Longino argue that the Cartesian method, which we have seen in Chapter 2 underpins modern science and scientific medicine, requires splitting the body from the 'real self'. This 'real self' was described by Descartes as a 'non-material substance, different in kind from the material world'. They quote Scheman's argument that,' in our actual circumstances of social inequality, that which was so rejected, namely the body, is reattached to the persons of all those excluded from social privilege – namely, women, members of ethnic and racial minorities, working class, sexual minorities, all of whom are identified almost exclusively with bodily traits or bodily functions. They argue that reintegration of mind and body would require new conceptions of subjectivity, which, in turn, would enable new epistemic relationships.' (Keller and Longino 1996 p 10). Doctors, of course, both work with and have bodies, although their embodiment is strongly suppressed during their intern and post-graduate training, where ordinary bodily functions such as fatigue, hunger, thirst, fear, despair and joy are required to be ignored or overridden.

Doctors are among the socially privileged and if Keller and Longino's argument is correct, will avoid being 'reattached' to the body of those excluded from such privilege. This may be one of the reasons why doctors having babies is such a critical incident. Pregnant and lactating women are demonstrably embodied, undeniably feminine and 'other', no longer Athena women, safely hidden in the intellect. This problematic relationship with the body is being dealt with by female doctors in innovative and empathic ways. Rural doctors and those taking part in the survey have documented how they use their embodied experiences to enhance their authority and usefulness to patients, thus helping to heal the mind/body split that underlies some of the coldness of medical practice.

Scott maintains that the body, as a symbol, can speak in a very precise way regarding the problem to be solved (she is talking about illness but this could be metaphor for 'what ails the profession'). She says the body

> can thus provide the necessary preconditions for the generation of a more accurate knowledge within standpoint epistemology… recent feminist discussions on the epistemology of care have .. (pointed) out that in attending to the bodily and social needs of others, women often become sensitive to the rich particularity of individual experience, and thus develop a distinctive and powerful epistemological approach. In attending to the body, a sensitivity to the knowledge of the body may be developed. (Scott 1997 p 116)

Family physician Ian McWhinney credits family practice with early identification of the importance of knowing through the body, and the 'body-mind'. He identifies how the Descartian thinking of the 'body as machine' is being replaced with the metaphor of the 'embodied mind' on the understanding that:

> The immanent mind knows the world through bodily feelings. The separation of thinking from feeling, and the relegation of emotion to a limited role, is being rendered untenable by cognitive science.' (McWhinney 1996 p 435).

So what is to be healed ? Quadrio identifies in her study of women in Australian psychiatry that

> An ethos of hyper masculinity prevails within psychiatry and poses significant systemic problems. A process of dehumanisation is set in train from as early as undergraduate days and damages the relational self of the trainee, impairing empathy and predisposing to impairment, depression and perhaps even suicide. It detracts from the professional development of all trainees but its effects are registered more clearly by women. It privileges an aggressive, competitive mode and a lack of tolerance for other viewpoints. These are hardly desirable attributes for a psychiatrist.' (Quadrio 2001 p 249).

Or, I would argue, for any doctor. Women in such an environment may act as 'canaries down the mine', responding earlier than men to toxic environments. The women in my study are taking action to heal this damage to their relational self by using their female embodied experiences as sources of clinical knowledge and practice, and insisting on the inclusion of their families as part of their identity as doctor (see Chapters 5, 8 and 9). Many are also working with a very human notion of healer that they have kept private and protected from the worst ravages of the medical culture. As Quadrio expresses it 'whatever special expertise she (the female psychiatrist) brings to these issues is as much a reflection of her experience as a woman as it is related to formal training.' (Quadrio 2001 p 294).

Professor Elizabeth Hultcrantz, Ear Nose and Throat surgeon from Sweden, agrees. She has written about the value of doctors including their own knowledge and experience, as well as science, in developing an approach to healing that includes caring, touch and warmth, and the importance of physical touch, the embodied healer, in a healing context. Hultcrantz details how hospital care, in particular has become divorced from comfort and care and ponders hypothetically whether in hospitals today 'is it the doctor who prescribes pills for the symptoms or the nursing aide who bathes the patient who is most important in the healing process ?' (Hultcrantz 2001 p 30). After describing the science and physiology of stress and the effect of touch she ended 'in all situations there is a very physical basis and meaning in that we 'always give comfort in order to heal.' (Hultcrantz 2001 p 32). In this she paraphrases the old medical dictum of 'cure rarely, heal sometimes, comfort always'.

McWhinney draws attention to a similar awareness of the work of healing. He says 'If we are to be healers as well as technicians, we have at some point to set aside our maps and walk hand-in-hand with our patients' (McWhinney 1996).

Not all the doctors in my study describe themselves as healers, but a majority do, both in the survey and the interviews. Some shy away from the term, fearing past associations with magic, the irrational and perhaps unknowingly, the witch burnings[51], using intellectualisation, the Athena mask, as a defense against feelings because of their fear of being labelled as 'histrionic'. However a substantial majority of women (and men) claim the role. There is a conflict between the dispassionate observer (scientist) and the empathic practitioner who uses herself as a therapeutic tool. The doctors in this study experience this conflict, however most of them overcome it in part through their private interactions with their patients, interactions in which they use their relational, embodied selves to do the work of healing.

Asked whether at any time when they became a medical student, or subsequently, did they think of themselves as a healer, two doctors interviewed responded with an emphatic yes*:*

> *All the time (laughter) and particularly recently. I have always been fascinated with women's healing stories and recently that sense of feminine healing as being very very different to male healing and a long tradition of it, and a sense that that I have known that for a long time. I just chose not to recognise it. P1*

> *Well that's what I do everyday with my patients, that's my work …I don't just work with their vulvas and uteruses. The first thing that comes into my room is a whole person, and you find out about what's going on with them first because that's what its all about. P3*

Many rural doctors were equally emphatic that healing was the purpose of their profession: *If I didn't feel medicine gave me a gift to facilitate healing, there would be no reason to practice medicine – rural doctor.* The survey provides quantitative data to make more concrete the possibilities uncovered in the qualitative data. The relationship of rural doctors to healing practice is considered from three perspectives: how many identify this as part of their identity, how many of them practice from this perspective, and examples they gave about practices of healing.

1. Healing in practice

One of the strikingly consistent stories about women and men as doctors is that women take a longer time with consultations, talk with their patients, and struggle to fit this consultation style into the prevailing activity-based fee structure. This struggle is likely to be reflected in their satisfaction with professional practice, and one way to explore it was to ask the rural doctors who took part in the survey about a possible motive for the way they practice.

The doctors were asked whether 'at the time you became a medical student, or at any time after, did you think of yourself as a healer?' Forty of the women and 12 of the men did not answer the question. A majority of women and men said they thought of themselves as healers (see Table 28). The next question asked if they practiced from that perspective and a majority of both sexes use this approach in their work at least sometimes.

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[51] *I do not like this word "healer". To me it implies alternative medicine treatment / magic / religion* – rural doctor

Table 28 Thinking and working as a healer

	Women		Men	
	N	%	N	%
Think of self as a healer				
As a medical student	85	15%	83	17%
As a doctor	210	37%	159	32%
As a student and doctor	47	8%	36	7%
Not at all	230	40%	223	44%
Missing data	40		12	
Total	612	100%	513	100%
What happened to that gift?				
Work with it regularly	194	57%	163	59%
Call on it sometimes	110	32%	87	31%
Too busy to work that way	14	4%	15	5%
I have lost it	7	2%	6	2%
Other	17	5%	8	3%
Missing data	270		279	
Total	612	100%	513	100%

There is no statistically significant difference between women and men in the way they work with this aspect of their profession.

Chapter 7 defined how the Probit model for the dependent variable Contentment with life as a rural doctor identified **Thinking of yourself as a healer** as significant at the 1% level for women, and that women who think like this are 11% more likely to be contented than women who do not.

This could be an explanatory factor in the struggle and determination of doctors to practice in a way that reflects their belief in who they are and why they became doctors, despite working environments that often militate against that. High workloads, short consultation times, little respite and financial imperatives could be factors that conflict with working as a healer. On the other hand, rural practice, with its continuity of care, located in the context of the community, could be supportive of practising as a healer.

Female rural doctors describe many instances where they use their authority to take care of the marginalised, the dispossessed and the vulnerable, people who would not otherwise have an advocate. They take care of young women, vulnerable women, girls who have been traumatised, of aboriginal and migrant women. One of the doctors interviewed described how she thinks *women do things that seem unnatural and for some men the most unnatural thing in the world might be caring for someone that's too lower class for them to relate to. P8.* The doctors in this study are on the side of the women and in taking that role can change the balance of power in a rural town. Rural doctors say the interaction is usually expressed by patients as *very prepared to listen to concerns of women in non judgmental way and discuss from woman's point of view. There is often the comment "the*

men just think I'm stupid or mad". – rural doctor. In this way female rural doctors are helping heal their communities by attending to wounds, and the wounded, who might not be recognised as needing care by their male colleagues.

The doctors had no difficulty expressing how they practiced as healers and in turn are healed by that interaction, a healing that allows them to contribute to healing the profession. The elements of healing practice they described can be grouped into four: the doctor as healing agent, healing patients and patients healing themselves, healing the doctor, and healing the profession.

2. Elements of healing practice

The doctor as the drug

McWhinney acknowledges the power of the therapeutic tool of 'ourselves in the healing relationship – the drug 'doctor'', relating the healing power of the doctor-patient relationship, enacted through symbolic acts and rituals, to the placebo effect (McWhinney 1996).

The rural doctors also identified the power of the *'Doctor as a drug'. Very often I realise that it is 'me' patients appreciate and not my knowledge, or decisions or drugs dispensed.* The doctor/patient relationship is the key to this, the 'being present' that one of the doctors interviewed says is a defining feature of the feminine. Another rural doctor acknowledged that *Often people just need a dose of "Dr",* drawing on the humanity and embodied experience of the doctor, so that *one's mere presence can work miracles*.

> *I don't know that I "work with it" - I just am one. The gift is there to use or be used when things go beyond ordinary medicine. I think that, like God, it is best left un-named. – rural doctor*

There are many ways in which the doctor can be the drug, the un-named element in the healing encounter. These were identified by the doctors in this study to include being present, listening, laying on of hands, intuition, compassion, acceptance and wholistic practice.

Guide to healing

Doctors told of the practical things they do that contribute to healing. The theme that comes through most strongly is the 'being present' and listening. Listening, it seems, is a gendered activity. Women do it, men either do not listen, or listen differently. As mentioned above, listening is one of the core difficulties women have with activity-based funding because listening does not count as activity. The following is a sample of the things female rural doctors do to heal their patients:

First you have to really want to help someone; see the patient as a combination of body, mind and soul and attend all 3 areas; listening/reflecting/encouragement and support; asking the right questions, counselling support and providing strategies; humour; impart knowledge, wisdom and empowerment; teach them about how the mind operates, what's normal or realistic about being an authentic respectful human being; relieving pain and suffering, often psychological in origin as much as physical; helping a person to an

acceptance of their situation, letting go of blame and being willing to look for a way forward; carer, touch, empathy, confidence.

This rural doctor 'guide to healing' was expanded by other doctors who provided extra detail about how this works in practice.

Listening/being present

One of the challenges of listening and being present is that people's feelings about their illnesses are often spoken, and I have mentioned above that feelings provoke anxiety in many doctors. Some doctors are able to manage this anxiety and work as healers to *listen actively so that they (patients) feel understood and feel better in themselves*. Being present, being a good listener, and *some medical / diagnostic acumen helps!* Listening intently to the verbal and non verbal content can heal, as patients have a chance to make sense of the pain in their lives by telling their story to a doctor who uses her authority and knowledge to encourage, validate, challenge, affirm, reassure and value the patient, to draw out from them a belief that they can overcome; this is healing.

> *As a female GP, I spend an awful amount of time, just listening, and people disclose very personal information, often distressing and often haven't discussed it with anyone before. I don't necessarily give advice or counselling, but I think the fact that they have shared this information, or have recognised it as the cause of other problems in life, is the start of a healing process. Nothing marginal or alternative about that. – rural doctor*

> *For me, the difference between the feminine and the masculine is that the feminine actually is the "being" and things flow because of the being, and then you translate that into action, and that's the masculine. That's why it has to be balanced in an individual because if you are just "are", things do happen and things do come but sometimes you need the action to actually propel it along. But if you just "do" and don't have time to actually "be" there's no time for things to flow and ideas, and for you to actually connect. P9*

McWhinney also describes the power of attentive listening in a therapeutic context. He says 'To listen to a person with total, undivided attention is one of the greatest gifts we can bestow' (McWhinney 1996).

The women in the interviews as well as the rural doctors know this and describe how making space to listen is part of the healing process, whether general practitioner or surgeon, and the challenging nature of the intimate stories that are told. Part of the role of a healer, it seems, is to be able to encounter life's great challenges, allow them into the light of day, add the mixture of wisdom and skill the lies within the doctor's experience, and hand them back to the patient, to whom they belong.

Laying on of hands

A unique attribute of the doctor-as-healer is the socially and legally sanctioned authority to touch, the laying on of hands to heal. As mentioned above Hultcrantz has established the physiology of the relief of the therapeutic touch, and doctors in this study understand this too. It even takes them by surprise. They say that the use of *touch and body language can be powerfully therapeutic; laying on of hands; a physical examination, a touch on the arm, a gentle hug or pat; sympathetic gentle touch can surprise by the power of personal contact.*

Doctors, then, can and do use their bodies to heal, not just by the actions they take, but by their attentive presence. They also use a sixth sense.

Sixth sense

Women in both the survey and the interviews nervously described working with intuition. They know it is taboo in medicine to speak so unscientifically but they cannot ignore their own experience. There is almost a sense of women communicating with a woman (me) about this, that it is not discussed publicly but because the question was asked and anonymity guaranteed, it was safe to claim it, and perhaps even a relief to be able to say so. And it does seem to be gendered, only three male doctors used the word 'intuition'. One of them said *It is something I speak of only to my wife.*

> *I think it is something that female practitioners do differently and in lots of cases it is almost ah, dare I say it, intuition that there is something more underneath and although I try not to be too intrusive with ferreting out the information I do try and make what I call a space that if they want to share it that it is there. And certainly in recent years I have been far more successful at that… (and) more and more patients have been able to talk to me about that. P1*

The rural doctors spoke of having a 'sixth sense' or a 'secret sense' that *comes when it comes* and *I can't imagine working without it*. The confidence to use this sixth sense seems to develop with age; doctors speak about having it when younger, but lacking the confidence to rely on it.

Compassion

Women doctors spoke about healing through compassion, opening their hearts to their patients, working with empathy, really caring, and having *an ongoing deep interest in the lives of your patients* and for some this enhances job satisfaction as well as the patient's well-being.

Acceptance

Part of compassion is accepting the patients as they are. In an earlier chapter I quoted the surgical trainee saying that male surgeons seemed quick to pass judgement on their patients and that she did not want to be like that. Another doctor said in her interview that female doctors may respect their female patients more so that the patients *haven't been hit by any assumptions, they haven't been closed down, they haven't been silenced. And they've been respected and reinforced as the individual with some sort of authority over their own decision making in their life. P5* Accepting people for who they are is part of the healing repertoire used by female doctors.

Wholistic practice

There seems to be fairly general agreement that healing involves working with the whole person, not just the illness, *Helping people towards healing emotionally, spiritually, perception and attitudes as well as diseases.* Doctors draw on their life's experience as well as medicine and scientific knowledge to do this

> *I have never found it necessary to try the quick fix. I believe that people get sick for important psychological/emotional /social/spiritual reasons, and that if they are willing and you both have the time, that it is possible to understand and heal the*

> *condition (not necessarily cure- though sometimes it happens!) not only does it improve people by making them more aware of how they tick, but to believe helps to prevent recurrence, or further illness. – rural doctor*

Skill/knowledge

The doctors acknowledge that healing takes skill, knowledge, time and confidence. They claim their knowledge and take pleasure in passing it on. For example the surgeon said she *had the experience of feeling like I was healing with surgery. P8* These skills may lie within the traditional medical model or outside it. Sometimes it takes the courage to *ask for inspiration, but often it does come* – rural doctor.

3. Healing patients

Again and again the doctors in this study were able to recount clinical episodes where their intervention helped the patient to heal. Many of these related to caring for vulnerable women, where the doctors used their femaleness as a therapeutic tool. They tell of patients bringing them gifts, thanking them, and how *People often feel better from being listened to and comment that they feel better "just for talking to me"* or say *"I feel better already doc!"* or *"It was great being able to talk to you!" I feel I have helped these people heal some of their suffering.*

A major theme of responses to questions about healing is that the doctor is the knowledgeable facilitator, helping patients to find the healing within themselves.

Patients heal themselves

> *the essence of healing is that it's an individual's own path and everyone around them, whoever comes into their life, are just facilitators. They are just a part in the individual's journey. You know that old thing about 'for a reason, for a season, for a lifetime, the people we encounter'… when I was working and would have patients come, what happened was, over the last few years certainly, I just sit, I would hold the space for them to speak, they would speak whatever they spoke, and I would speak back… saying "hey, this is something I can feel in you. What's going on?"… we empower a patient to heal. And what we do in western medicine is we take away that power and say that "this belongs to us, you come to us and we will provide the solution". For women, that's a much, much much greater thing of disempowerment that happens. P9*

The rural doctors describe how they work to empower people to find their own healing by supporting them through *a natural healing process*. They do this by showing people the healing qualities within themselves, providing advice, support and medication based on their skills and experience. This approach is not well supported by the Medicare financing system and often doctors do this to their financial disadvantage. One doctor ruefully acknowledges this with her comment:

> *I wish I could do it more. Holistic medicine is far more healing than just modernistic medicine. To help the sick and sad patient find their own strength in themselves is more curative in many ways. – rural doctor*

When they are able to work this way the doctors describe the pleasure and professional pride it brings them.

4. Healing the doctor

Some of the doctors wrote or told me that being able to work in a healing way, to be on the side of the patient and be themselves fully in that, helps heal their relationship with medicine. The surgical registrar has not lost sight of why she became a doctor, describing how *I really do love my contact with patients, that's a huge part of it all. I really enjoy taking care of them. P6.* This connection with the patient is a major source of strength, particularly for doctors who find their practice style and values marginalised by medical culture. A doctor describes how important this is to her *My greatest joy is long term contact with "my" babies - several of whom are now mothers themselves or (in) medical school!! – rural doctor.* Rural practice is well suited to long-term connection with patients, even for multi-generational contact, so that doctors are able to observe the effects of their interventions and relationships with patients in ways that some find very satisfying and that provides balm to the wounds inflicted by colleagues who call them 'hobby doctors'.

Some doctors describe how they gain satisfaction from working in ways that are natural for them, such as being able to cry with the parents when dealing with a neonatal death, and that they find self-fulfilment and reward from working in a healing way. Rural doctors speak of how this work can help heal them as well as their patients:

> *I derive much of my satisfaction as a GP from learning from my patients.*
>
> *we are privileged to be a part of the process of being healed*

The collaboration between patient and practitioner is a key theme for female doctors. We saw in Chapter 4 how women derive deep satisfaction from being valued by their patients for their work, their work style and for using their sense of their female selves and life course as a source of wisdom and healing. This valuing helps heal the pain of having women patients, the feminine and themselves as female doctors derided, silenced, attacked, ridiculed and hurt by processes within medical culture that are antithetical to the well-being of women.

Comes with maturity

Working as a healer seems to be something that doctors grow into. The data in Table 25 above shows that some doctors come into medicine with this concept of themselves, but that more develop it as they practice. It is an aspect of practice that is scorned in medical training and medical students quickly learn to avoid language and behaviour that suggests they might use or value intuition, feelings, emotion, or compassion, the approaches to clinical interaction that they describe as healing practice. Doctors therefore are likely to bring these aspects into their practice when they have the authority and autonomy to do so, and when experience has taught them to be able to trust in what they know. Three doctors describe this emerging aspect of their practice:

> *I think that my understanding of myself as a 'healer' has grown with the years, as I have gained experience and confidence. – rural doctor*
>
> *I don't think doctors see themselves as 'healers' however I increasingly see myself as having this gift as I get older, wiser, more (comfortable) with new ideas and ways of healing. Thankfully this has happened to me and is getting stronger and stronger. – rural doctor*

when I practice, I think I can heal things but I only think of it as healing if I think I'm in there, like a part of me is in there and helping. I don't think I ever felt that until much, much later in my career. – P8

These women are overcoming the terror of the witch-burnings, the horror of embodied knowledge, the Descartian distancing of the intellect that has been a requirement of being licensed to practice as a physician, and healing the split between heart and mind. They are finally able to use their authority to believe themselves, with the encouragement of their patients.

The purpose of medicine

For some of the doctors this intention to heal has been the driving force of their vocation, although they would have quickly learnt to keep it hidden. These are some of the ways they describe their purpose to heal:

Wonderful that you are asking. I started this way perhaps before I even trained. I lost it for a while. I am now "retraining" in Spiritual healing which is wonderfully restorative. I hope later to work only this way. – rural doctor

From the moment the patient walks in the room we look at him or her with the sole intent of healing him/her in some way. – rural doctor

Most of the time being a healer is rewarding and is what we do, and why I became a Dr in the first place. – rural doctor

Part of the job isn't it? – rural doctor

I knew I wanted to be a doctor (if I could) in primary school. I was 'healing' my tadpoles & frogs with potions I made. – rural doctor

I currently work for the RAAF and boy do they need healing but would probably throw me out if I appeared anything less than conventional. Nonetheless, 'healing' is what medicine is about and often it is emotional healing that can be offered in a variety of ways. – rural doctor

If I ever feel that I have lost the ability to be a healer then it would be time to give up medicine and become a computer technician. If I can't make each patient I see feel a little better than before they saw me - either by treating an acute condition, alleviating their fears or just listening to what they have to say - I don't feel I'm doing my job. – rural doctor

I did a caesarean section and I thought well I guess a hundred years ago or maybe even 50 years ago that is true, that the life of the mother and child may well have been in jeopardy. That was the most poignant reminder of what I was actually here for. P4

Healing is their trade, even if the RAAF and their medical colleagues are not going to hear them say it. Healing is the trade of a majority male rural doctors too, which demonstrates the power of the taboo. Only patients know this about their doctors. The shadow of Zeus casts a pall of silence over an aspect of practice that was supposedly cauterised from medicine in the 16th and 17th centuries.

5. Healing the profession

The women in this study describe in many ways how, from positions that are sometimes on the margins of the profession, they are creating a scientific practice for the many. They are answering McWhinney's call to 'know the world by experience' and to bring feelings into their practice. Gilligan and Pollock found women medical students struggling to 'hold professional achievement and human connection together', conscious of the healing power of relationships and vigilant to the dangers of detachment (Gilligan and Pollak 1988 pp 260-261). So too are the doctors in this study conscious of the healing power of relationships. Some are even conscious of working to heal medicine through relationships with other women doctors, such as the surgeon who said *the work that I do with women doctors, I feel as though I can do some healing. P8* and the surgical trainees who were also working consciously to transform medicine by being present as women:

> *I think being overtly female within the medical profession is something that is important to do, and the more publicity we can give to that, the better, rather than just kind of sneaking through the back door and just being there. P6*

> *I really did enjoy surgery and… I was seen as having capabilities in that, but I was also quite proud of the thought that I'd be doing something that was different and … that I thought was important because there weren't women doing surgery in (my state). P4*

These women are claiming their difference, celebrating it, intentionally using it to transform medical culture and practice, to heal medicine from its casual abuse of women and the feminine. They are throwing off Athena's mask, standing strong with the fathers, yet claiming the mother-line too. This is just a beginning. Individual women working individually, supported and encouraged in private by their patients, sometimes sharing that with trusted colleagues, keeping going.

Not all female doctors are engaged in this project, just as 40% do not think of themselves as healers. It is not enough that women are doctors. The transformation that may save medicine from the 'mechanical metaphor' will be a transformation in the relationship between medicine and the feminine. A general practitioner sums this up:

> *Are women changing medicine? Yes and no. I think what's happening is that while we keep focused on gender without looking at the feminine in gender, nothing's going to change. Gender is not going to change medicine. It's the integration of the feminine in both the men and the women that's going to change medicine. P9*

This integration is not yet a certainty. There are many forces at work that threaten to split the profession along gender lines, to marginalise and impoverish women's practice, and as we have seen these are being resisted and circumvented in many ingenious ways, but at a price to individual women. What is certain is that a revaluing and integration of the feminine into medicine is a project that requires the presence of women as doctors, and patients are voting for this presence with their bodies.

6. Interviews as a healing process – 'a really good listening to'

It has been a guiding purpose of this research from the beginning that the findings be useful to women who are doctors. I wanted to construct a plausible tale that would help them make sense of some of the maddening experiences they have had, the challenges they face in fitting their spiral-shaped, embodied, relational lives into a profession dedicated to the disembodied intellect where bodies are serviced by others and the god-doctor stands alone. I particularly wanted to avoid the rape model of research, that takes without giving in return. So I built gifts into the questionnaire that gave something in return for the doctors' time and attention; and I asked the women I interviewed what was their experience of taking part in the research. This is what they said:

> *its been really good. No, its got me thinking about all sorts of things in different ways, its been really positive for me.* P3
>
> *I feel quite positive (laughs), and in one aspect as far as for me personally, I'm happy with where I am at the moment but, I think there's still a long way to go for being a women in medicine in the surgical college or obstetrics and gynae or any field at all. It is still very difficult. P4*
>
> *It's weird actually, I feel a bit sort of excoriated. Didn't expect to be so emotional. P5*
>
> *Oh it's been it's been wonderful. I've had a chance to talk about myself for hours on end which is always good and having an outsider bring up issues about these issues, is a very interesting process because you gain an outside view of the whole system, which helps you gain insights yourself into what's strange and what's normal about it for yourself. It gives you a chance really to think things through perhaps in more detail than you would do otherwise. To clarify issues for yourself - myself. There have been lots of particular areas I hadn't thought about before that I've had to think about. You know lots of, I guess, self talk that I've not recognised, has been brought to the surface.*
>
> Q: Is that okay?
>
> *Yeah, yeah that's very good. I mean emotion is very powerful and I haven't thought about particularly over the last 3 or 4 years, and the reason is that it's almost good to have a second person to bounce things off, because most people, men and women in medicine, don't do that very much, certainly not at work and, you know, I don't try and do that with people at work because it's not professional. P6*
>
> *I guess the interviews that we've had have actually provoked some thought. I actually saw (colleague) this morning and I said 'It's been very interesting' and I actually said to her half in jest, and half not I suppose 'In many ways it just feels like therapy, to be talking openly'; that you're very conscious of not talking openly for fear of getting that label as a 'chip on your shoulder' type person or looking for excuses. So, yes, it's been very thought provoking… A bit therapeutic in a way. It provoked a bit of ongoing thought. This is the opportunity to kind of offload it, talk about. It's good. P7*
>
> *I like being flattered Jo. I like being told I'm a good story teller. It's nice. And I guess I'm allowing myself to kind of be imperfect which is also nice, it's another part of medical culture that is something to do with getting everything right the first time and not leaving any space open for ambiguity or changing your mind, whereas I get the sense I can change my mind and still be real… I felt completely exhausted last time for a day, very upset and*

> *wanted to read my stories and then I read them and I felt worse (laughs)…Yes, it's emotional. I'm pleased. I feel privileged. P8*
>
> *A little vulnerable, actually because it's interesting when I always talk very openly anyway and it's not something I put boundaries around; if people ask me, I'm quite open about things and it's interesting to sit and speak about yourself; it's a different place. Most of the time what happens is that we, particularly in medicine, you speak about someone else.* P9

McLaren makes the point that women 'are struggling to find their way in the world, their own way, and there will only be new stories about the truth of their lives when women turn to each other and take the time to listen'. Her participants noted how extraordinary it was to have someone listen to them so intently and how it gave them permission to believe their own stories. (McLaren 1999 p 98-99). Some of the participants in my research report a similar experience.

These accounts are a brief demonstration of the value of a good listening to. It was always my intention to 'first do no harm' and that seems to have been achieved. It is possible also that the work of including women in the project of medicine has been given a nudge by careful attention to the feminine during the process of this research.

7. Research reflections

Listening care/fully to women brings forth new possibilities for the individual woman, and also for the knowledge base and practice of their profession. This research has demonstrated that documenting women's experiences strengthens the cultural knowledge of medicine by identifying the scientific absurdity of aligning 'normal' with 'male'; it has done this by acknowledging that women who are doctors have relevant and important knowledge and experiences that deepen as well as broaden the scope of the profession.

A research programme based on knowledge compiled in this thesis and by the many other researchers whose work has provided the foundation for this study, will have broad reaching effects on the culture and practice of medicine. Now that we know that the feminine is both missing and active in medicine, it is important that future studies identify ways in which women's strengths can be fully incorporated into professional practice. This may lead to further inquiry into the relationship between medicine and healing.

Now that doctors are women, there is an urgent need to identify how professional structures, training programmes, curriculum and resourcing need to be adjusted to ensure that medical women have the chance to contribute fully to their profession as well as to patient care. Academic medicine has a serious responsibility to engage fully with what women know about healing, about professional practice, about education and training for doctors, to both heal the profession from some of its most unsustainable and untenable blindnesses, and to maintain scientific credibility.

Research that identifies the elements of flexible and non-abusive training programmes, examines the processes that maintain and develop confidence as well as competence in young doctors, identifies workplace structures that support the relational life of doctors, and continues the work that individual doctors are doing to bring an ethic of care into a profession at risk of losing its humanity in the jaws of technology, will help medicine continue to attract the best and brightest of each generation to relieve human suffering.

This study has identified the power of situating knowledges within their historical context in order to throw light on what is missing as well as what is known. Working with myths and archetypes, those mysterious stories that touch into the collective unconscious, has provided greater depth to the research process and analysis and it is almost certain that other myths explored in a similar way will bring forward new understandings. Hygeia, the ancient goddess of healing, is likely to provide a powerful archetype for women doctors today.

10

Conclusion

I love being a woman. (sigh) I think I love it. P2

re-visioning = 'the act of looking back at the personal and political lives that inform a woman's psyche' (McLaren 1999 p 43)

I have come to the end of this study of women doctors. The myth of Athena that has provided a guide to my thinking has proved to be useful. Like women's lives, the myth is full of complexity and ambiguity and has layers and layers of interpretations and levels and levels of understanding. Women's relationship with the profession of medicine is equally full of complexity, ambiguity and promise. In this final chapter I will draw aside another layer of the veil of silence about women and the feminine, viewing Athena from new perspectives so that, by the end, the potential in things, the possibilities for women in medicine, can be imagined.

As Rachel Pollack has described, Greek myths, such as that of Zeus and Athena, allow layers of meaning to exist at once, that understanding the world through experience and the body lies within the same story as the sunlit worship of abstraction and rationality (Pollack 1997 p 170). The mirrors of Greek myth have infinite depth and looking deeply can reveal a double image, the story as it is told, and the much older source of the story, the four sacred elements of earth, air, fire and water, ancient human experiences connecting us today through the eternal truth of the body. Knowing this, it is time to see what else Athena can tell us about doctors who are women.

1. Athena and Metis

At first pass Athena is a father's daughter, powerfully described by Grosz as

> a motherless daughter, a passionless woman, preserver of patriarchal law and justice. … She is the necessary mediator of the father's law, taking the place here of the repressed, devoured mother. … Veiled from head to foot, the virgin figure conceals her beauty, or corporeality and her femininity, revealing only her face. … she speaks words that are not her own (they are her father's), she brings harmony to those around her. She promises status but has none in her own right …Athena epitomises a femininity formed in man's image; she mediates his relations to the natural, to productivity and fecundity. In this sense she represents not only the veiled (and hence alluring) woman; she also represents science and knowledge…. Order, harmony, subordination of the feminine to the masculine… scientific and philosophical knowledge" (Grosz 1989 pp 163-164) .

Athena's evolution from the primal snake goddess and protector of feminine wisdom, to the Greek "daughter of the patriarchy" parallels the path for women through the centuries.

This Athena is well known in medicine, although hinted at rather than revealed in my research. All women who study medicine have to disguise their feminine selves and learn scientific and philosophical knowledge that has been created by the fathers in their own image. All the doctors I interviewed could describe medical women they knew who spoke words that were not their own. Some had played these roles themselves and one still sought to do so, trading relationship with the mother for the esteem of the fathers.

However Athena, goddess of owls and snakes, is far older than the armed warrior who leapt from her father's head. Athena possesses the wisdom not merely of the intellect, but instinctual feminine wisdom, symbolised through the attribution of the owl as her sacred bird. The owl is known as a bird of 'wisdom', a wisdom that is a deep inner knowing or understanding rather than purely intellect. It is also a bird of prey, a bird of the night, destined to feed upon whatever does not serve its higher purpose. The ancient association of the owl and the serpent with Athena suggests the ambivalence inherent in this goddess, that beneath the layer of the father's daughter lies a protectress of feminine ways of knowing, of women's wisdom.

Athena's familiar, her owl, must be Metis, the goddess of wisdom who must have learnt to see in the dark when swallowed by Zeus. Metis, the mother, is travelling with Athena women, keeping them safe, whispering her secrets. So feminine wisdom has been out there all the time, for everyone to see, but in disguise so only the initiated can recognise her. What a relief. The feminine was disguised so that she could survive and move through the ages until it was time for her to surface once again. The owl is Metis's wisdom, and the snake is earth wisdom, embodied seasonal wisdom. She was/is there all the time for those who have eyes to see and ears to hear. She is the Caduceus.

Athena's shield carries the image of Medusa's severed head, her snake-hair the ancient symbol of feminine wisdom. She is protecting the untamed and undefended feminine from the onslaught of the Piscean age. She uses the tools of the fathers, the shield and the spear, to hide, protect and disguise her true purpose. The original untamed feminine is there for all to see who know what to look for.

The women in this study struggle to value the feminine aspect of Athena, to valourise mothers as easily as fathers, to forgive women as easily as men are forgiven. Yet in their actions they are protectors, upholders of what is right, healers of patients, of themselves, of the profession. With the night-vision of the owl they can see what is really going on and work with the particularities of their lives, their families, their practice and their profession for change that includes the feminine.

I suspect Metis told Athena of her connection to Medusa and the serpentine wisdom goddesses. This she gave to her to make sure the whole of the feminine would survive and be passed on. Athena, although she says she is "strongly sided with her father", is at the essential values level identified with feminine power, knowledge, wisdom, learned from Metis in the womb. Metis represents, and bequeaths to her daughter, a "watery" wisdom - intuitive, psychic (past) attuned to subtleties and transformations, sensitive to the nuances of personal feeling, poetic rather than abstract, receptive rather than commanding. This watery wisdom perhaps heralds the incoming age of Aquarius, the water bearer.

I asked the women I interviewed what Metis might have whispered to Athena while they were both swallowed by Zeus. This is the gift given to me by one of the doctors:

Today what I am whispering, me being Metis here, to my daughter, is that women, if we want to, can exchange something much more valuable than money, something also very precious, it is connection with other women.

There are so many women who it seems feel this kind of connection between women, it feels qualitatively different from one's connection with children or with men, for me it came was when I gave birth, not through any 'training' experiences in healing, as one can imagine might happen in some mystical other world of education to become a doctor. Women cling to this connection, not only, but commonly, when there is nothing else to grasp for one's identity.

A trick for women in medicine is to grasp this and use it as a 'platform', a firm base, a point of departure, a solid launching pad, a beginning not as a last resort. This kind of thinking allows a reverberating model of women in medicine, women are in medicine, it changes us, and medicine IS women, we ARE medicine, and wherever the feminine goes we reconfigure, rejig, and remake connections between one another with men and with the organised institution of medicine.

Thinking of me being Athena for a while now, I wasn't whispering, I was stating clearly and audibly - to say that normally training is full time and continuous is ludicrous, a stark manifestation of the power of discourse - it seems monolithic. I read visibly and audibly from a solid, old, unrevised, college publication.

When I broke out of Zeus' head that day I was staying connected with my mother Metis and breaking through Zeus' power, and leaving him, getting outside his body, and being separate. I stayed close by to Metis's philosophy - she who gave me the strength to stay connected with what I believe, that I remain linked with other women, other people, in fact, that I would be portrayed as an alien when I am not an alien, I am in the world as much as he, Zeus.

The funny thing, the surprise to me, now being repeated in various forums in my life, is that Zeus' rage deflates when women stand firm. He gets furious, calls a meeting, and then folds, 'goes to water', if women simply hold fast, stand steady. Perhaps we only stand steady when we have a watertight case. Perhaps that is our error, I mean, only standing fast when holding a watertight argument. We do this because of inequality, if we were equally valued, we wouldn't have to only have an argument that makes rational sense to make a bully fall into line.

Zeus, as her father, gives her a different sense of authority. When she aligns with him she can disconnect, become individual, become objective, away from sensation from within and without. She can simply copy her father, swallow that problematic and wonderful fly, and pretend she isn't there, while knowing he has her where he wants her, within, in hiding.

Perhaps me being Athena, morphing into the creative Metis becoming an educator makes me push this knowledge back earlier into the careers of my daughters and sons - that this knowledge is a beginning, a platform for practice, not a finality of practice, a last resort, a death bed.

Don't need to gestate corporally, bodily, physically, but can do it metaphorically, and repeatedly, and with a different kind of authority, in medicine and surgery. Here we have the crossroad of authority and nurture. In education. For many doctors it comes into medical practice, being caring, and being authoritative, at once. P8

So it seems Athena does still have a story to tell that is relevant to female doctors today as they do the creative work of unpicking the threads of a discipline that was woven with only the weft and missing the warp, and reworking it with an ethic of care and the healing

power of presence to balance heroic activity. After four millennia behind the veil women are forming connections and becoming restless.

Medical women are at the leading edge of a new wave of consciousness that will include the feminine again, although it is just beginning and the struggle is hard, the resistances embedded. Maybe medicine is the patient that women have come to heal while learning to heal themselves.

2. Paradigm shift

Oakley concluded after her study of the creation of scientific knowledge that 'We may be in the early stages of a paradigm shift' as Kuhn has described the process of scientific adaptation (Kuhn 1970; Oakley 2000 p 306). My study too has within it the seeds of a paradigm shift in ways of knowing. Medical women are using the power that comes from their locations on the margins of the profession to resist the silencing and coercion that is part of the struggle for epistemic privilege, and quietly inserting into the profession new knowledges and new ways of acting as doctors.

The inclusion of women and the feminine in the creation of scientific knowledge is the next paradigm shift, the next scientific revolution.

3. Rising feminine

To use an astrological framework, western culture is facing the upheaval of the change of eras commencing in 2012. This change will be from the Piscean Age, the age of the fish, to the Age of Aquarius, the water bearer. In this age women and the feminine will be re-included in the design of public life and we are already seeing signs of this as women shift in their relation to work and family and their views of who it is possible to be.

The rising of the feminine means that navigating their way will be easier for women, because she can no longer be locked out, she is in the psyche, in the feeling nature, in water and she has access to the collective unconscious.

Medicine will be profoundly altered by this, and this study has undertaken a systematic examination of data to adumbrate the changes that are coming.

The metaphor/myth that might work for modern medical women is that of Hygiea, the daughter of Asclepius, who taught her the healing arts. Hygiea is a snake goddess, linked to Athena's instinctual wisdom (the python) which came from Metis. The Caduceus staff of healing is also with her. Asclepius carried this staff, which links back through the snake symbology to the Serpentine Goddesses, as well as to Athena. When Hygiea heals, she brings the patient to sleep in the temple to be reconnected to psyche/soul through the healing images in dreams. Through psyche's honouring the wound it can also be protected and healed. (Clark 1996). We have seen how women, working as healers, attend to the psyche and the soul, and if they investigate closely, Hygiea may lead them on.

4. Tricky games

I have worked with pre-patriarchal myths to establish some of the enduring themes that help us understand the possibilities for the way medicine will be changed by the presence of women. This has required an examination of the culture of both medicine and women, and how they intersect, collide, oppress and subvert each other. It is clear from the interviews and the survey data that women bring their culture into medicine and hold on to it tenaciously. Twelve years of constant attack through undergraduate and post-graduate training is not enough to destroy this culture. Instead women learn to mask and hide, to work in private, to create microclimates for themselves. In doing so they experience considerable psychic and soul pain. Women long to be included, to have their culture valued and valorised, to be rewarded for being who they are.

Some women are attracted to medicine because of the prestige and income that have been constructed by the medical forefathers as proper recognition of the power and necessity of the discipline. Women may need to think carefully how they will manage the tension between wanting the benefits of working in a male-defined profession, and yet to be included in the whole project of medicine. The women in this study are for the most part too hurt, or too busy managing their identities, to engage with this question. It remains a question for further examination, collaboratively with male colleagues who, too, are anxious that if women are allowed to bring their culture with them that will devalue the whole profession.

There is evidence from this study that women will work for less money, that money and power and prestige are not the drivers for women that they are for some men. This is part of what patients find when they want women doctors, but it frightens the men in the profession. One way the men have managed this is to constantly shift the location of the levers of power to move them out of reach of women, just as they seem to be on the point of grasping them.

Mechanisms of coercive power have been identified that are system-wide and have the effect of distracting women from engaging with their own authority, keeping them on the defensive so they cannot see what is going on, and dropping them into personalising the troubles they encounter by throwing a veil of obfuscation around the tricks and games that are played. Women get into medicine by being earnest and determined. These same attributes leave them at a disadvantage when engaging with the trickster, the Alice in Wonderland world of medical power broking where things are not what they seem and the distribution of power goes on in secret places women do not even know exist.

The structure of the profession is constantly changing, in part in response to changes in medical technology, but also in response to the new heterogeneity of the medical workforce. Some of these changes, which are rarely articulated or identified, make it even more difficult for women. One example is increasing sub-specialisation, which reduces the community of peers for each sub-specialty and magnifies the impact of personalities. The more rarefied the environment the more difficult it is for women to be there because the codes are so dense, the requirements for belonging so coded and embedded and so naturalised as masculine.

5. Medicine and women heal each other

While all these tricky games are being played at the top of the medical hierarchy, there is a quiet revolution going on that is invisible to those who command power and resources. The revolution is taking place in models of clinical care, and in undergraduate university-based education. In these environments women are using their authority to practice care/fully, to mentor young students and doctors, to introduce innovations to teaching, curriculum, practice and practice environments. They are identifying how the multiple layers of disenabling operate and in some cases telling other women what they have found. They are working to change structures such as training programmes, practice environments, curriculum content. They steadfastly refuse to be engulfed by the profession and continue to find multiple sources of identity. They resist pressures to work themselves into exhaustion and psychic isolation. They have learnt that overt challenge to the prevailing culture is very costly and so continue the strategy women have used for millennia, they work covertly for radical change while appearing to toe the line.

Some of the women are training themselves for the leadership that will be required of them when it is time to bring their covert knowledge and work into the light so that all of medicine can benefit. Others continue to struggle to find their way in the dark, and others put their hand up for leadership positions within existing structures and are punished over and over again. Each time they are punished they learn something new. Each time their resolve strengthens, their antennae become more finely tuned, their repertoire expands. Some are crushed and withdraw from the struggle, some are mortally wounded, but others are quietly preparing for a revolution. Like the feminine element of water, when one path is blocked they find another. They are grounding their resilience and will not be diverted.

The theme of women searching for images of the feminine, drawing strength from each other, and taking care of the young women in medicine is the most persistent theme to come through the study.

Women are now embedded in medicine and in sufficient numbers that the profession will have to engage with the feminine and the culture of women in a more subtle way than either marginalising individual women or requiring all women to behave like honorary men. Women of past generations have been prepared to do that, indeed some have actively embraced it. Today's women are resisting, and I predict that tomorrow's women will require a transformation in medicine so that it fully engages with who they are. They will not be interested in being obedient. There are men who know that this transformation is necessary and who will guide, encourage and resource strategies for change. There are many others who will resist fiercely. The masculinization of the profession occurred at the time of the burning of the witches. We are entering a new era, the age of Aquarius, the water bearer. Water is a feminine element and heralds the re-emergence of the feminine from 3000 years of hiding. She is back and she will not lightly be put aside a second time. Women doctors will not necessarily be aware of the changing energy at a cosmic level, but it will be reflected at a feeling level, at the level of what it is possible to imagine, and the strategic skills individual women have gained in the meantime may combine with this shift in energy to cause a disturbance. They are unlikely to be deflected.

6. Lilith is back.

Lilith is back. She is in our daughters and granddaughters. She refuses obedience, acknowledges her own desires, authors her own actions. She abhors hierarchy and compliance. She can be guaranteed to create a stir.

The inclusion of women in the canons of medicine is likely to cause a revolution in medical science and practice of parallel significance to the revolution in the 15th and 16th centuries that saw them excluded. Athena is about to take off her 'father's daughter' mask and use the insight of the owl, the learning and wisdom of the texts, the protection of helmet and shield, the potency of the spear and the art of the healer to speak again the secrets whispered by her mother. Athena did have a mother and has kept her secret safe for the whole of the age of Pisces. She has been in service long enough and learnt what she needed to know. She has demonstrated determination, resilience, leadership, the capacity to hold intention, great learning and healing skill, a warrior's steadfastness. With the aid of Lilith, she will reclaim her authority and Zeus will be left with a mighty headache.

Appendix 1
Cooperative knowledge-making with female and male rural doctors

Appendix 2
Sustainable rural practice for female general practitioners

Appendix 3

Interview Schedule

Interview 1: What do women doctors do with their feminine ? – the experience of being a female doctor

"You are in charge of this interview, so I want you to feel completely comfortable with not saying anything you do not want to"

1. Tell me about your journey into medicine

2 What was your dream ?

3 Tell me about your relationships with your:
mother
sisters
other female role models
father
brothers

grandparents

4 Tell me some stories about being female
as a student
as a registrar
as a doctor

5 Do you have examples of experiences in which you were valued as a female doctor

6 Tell me some stories about how being female has been a problem to you in medicine

7 Tell me about some confrontations or encounters that you have experienced

8 At the time you became a medical student, or at any time after, did you think of yourself as a healer ?

9 How have you used that gift ?

10 In your experience do women and men practice medicine differently ?

11 In what way ?

12 What have you done with your female body as a doctor ?

13 What have you done with your female feelings ? eg. empathy, intuition, engagement, reciprocity

14 What have you done with your female ways of knowing ?

15 How do women create knowledge

16 How has this been an advantage to you

17 Do you think of yourself first as a woman, or first as a doctor

18 Does being a female doctor influence your relationship with medicine

19 What is it like, being a woman in a male-defined profession

20 As a female doctor what has been your greatest dilemma ?

20 Where is your journey now ? Is there anything you want to say that I have not asked

21 How do you feel after answering these questions ?

Interview 2: What do women doctors do with their feminine ? – the Mother-line

1. Have you had any thoughts about our last interview
2. Have you ever had a chance to discover some of the history of women in medicine
3. What about women healers who were not doctors
4. Who are the strong ones in your family
5. Tell me about the women in your family
6. What stories did your mother tell you about who you were
7. Can you think of the comments your mother/sister/grandmother made about you
8. Is it possible that you are carrying your mother's or grandmother's unlived dream for her own life ?
9. Who have you drawn on in constructing your femaleness
10. Do you have daughters and if so what are you telling them about the woman's journey
11. Is there a Mother–line in your family
12. Have you reflected on some of the ways society has kept women domesticated
13. Have you experienced being silenced as a woman, or as a doctor
14. How have you talked with your daughter/s about this
15. Most women have self-talk in their head, can you describe yours ?
16. What do you think of the idea of women's lives being lived as a spiral

17. Have you heard of the phases of a woman's life being described as Maiden, Mother, Crone ?

18. What is there for women to do with the fourth stage, the extra life we are now being given ?

19. Where do you feel your life force or source of energy comes from (earth = female, nervous = male)

20. Do you have any sense at all of being connected to your soul's journey ?

21. Number of children, their age and what stage in her medical career did she have them, marital status.

22. Where is your journey into medicine now ?

23. Is there anything you want to say that I have not asked

24. How do you feel after answering these questions ?

Interview 3: What do women doctors do with their feminine ? – Managing tensions between the feminine and medicine

1. Have you been aware of instances where the authority of medicine was used to promote women's autonomy ?

2. What about to keep women under control

3. Have you ever been involved in that

4. What did you do

5. What did you learn

6. How do you reconcile that

7. Thinking about your experience of being a woman doctor, what are the mechanisms of suppression of your feminine in medicine

8. Many women have told me of instances where they were required to take part in some conversation or process that was demeaning or damaging to the woman patient, have you ever had to do that

9. Describe how you managed that

10. One of the unconscious techniques women use to gain acceptance in a male-controlled environment is to put down other women. Have you ever seen that happen

11. Have you ever felt it necessary to do that in order to keep in favour with others whose opinion was important to you

12. Some women doctors identify with the male culture of medicine and adopt the manners and habits of their male colleagues. Have you seen that happen

13. Can you think of a time when you used that strategy yourself
14. In what other ways do women gain the respect and acceptance of their male colleagues
15. Tell me about some of the difficulties you have had with your female colleagues
16. What are some of your ideas about what this might be about
17. What has been most important to you in terms of survival in medicine as a woman
18. What advice would you give to young women about strategies for survival in medicine
    19. Can you remember the dream you had for yourself as a doctor
    20. What has happened to that dream
    21. Is there anything you want to say that I have not asked
22. How do you feel after answering these questions ?

Appendix 4

Questionnaire

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