FROM THE PATIENT'S POINT OF VIEW: PRACTITIONER INTERACTION STYLES IN THE TREATMENT OF WOMEN WITH CHRONIC STDs

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ABSTRACT

Medical encounters are interactional/interpersonal processes taking place within contexts shaped by macro-level social structures. In the case of sexually transmitted diseases (STDs), medical encounters occur at a stigmatized crossroads of social control and gendered norms of sexual behavior. When women are diagnosed and treated for chronic STDs, practitioner demeanor has an important impact on how patients will view not only their health status but also their moral status. This chapter draws on in depth interviews with 40 women diagnosed with genital infections of herpes and/or human papillomavirus (HPV – the cause of genital warts) to explore three models of patient–practitioner interaction. The analysis focuses on the relationship between gender, construction of illness, and practitioner interaction style. In a broader context, the health risks posed by particular interaction styles to female STD patients shed light on
larger public health implications of combining morality with medicine for the broader range of patients with stigmatizing diagnoses.

Each year in the United States, millions of Americans become infected with one or more STDs (sexually transmitted diseases). I studied women living with HSV (herpes simplex virus) and/or HPV (human papillomavirus) infections because the long-term and unpredictable nature of these two chronic STDs typically result in serious illness experiences with negative ramifications for physical health, mental health, and interpersonal relationships. In addition, the incidence rates of both viruses are high, and, due to the fact that they are transmitted by skin-to-skin contact, their transmission rates are not necessarily decreased by the practice of “safer sex” techniques, such as the usage of latex male condoms. According to the Centers for Disease Control and Prevention (CDC, 2008a), “Nationwide, at least 45 million people ages 12 and older, or one out of five adolescents and adults, have had genital HSV infection ... Genital HSV-2 infection is more common in women (approximately one out of four women) than in men (almost one out of eight). This may be due to male-to-female transmission being more likely than female-to-male transmission.” In terms of HPV, “Approximately 20 million Americans are currently infected with HPV, and another 6.2 million people become newly infected each year. At least 50% of sexually active men and women acquire genital HPV infection at some point in their lives” (CDC, 2008b).

My research focuses on women’s experiences of being diagnosed with and treated for these STDs because the socio-historical constructions of sexual diseases (especially the gendered double-standard of sexual morality) have produced much stronger stigma for infected women than for infected men. While women’s understandings of STD stigma do not begin at the diagnostic encounter (see Nack, 2002), practitioners play an important role in shaping the meanings that these patients attribute to their illnesses. This chapter presents the analysis of 40 female patients’ experiences of interacting with medical practitioners during visits in which they received examinations, diagnoses and/or treatments for HSV and/or HPV. The analysis aims to expand medical sociological conceptions of practitioner interaction styles but to also begin to answer the question of how different practitioner interaction styles impact female STD patients’ health outcomes (e.g., patient satisfaction, compliance, and overall well-being).
In this piece, I aim to answer the following questions. What practitioner-patient interaction styles do women with STDs experience? How can the example of women with STDs expand current medical sociological models of practitioner-patient interaction? What correlations exist between practitioners' sex/gender and interaction styles? What are the public health implications of different practitioner-patient interaction styles for the variety of patients with stigmatizing illnesses?

**INTERSECTIONS OF MORALITY AND MEDICINE**

The impact of social mores on health policies and social attitudes extends beyond sexual health. Several diagnoses continue to create “immoral patients,” those who are judged according to the moral culpability of their conditions: for example, the mentally ill, alcoholics, drug addicts, smokers, and the obese. Gausset’s (1998) study of “good drinking” found that individuals either perceived alcoholism as a disease, a sign of creativity, or proof of social and moral failings. Smyth’s (1998) sociohistorical analysis of female alcoholics found that social discourses portrayed alcoholic women as promiscuous, impoverished, and bad mothers. This gendered “moral outcast” model of female alcoholism promoted secrecy and denial amongst affected individuals.

Drug users have also employed denial as way to manage the stigma of being diagnosed as a drug addict. One study of injection drug users found that they were conflicted by internal contradictions: their saw themselves as responsible and careful injectors, but these self-concepts did not match their high-risk behaviors of lending and borrowing injecting paraphernalia (Plumridge & Chetwynd, 1998). The researchers determined that drug users resolved their identity contradictions via discourses of exoneration which fit the moral implications of the different risk behaviors. Sadly, the drug users put more energy into – and were more effective at – shielding themselves from moral stigma than at reducing high-risk behaviors.

Similarly, a lack of medical compliance has been found among individuals labeled by practitioners as obese. “If the fitness ‘revolution’ was driven by scientific findings about risk and behavior, it also took on a powerful moral and prescriptive dimension” (Brandt, 1997, p. 67). An interview study of obese patients found that each had been subjected to “contemptuous” treatment from their medical practitioners, and their resulting “fear[s] of humiliation prevents [them] from seeking health care” (Joanisse, 1999, p. 14).
SOCIO-HISTORICAL PERSPECTIVES ON STDs

By the late 20th century, epidemiological studies had shown behavioral choices to influence ill health. “No longer would disease be viewed as a random event; it would now be viewed as a failure of individual control, a lack of self-discipline, an intrinsic moral failing” (Brandt, 1997, p. 64). In contemporary society, many believe that illness is a consequence of individuals’ poorly chosen, and hence irresponsible, behaviors. This mindset helps to explain why social prejudices intensify against individuals such as those infected with STDs who are believed to have caused their own stigmatization (Goffman, 1963).

The social histories of STDs in the United States and the United Kingdom reflect traditions not only of assigning responsibility to individuals with STDs, but also of differentially assigning stigma of moral character on the basis of sex/gender (Brandt, 1987; Davidson, 1994; Luker, 1998). Women with STDs, much more so than men, have been and continue to be socially constructed as morally culpable: they earned these diseases via promiscuous sexual behaviors that violated norms of feminine morality. Gendered social constructions of STD patients mirror the “double standard” in which “males are morally elevated by multiple sexual encounters while females are morally demeaned” (Eyre, Davis, & Peacock, 2001, p. 13).

The dominant ideology in our society has assigned stigma to certain kinds of patients (e.g., the obese, the sexually diseased, the mentally ill, the addicted), so how and why does the construction of stigmatized patients shape practitioners’ interactions with such patients? Health care practitioners undergo professional training that is supposed to counteract underlying prejudice. However, research shows that practitioners are not always able to remain objective towards their patients: “In their encounters with patients, doctors may interpret personal problems and encourage individual behaviors in directions that are consistent with society’s dominant ideological patterns” (Waitzkin, 1989, p. 225). As noted by Radley (1994), health care practitioners are not immune to stigmatized portrayals of disease: “How the doctor views the patient, whether the individual is seen to be a member of certain groups that are negatively stereotyped, can have an effect on how (or whether) treatment is carried out” (p. 103). For example, a recent UK study found that most male STD patients experienced relief from practitioner interactions that allowed them to voice their “sense of pollution experienced as disease” because the practitioners employed “strategic interactions” to protect patients’ sexual
selves (Pryce, 2001). In contrast, a study of HIV-positive women found that they experienced “stigma and discrimination” in interactions with medical practitioners: in general, female patients who are “assumed to be promiscuous may experience great difficulty in accessing appropriate medical care, support and services that are nonjudgmental” (Lawless, Kippax, & Crawford, 1996, p. 1373).

**SEXUAL HEALTH INTERACTIONS: STIGMATIZED CROSSROADS**

In addition to the control of health information and services, medical practitioners may serve the functions of being social control agents: they have implicit authority to attribute moral statuses to a variety of illnesses. Foucault (1978) asserted that social control has become more professionalized and oriented to the surveillance of deviant behavior. In particular, professionals’ ability to intervene in and control others’ behavior is enhanced by the discourse used by professionals to communicate specialized knowledge. His (1978) work on sexuality pertains directly to medical encounters. The ways in which both medical and lay people speak about particular diagnoses may denote blame and individual responsibility to the sick. Moral explanations for illness often serve the function of relieving public anxiety by defining illness as deserved punishment.

Scholars have asserted that sexuality has become medicalized and that one of the ramifications is the transformation of various aspects of sexuality into diseases: for example, homosexuality and fetishism (Foucault, 1978; Tiefer, 1996). This emphasis on medical aspects of sexuality resulted in a new morality of sexuality that has been cloaked in the legitimacy of science. Sexual “lifestyle” has become a key part of contemporary discourse on health and morality, such that medical research findings are used to support the moralization of sexual behaviors (Brandt, 1997; Luker, 1998).

This “science” of sexual morality is clearly evident in the moral agendas that have informed medical philosophy and public health services related to STDs. In 1909, the American moral reformer Mable MacCoy Irwin wrote, “I rejoice that they have put the scientific facts under our feet on which we may stand, as we tell our message of chastity to a sin-sick world” (as quoted in Luker, 1998, p. 613). Davidson (1994) argues that the
ideology of the medical profession in the United Kingdom “viewed venereal diseases not just as a physical pathology but as the stigmata of the transgression of moral norms” (p. 271). During the period between World War I and World War II, he documents how “the moral surveillance and regeneration of patients came increasingly to be perceived as part of the functions of the VD treatment clinics in Scotland” (p. 272). In these eras of public concern about dreaded diseases, both reformers and practitioners “could call upon seemingly-neutral ‘scientific’ and medical information ... to argue to for a new moral, social, and sexual order” (Luker, 1998, p. 13).

Historically, public health campaigns and public opinion in both the United Kingdom and the United States have often targeted minority, sexually active, and working class women as the “vectors and vessels” of STDs (Davidson, 1994; Luker, 1998; Mahood, 1990). The social hygiene movement during the Progressive Era (1890–1913) was a time when medical practitioners and female moral reformers combine forces to more explicitly promote moral boundaries of sexual behavior in the pursuit of public health. However, these boundaries were gendered with regard to STDs: a doctrine of “physical necessity” justified men’s forays into promiscuity. However, “the cowardly and cruel theory of innate depravity has been industriously disseminated as applying to ‘fallen women’ ... men the stronger, have remained free from blame; women the weaker have lived under a curse” (Dock, 1910, p. 60). For these reasons, I contend women’s experiences of STD diagnostic and treatment interactions must be examined within the larger context of how female sexuality and sexual morality have been and continue to be constructed.

A modern merger of morality with medicine became evident when many Americans in the late 1980s displayed unsympathetic reactions to persons infected with HIV (Brandt, 1987). Eng and Butler (1997) argued that sexual mores are reflected in societal attitudes toward sexual health and, in turn, explicitly shape public health policy. Assigning moral culpability to illness may encourage policy makers to ignore environmental and social factors that contribute to disease and may reinforce the tendency to ridicule, reject or ignore those who suffer from a morally stigmatized illness. The intersection between science and sexual morality is further illustrated in the moral agendas that have informed medical philosophy and public health services related to other STDs. As contagious infections, genital HSV and HPV are the type of illnesses that represent “risks posed to the ‘moral’ by the ‘immoral’” (Brandt, 1997, p. 71).
MODELS OF PRACTITIONER–PATIENT INTERACTION STYLES

Increased concerns for patient autonomy and interest in producing patient-centered outcomes have some bioethicists claiming that we are in an age of "new subjective medicine" in which "[p]atients' lives rather than patients' bodies will be the focus of medical interventions" (Sullivan, 2003, p. 1602). As such, the social roles of patient and practitioner are in flux. A survey of contemporary literature on physician–patient communication points to two general interaction styles: the "conventional biomedical approach [that] ignores the person with the disease" and the patient-centered model which "includes the conventional biomedical approach but that also goes beyond it to include consideration of the patient as a person" (Stewart, Brown, Weston, McWhinney, & Carol, 1995). These models fit well with two of the three patterns that emerged when coding my data on women's perceptions of their sexual health practitioners' interaction styles.

However, the literature does not provide a model that encompassed the third practitioner interaction style which emerged from my data analysis: I conceptualize this type as the moral surveillance model. In some ways, the foundation of this interaction style can be linked to early models of doctor–patient relationships that emphasized physician control (Ben-Sira, 1980; Friedson, 1970; Szasz & Hollender, 1956). However, this subset of practitioners, whom patients described as interacting via a moral surveillance model, exercised their authority in a manner that went beyond paternalism to communications of negative judgments about female patients' moral characters during medical encounters. In keeping with this conceptualization of the moral surveillance model, findings of a British cervical cancer prevention study can be read as evidence that this practitioner interaction style may be common beyond my sample: "In questioning women about their sexual history, doctors are using their authority to gain access to privileged information, and may be extracting a 'confession' without giving 'absolution'" (Posner & Vessey, 1988, p. 95). These researchers found that some doctors' subscribed to causal theories of how women contracted STDs which reflected negative beliefs about the women's characters: "The most frequently mentioned factor was 'promiscuity,' changing partners, or 'too much intercourse'" (Posner & Vessey, 1988, p. 91). As such, this practitioners were observed to have "offered a series of injunctions" during their interactions with their female STD patients (Posner & Vessey, 1988, p. 66).
THE IMPORTANCE OF STUDYING PATIENTS’ PERCEPTIONS OF PRACTITIONER–PATIENT INTERACTIONS

Does the manner in which practitioners interact with patients to deliver health care have any significant impact on patients’ health outcomes? Practitioner interaction style has emerged as an important determinant of patient satisfaction with both practitioner and medical treatment (Daly & Hulka, 1975; Korsch, Gozzi, & Francis, 1968; Spiro & Heidrich, 1983). “Patients rely heavily on the physician’s mode of communicating when evaluating the care delivered by the physician” (Buller & Buller, 1987, p. 347). From the perspective of public health, this issue becomes more important because researchers have found that compliance may be largely a result of patient satisfaction (Korsch et al., 1968; Korsch & Negrete, 1972; Woolley, Kane, Hughes, & Wright, 1978).

In a study of the relationship between doctor–patient conversation styles and changes in health outcomes, researchers found that “more patient control (in the form of questions and interruptions) expressed during office visits was associated with improvements” (Kaplan, Greenfield, & Ware, 1989, p. 243). Anspach (1988) argues that the language used by medical staff and practitioners not only communicates information and organizes tasks but also reflects underlying attitudes and affects the delivery of patient care. Other research has found that, beyond verbal communication, “physicians’ task behaviors carry socioemotional significance for patients” (Stewart & Roter, 1989, p. 194).

From a symbolic interactionist perspective, meaning is created interactionally, and communication strategies create, maintain, or transform social positions and roles. This chapter focuses on female patients interacting with practitioners during STD diagnoses and treatments, with the focus being on the women’s perceptions of practitioners’ interaction styles and the meanings created during medical encounters. The population in my study faced particular challenges in their medical encounters because their diagnoses represented incurable, contagious, and highly stigmatized conditions. Researchers studying non-stigmatizing yet chronic conditions found that doctor–patient interaction, whether perceived as positive or negative by patients, was highly significant in determining patient outcomes: “Doctors may in fact influence the outcomes of patients with chronic illness, not only by competent medical care, but also by shaping how patients feel about the disease, their sense of commitment to the treatment process, and their ability to control or contain its impact on their lives” (Kaplan et al., 1989, p. 244).
From a feminist public health perspective, I am primarily concerned with how practitioner–patient interactions impact patients who, by virtue of their gender, race, class, and/or age are usually in subordinate social positions. Even within medical encounters that do not involve sexual health, research has found that “patients (especially lower-income minority patients) may experience the powerful medical gaze of high-status professionals as morally judgmental as well as therapeutically curative … their social disease is in the presence of medical surveillance” (Baker, Yoe1s, & Clair, 1996, p. 99). Friedson’s (1970) critique of Parsons (1951) pointed out the importance of taking a conflict perspective on the asymmetry of physician–patient relationships: the mutuality of interest between patients and practitioners should not be overstated. Waitzkin (1991) describes the “therapeutic agenda” as the tendency for physicians to encounter patients with the narrow objectives of diagnosing and treating disease at the risk of ignoring the psychosocial aspects of patient care. However, he contends that class is the most important factor in physician–patient communication and ignores race and gender.

In this chapter, I investigate women’s perceptions of interacting with the practitioners who diagnosed and treated them for chronic STDs: genital HSV and/or HPV infections. I seek to do more than merely describe and categorize interaction styles. I present a grounded theory (Glaser & Strauss, 1967) analysis of women patients’ illness narratives and focus on their descriptions of communications with their practitioners. Via a grounded theory analytic approach and constant comparative analysis of the interview data (Glaser, 1978; Glaser & Strauss, 1967), three distinct types interaction style emerged from the data. In this chapter, I discuss the ways in which these models are similar to and differ from prevalent conceptualizations of doctor–patient interactions. I also explain how patients’ experiences of different practitioner interaction styles shaped their self-conceptions of health and morality. Exploration of the ways in which female patients experience different practitioners’ interaction styles provides insight to the nature and effects of practitioner–patient STD interactions. In addition, the findings of this study shed light on practitioner behaviors that may serve to increase or decrease the effectiveness of practitioner–patient communication in promoting positive patient health outcomes.

My goal is to uncover how professional norms of medical interaction, gender roles of both patient and practitioner, and stereotypes of sexual morality impact women’s experiences of STD diagnostic and treatment interactions. First, I describe the research setting and methods. Next, I analyze the women’s illness narratives to evaluate their perceptions of their
practitioners’ attitudes and behaviors. Then, I analyze the gendered nature of practitioner–patient STD interactions, looking at gender discrepancies in interaction style and in patients’ preferences for practitioners on the basis of both gender and interaction style. Finally, I conclude by exploring how the women’s diagnostic narratives illustrate broader implications of combining morality with medicine. Beyond STDs, these women’s illness narratives point to micro-level effects of socially constructing patients as immoral (e.g., patients’ satisfaction with medical interactions and overall well-being), as well as the macro-level public health implications of practitioner–patient interactions that may threaten patients’ comprehension of and compliance with medical recommendations.

SETTING AND METHOD

Motivated by personal experience, I entered the setting as a “complete member” (Adler & Adler, 1987). At age 20, I had been diagnosed with a cervical HPV infection. Via self-education and involvement in STD education/outreach, I managed the stress of being diagnosed and treated. My investment in managing my sexual health status became the foundation for this research and provided me with the personal insights and clinical knowledge needed to connect with others facing STD diagnoses.

One of my concerns was practitioner–patient interactions. My goal was to understand patients’ experiences of practitioner interactions; for this reason, their subjective perceptions became more important than any “objective reality.” I realized that I was most interested in how practitioner interactions affected the patients and not in how the practitioners viewed themselves during these interactions as my focus of concern became the variety of factors that shaped female patients’ experiences of STDs. While study of “the lived experience” carries its own set of limitations, I wanted to understand how the experience of the self and the body combine in an illness narrative. I decided to conduct an in-depth interview study of patients, focusing on female patients for this first part of the study. Literature on patient-centered medicine in family practice has found that patients’ own ratings of care received are significantly strong measures of patient outcomes (Stewart et al., 1995). My goal was to analyze the women’s accounts to discover what kinds of meaning they assigned to their interactions with practitioners, and, specifically, how they viewed the role of their practitioners in creating these meanings. This chapter focuses on my interview study of 40 women living with HPV and/or herpes who shared...
with me their experiences with sexual health practitioners during STD diagnostic and treatment encounters.

I constructed my research methods to reflect a reciprocal intention: before the women would give their stories to me, I would offer my support and resources as a sexual health educator. I also made it clear that, first as a volunteer and later as a professional sexual health educator, my assistance was available whether or not they chose to do an interview. However, I cannot be sure that very real power inequities of knowledge and expertise did not influence women’s decisions to participate. The challenge was to locate myself as researcher in the “same critical plane as the overt subject matter” (Harding, 1987, p. 8). In this way, I viewed my values and actions as empirical knowledge that might either support or weaken my findings.

Obtaining approval from the university’s committee on human research required that I not directly recruit subjects. Rather, subjects had to approach me, usually after hearing me present on sexual health, seeing my flyers in local clinics, or hearing about my research from other participants. Once interview subjects contacted me, I gained acceptance via my status as a sexual health educator and a complete member. At the completion of interviews, I would often ask participants to pass on my flyer if they knew another woman who might want to participate. In this way, I utilized snowball sampling to generate interviews (Biernacki & Waldorf, 1981).

Many researchers have criticized traditional methods of interviewing that emphasize distance, instead these researchers answer subject’s questions, providing important educational information, and maintaining friendships with participants long after studies reach completion (Nielsen, 1990). During the interviews, I used researcher self-disclosure to create and maintain rapport, and I included self-reflexive reporting of the interview process as part of the transcribed data that I analyzed (Reinharz, 1990).

I conducted conversational, semi-structured interviews with consensual subjects who had all been diagnosed with genital herpes and/or HPV (including external genital warts and cervical lesions). Approximately 87% of the women lived in the Denver-Boulder metro area, with about 13% of my interviews being conducted by phone with women living in other states. Semi-structured or unstructured interviewing has been favored by many researchers because it “produces non-standardized information that allows researchers to make full use of differences among people” (Reinharz, 1990, p. 19). The subjects ranged in age from 19 to 56.

This chapter draws on the 40 women’s descriptions of diagnostic and/or treatment interactions with 62 different practitioners: 40 female and 22 male sexual health practitioners. Some patients had been diagnosed with more
than one STD; others had switched practitioners after receiving initial
diagnoses. The interview gave each woman the opportunity to discuss with
me her unfolding experiences with specific sexual health issues. I conducted
the interviews in private locations of the subjects' preference. Informed
consent forms assured all participants that pseudonyms would be used in all
written research derived from this study. The interviews lasted from 45
minutes to 2 hours and were tape recorded with the permission of the
subjects. When appropriate, I concluded the interview be reiterating offers
of sexual health information and resources, either in the form of health
education materials or referrals.

Methodologists have criticized single interviews for offering a glimpse
into a life rather than the whole story. Given the sensitive subject matter
(willingness to participate was dependent upon only having to be
interviewed once) and transitory nature of the sample (approximately
75% graduate or undergraduate college students) made it improbable for
me to incorporate follow-up interviews into the design. Inherent in the
absence of follow-up interviews, was my inability to receive all participants’
input on my final data analysis. Fortunately, I remained in contact with six
participants after conducting their interviews. I asked for and received their
input on preliminary drafts of chapters from this study.

I analyzed the data according to the principles of grounded theory
(Charmaz, 1988; Glaser & Strauss, 1967), using constant comparative
methods (Glaser, 1978) to adjust analytical categories to fit emerging
theoretical concepts. Over time, I verified some categories and discarded
others as data patterns reappeared. Initially, I sorted descriptions of
practitioner interactions into levels of comfort/discomfort as recalled by the
patients. Then, I re-examined the data with a focus on the particular aspects
of each interaction that the patients causally attributed to their own
emotional responses.

With each interview, I clustered subjects’ experiences around particular
levels of comfort/discomfort and causal attribution to assess the validity of
my emerging three-tier model. The resulting evolutionary analysis was
what Wiseman (1970) called a "total pattern," a sequence of events that
held true for the overwhelming majority of those studied. I followed this
plan of data collection and analysis to maximize the validity of my
findings.

Analysis of patients’ perceptions found that all 62 of the practitioner-
patient interactions fit into one of the following exhaustive and mutually
exclusive models of interaction style: the moral surveillance model, the
biomedical model, and the patient-centered model. I coded each of the
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patient's descriptions of practitioner interaction to identify (1) the level of emotional distress or comfort that the patient attributed to a practitioner's interactions with her; and (2) the specific interactions described by the patient as having shaped her perceptions of that practitioner.

Interactions were coded as fitting the moral surveillance model if the patient described a high level of emotional distress resulting from the interaction and attributed this distress to specific instances of the practitioner demonstrating moral condemnation of her. To be coded as a moral surveillance interaction, the patient had to explicitly describe feelings of being judged as immoral by the practitioner. In contrast, I coded a patient's perception of a practitioner as fitting the biomedical model if the patient described a moderate level of emotional distress as a result of the practitioner interaction and attributed this distress to specific instances of the practitioner treating her in a reductionist manner (i.e., as a sick body part) and using words and/or actions that made her feel intimidated from asking questions. Finally, patients' perceptions of practitioner interactions were coded as fitting the patient-centered model if the patient described a low level of emotional distress and attributed her comfort to specific instances of the practitioner treating her as a whole person dealing with psychological and interpersonal ramifications as well as physical consequences. In addition, to be coded as a patient-centered interaction, the patient had to explicitly use positive adjectives in her description of the encounter (e.g., caring, nurturing, comforting). After conceptualizing these models and analyzing the data, I investigated the literature on doctor–patient interactions and compared my findings to others. Throughout this chapter, I incorporated relevant comparisons to demonstrate how my models confirm, expand upon, or differ from these existing models.

PRACTITIONER INTERACTION STYLES

All 40 women distinctly recalled how their practitioners presented their STD diagnoses and interacted with them during treatment encounters. The women's descriptions of 62 diagnostic and treatment encounters focused on all aspects of their practitioners' demeanor: what, how, and when the practitioners delivered the diagnoses. Their clarity and level of detail distinguished each practitioner and helped me to place them into one of these three categories of interaction style.
**Moral Surveillance Model**

The moral surveillance model surpasses Szasz and Hollender's (1956) most authoritative *activity-passivity* model in that the practitioner not only comes across as thoroughly dominant, but the patients also perceived this type of practitioner as condemning, and felt explicitly labeled as immoral during their STD diagnostic interactions. Practitioners who fit this interaction style exemplified Foucault's (1979) connection between knowledge and power in that these professionals exerted social control and were oriented toward the surveillance of deviant behavior. These practitioners behaved in ways that led their patients to view them as part of the medical elite who believed in the negative auxiliary traits of sexually diseased women: promiscuity, dirtiness, moral depravity, irresponsibility, and lack of intelligence. Of the patient–practitioner interactions described, 27% were coded as meeting the criteria of the moral surveillance model.

In some cases, the practitioners directly attacked the moral character and sexual conduct of their patients. Diana, a 45-year-old, single, African American professional remembered the accusations of her male gynecologist.

At first I didn't know exactly what was wrong with me. I just knew that I was having some pain in my vagina. So I went to go see my gynecologist, and he said, “Well, you know, it looks like you had some really rough sex.” Then, he actually asked, “Did you have some rough sex?” And I said, “Well, I didn't think it was rough - it was passionate.” ... I thought I was going to die, literally die. And, I think that has probably been, up next to a doctor telling me I might need a transplant, probably one of the most devastating moments of my life - ever!

Many feminist scholars have documented the damaging social constructions of African-American women as a “Jezebel” character: hyper-sexual and “naturally” promiscuous, the kind of woman who would seek out “rough” sex (e.g., White, 1985). Diana’s example illustrates how moral surveillance practitioners can be both sexist and racist.

In other cases, medical interactions left a patient feeling that her practitioner doubted both her level of virtue and her intelligence. These women felt as if they had been labeled morally inferior and incapable of avoiding sexual disease. Jasmine, a 20-year-old, White, upper-middle class undergraduate, described her encounter with a female practitioner.

She's like, “Well, you've had unsafe sex?” And, I was like, “Yeah.” She's like, “Well, you know the offer of free condoms here” ... And, I just wanted to pull out my SAT scores and be like, “Just look. I'm not stupid!” ... It really hurt because when you're trying to prove to yourself that you're a good person, and when you hear that from the
doctor it's very unsettling. And, you just walk off feeling like crap ... I remember crying and thinking how can I prove to her that this is not something that I normally do. 

A third variation of the moral surveillance practitioner seemed to display general disgust and revulsion towards their patients. Chris, a 40-year-old, divorced, White professional recalled laying down with her feet propped up in gynecological stirrups that were hinged when her male gynecologist examined during her first genital herpes outbreak. "He just like looked at my crotch and said, 'Yep, that's herpes,' and sort of slammed my knees back together. He like smacked the sides of my legs...I felt shitty. Like, 'Let's close this back up.' You know, like a car, slam the hood down! Don't want to see anymore of this one." Treating the patient as the owner of diseased body parts illustrates an overlap between moral surveillance and biomedical model interaction style. However, only those practitioners who followed the moral surveillance model communicated negative perceptions of their patients' genital anatomy. Jasmine summed up the general complaint with moral surveillance practitioners: "Someone in the health field should be objective about it and should be there to help you and be there to answer questions and not be there to pretty much say, 'You've done the wrong thing.'"

**Biomedical Model**

The women viewed these practitioners as "aloof" and "matter of fact." Todd's (1989) study of communications between gynecologists and female patients found that while practitioners "concentrate on a biomedical approach to the body or organ," the patients' "biological concerns are embedded in broader contextual experiences" (p. 5). This type of practitioner embodies medical expertise by controlling communication flow and making all of the important decisions. Practicing medicine as neutral and scientific, these practitioners definitely sought the cooperation of their patients. However, the female patients' descriptions of diagnostic interactions reflected liberal use of the *medical gaze*, an interactional stance taught in medical schools that helps practitioners to remove their own and their patients' emotions from medical encounters (Baker et al., 1996). Of the patient–practitioner interactions described, 42% were coded as meeting the criteria of the biomedical model. 

In some cases, the practitioners approached the work of medicine from a reductionist standpoint, considering the infected body parts as separate from a social and emotional human being. Summer, a 20-year-old, single,
working-class Native American described her female gynecologist giving her a diagnosis of external HPV.

She walks in like she's telling me I have a tonsil infection or something ... "Oh, you have genital warts." And I'm like, "Okay. So what's that? Are you gonna give me some pills?" And she explains to me that it's not curable. Then she gets me this mirror, and we're doing this funny little thing on the table and she's showing me what they look like. [She didn't ask you if you wanted to see them?]

... Well, I wanted to know, but it didn't feel very good because the moment I saw them, I knew that I'd seen them before, and I remembered who I had seen 'em on. Then she just walked out of the room and left me crying and thinking that I have this fucking disease that will never go away.

It was inappropriate for her practitioner to force her to view her infected genitalia. As illustrated, biomedical model practitioners may be oblivious to the emotional state of their patients, including the possibility that the women could feel both betrayed and angry with themselves for having trusted a partner with visible STD symptoms who had lied about the true cause of these symptoms.

Another variation of the biomedical model practitioner treated patients with blatant insensitivity, however not offering condemnation or explicit moral judgments. Sarah, a 24-year-old, single, Jewish graduate student's memory of her diagnostic interaction began with how her male gynecologist treated her during a cervical biopsy to check for HPV: "He left me with the parting message of: 'We'll find out if you have cervical cancer or not' ... I was contemplating infertility." Her practitioner was oblivious to the impact of his use of the word "cancer," and, in Sarah's case, this was enough to make her seek a female practitioner whom she hoped would show her more sensitivity. She recalled that this male physician was surprised that she was offended by his casual reference to the possibility of cancer.

However, seeking a female practitioner did not guarantee escaping the biomedical model interaction style. Rhonda, a 23-year-old, single, working-class Cuban American, recalled how her female gynecologist had delivered her diagnosis of genital herpes.

It was very sterile throughout the entire experience. I went in, and she looked at me, and she said, "You have herpes." [When you were still in the stirrups?] Yeah, I think so; I think she just gave me a pamphlet. She didn't really tell me that much about it. But, she did tell me that I could not have unprotected sex because I could transmit it. And, I asked about oral sex, and she said, "No, because even when you don't have an outbreak, you can still transmit it." So, she made it seem like I could never receive oral sex again. And, I felt horrible!
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Here, the practitioner’s actions embodied efficiency and impersonality, leaving Rhonda feeling confused and too intimidated to ask for clarification. The women who had diagnostic and treatment interactions with biomedical model practitioners unanimously felt that the practitioners focused on treating the disease, not the patient.

**Patient-Centered Model**

When I concluded interviews by asking what advice these women would give to practitioners, all of them advised practitioners to be more holistic in regard to interaction style: e.g., “show more concern,” “make it easier to ask questions.” In contrast to the two former types, the female patients perceived this third category of practitioners as compassionate and sensitive to the emotional implications of the diagnosis. This type of practitioner–interaction style has been well documented by Canadian researchers (Stewart et al., 1995): the patient’s feelings are explicitly acknowledged by the practitioner, but the patient is not necessarily elevated to full participation. However, patient-centered practitioners do interact with their patients as human beings with agency who have multiple levels of concern (i.e., concerns beyond their immediate physical health and well-being). Of the patient–practitioner interactions described, 31% were coded as meeting the criteria of the patient-centered practitioner.

In all cases of this model, practitioners interacted with patients in ways that showed concern for non-physiological implications of STDs. Gita, a 23-year-old, single, middle-class Persian American described her diagnostic interaction with a female gynecologist.

She didn’t talk to me about HPV with my legs spread open. She put me in her office in a comfortable chair and talked to me. “How are you feeling? What’s going on?” She really got deep with me – she took the time. She didn’t just say, “We’ll freeze them off, this is this, this is that, and you’ll be fine.” She explained that 70% of the population have it and how some people don’t even know that they have it. She sat there with me and went over everything. And, then she said to me, “I give you permission not to look at your vagina for three weeks. I give you permission to feel okay because you’re going to be okay.”

Exemplifying a holistic stance, Gita’s practitioner viewed her in her entirety – rational and irrational emotions included. This practitioner understood that simply telling a woman that her external warts were treatable was not enough to make her feel okay about seeing three-dimensional evidence of a contagious and possibly long-term disease on her genitalia.
In other cases, the practitioners put their patients at ease by taking extra time during both diagnostic and treatment interactions to anticipate questions and facilitate the patient getting all of her questions and concerns addressed. For Lily, a 40-year-old, widowed, White graduate student, the whole atmosphere of the clinic, in addition to her male gynecologist’s interaction style, eased the diagnosis of a severe cervical HPV infection that would require a conization procedure (the most severe treatment before resorting to hysterectomy):

He gained my confidence and was very respectful to me. They all treated me with an incredible amount of respect ... the nurses called you by your first name. It was warm, but there was also a lot of privacy ... I’m not afraid of asking questions, and, I made him explain everything to me ... Sometimes doctors don’t like that, but this doctor preferred it. He preferred that I was involved in my own care and that I understood what was going on ... the doctor told me when I could expect to get the news. He called me himself, at home, and told me the results.

This practitioner’s openness to his patient taking an assertive stance in asking questions, in addition to him taking the time to personally deliver her diagnosis distinguished him as a patient-centered practitioner. The majority of moral surveillance practitioners and biomedical model practitioners had less considerate ways of delivering diagnoses: ranging from not all (jumping straight into treatment without every sharing the diagnosis), to having staff leave messages on patients’ answering machines (with no regard that the patient might share a phone line with family members or roommates).

Another variation of patient-centered practitioners displayed a more subtle empathy. Marissa, a 31-year-old, single, Hispanic graduate student explained how her male gynecologist put her at ease, both during the diagnosis and treatment for external genital warts.

He was very nice because it was an awful thing. And I just felt lousy about the whole thing. So he just made small talk with me, but I felt so awful. [He made you feel more okay about what was going on?] Yeah. It was like this isn’t a big deal. He just sat and talked to me about his daughter who played tennis and about my trip to London for the summer.

Marissa’s practitioner recognized her distress, and gently distracted her so that her first wart removal was less traumatic. The women described patient-centered practitioners as coming to the STD encounter with assumptions that their patients may be experiencing both discomfort and shame. Patient-centered practitioners showed that they understood STDs as a social experience and interacted with patients in ways that were sensitive to the emotional and moral implications of their patients’ diagnoses. This type of
practitioner made sure to never give diagnoses when their patients were in compromising positions (e.g., half-undressed and legs up in stirrups).

Delivery of Healthcare Services

Both the practitioners' interaction style and also their gender affected patient interactions. Analysis of interaction style by gender reveals differences that are, in turn, reflected by female patients' preferences of not only particular interaction styles, but also practitioner's sex/gender. In addition, the women's illness narratives reveal several underlying health risks associated with practitioner interaction style.

Practitioner Sex/Gender: A Factor in Interaction Style

Parsons (1951) characterized patients as, "helpless, technically incompetent and too emotionally involved, therefore needing to put (themselves) into the hands of a professional who is technically expert, functionally specific and affectively neutral" (p. 456). Zola (1991) observed that this description of normative patient–doctor interaction roles sounded, "uncomfortably similar to the way in which society, through much of its history, has thought of female–male relationships" (p. 7). The data in this study support the relevance of gender roles and norms in how female patients view their interactions with sexual health practitioners.

Of the 62 sexual health encounters described, 40 were with female practitioners and 22 with male practitioners. Breaking down the frequency of practitioner interaction style by the gender of the practitioner revealed systematic patterns (see Table 1). A chi-square analysis was performed to determine the statistical significance of the association between practitioner gender and practitioner interaction style. Generally, male practitioners were overrepresented in moral surveillance interactions, and female practitioners were overrepresented in biomedical model interactions. The findings suggest that practitioner gender is an important and statistically significant factor in practitioner interaction style (p < .05). Slightly more than half of the female practitioners (52.5%) had been described as interacting in the biomedical model style, while the female patients had described half of the male practitioners (50%) as interacting through the moral surveillance model. More female practitioners (37.5%) than male practitioners (27.3%) were described as fitting the patient-centered model.

While sample size prevents any claims of generalizability, analysis of these data reveals intriguing questions and grounded theoretical explanations.
Table 1. Frequency of Practitioner Interaction Style by Sex of Practitioner \( (n = 62) \).

<table>
<thead>
<tr>
<th>Practitioner’s Sex</th>
<th>Patient’s Perception of Practitioner’s Interaction Style</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Moral surveillance model</td>
<td>Biomedical model</td>
</tr>
<tr>
<td>Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>52.5%</td>
</tr>
<tr>
<td></td>
<td>(4)</td>
<td>(21)</td>
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<td>22.7%</td>
</tr>
<tr>
<td></td>
<td>(11)</td>
<td>(5)</td>
</tr>
<tr>
<td>Totals</td>
<td>24.2%</td>
<td>42%</td>
</tr>
<tr>
<td></td>
<td>(15)</td>
<td>(26)</td>
</tr>
</tbody>
</table>

\( x^2 = 7.25, df = 2, p < .05. \)

An alarming proportion of male practitioners fit the moral surveillance model of interaction. As the beginning of this chapter documents, research shows that the medical profession has long seen itself in the role of moral surveillance – especially on issues of sexual health. In keeping with Habermas’ (1970) theory that science legitimates current patterns of domination, I propose that these factors combine with pervasive cultural constructions of females as inferior to foster misogynistic moralizing on the part of male doctors towards “fallen women.”

Only 22.7% of the male practitioners were described as fitting the biomedical model of interaction style, but 52.5% of female practitioners fit this style. This gender discrepancy fits research findings on gender norms in many male professions, including medicine. Drawing on Hinze’s (1999) study, the structure of the gender prestige hierarchy in medicine elevates masculine images and symbols. Therefore, I suggest that many female practitioners felt professional pressure and were socialized to masculinize their interaction style by employing interaction techniques such as affective neutrality, thereby pursuing a biomedical model approach with their patients. Acker’s (1990) work supports this hypothesis, arguing that female professionals feel pressure to de-emphasize their feminine qualities in order to be successful in male hierarchical medical professions.

Even with the majority of female practitioners fitting the biomedical model, the majority of the female patients (82.5%) ultimately choose to see a female practitioner for sexual health services. Their choices may be evidence of the women’s intuitive knowledge of gender disparity in moral surveillance interaction style. Approximately 38% of the women switched from seeing male practitioners for their first gynecological exams to seeing female
practitioners for STD diagnosis and/or treatment. Gloria, a 48-year-old, single, Chicana graduate student explained her rationale for choosing female practitioners.

I started demanding female doctors — I don't see male doctors anymore. I don't allow them to poke in my privates anymore... They were insensitive, harsh with the way they would look in my area. I just didn't feel like they were gentle at all. Their hands were too big... and it just didn't feel like they cared that much. That's what it was — I felt like cattle being herded through an office.

This strong preference reflects the women’s fairly uniform rationale that female practitioners are more likely to interact with them in a patient-centered manner, which they often saw equivalent to exhibiting feminine traits (e.g., being good listeners, showing compassion, etc.). However, the female patients' overall views of female practitioners did not match their detailed descriptions of specific interactions with these same practitioners: 62.5% of the female practitioners fit either the moral surveillance or biomedical models of interaction style.

A minority of the women, 17.5%, switched to or continued to see male sexual health practitioners. Rhonda, a 23-year-old, single Cuban American explained her preference for male gynecologists.

Women might be a little harder on you — they know where you’re coming from, so they don’t treat you with kid gloves. I think maybe a male doctor would treat you a little bit more cautiously because he’s not really sure if he’s treading on sensitive feelings. You know, he doesn’t have firsthand knowledge of what you’re going through and what’s going on with you... I think he might be more cautious.

Her rationale reflects the belief of a few women that a gender mismatch between patient and practitioner might lead to more polite interactions. In addition, I suggest that the small number of female patients who prefer and remain loyal to male practitioners might do so because of exposure to and belief in occupational gender norms of male prestige and expertise in medicine. However, as Pam, a 42-year-old White working-class graduate student pointed out, “class is an important factor in being able to choose a doctor by gender.” She sees the fact that she ultimately was treated by a male practitioner as a result of socioeconomic restrictions that prevented her from being able to see a female practitioner, her true preference.

**Interaction Style as Risk to Patient Health**

Behind the statistics in Table 1 are stories about the health damage done to these female patients by practitioners who employed moral surveillance and biomedical model styles of interaction in the examination room.
The women’s narratives revealed that practitioners who fit the moral surveillance and biomedical models of interaction style directly damaged patients’ physical health because they were the most prone to delivering inaccurate and incomplete information. Moral surveillance and biomedical model practitioners were not empathetic and, therefore, failed to accurately predict what types of information their patients most needed during STD diagnostic and/or treatment encounters.

The data revealed that practitioners whose interaction styles could be classified under the moral surveillance or biomedical models were responsible for every case of a practitioner giving significantly incorrect medical information. Helena, a 31-year-old Greek-American graduate student, describes having been given incorrect and incomplete information about HPV. “There was never any discussion about [HPV] ... There was really no, ‘this is what you should do, this is what you shouldn’t do from now on’ ... There wasn’t any discussion like, ‘And, you have this for the rest of your life, and you may get cervical cancer from it.’”

As illustrated by Helena’s recollection, some of the biomedical model practitioners did not fully explain the chronic nature of herpes and HPV. The women in these situations reflected that while the absence of this vital information made them calmer in the doctor’s office, they were more upset and confused later when they found out the truth from other sources (e.g., the internet, pamphlets, friends, etc.). Francine remembered feeling calm when she and her partner were given genital warts diagnoses, “because as far as we knew, once we got rid of them we didn’t have this anymore.” Similarly, Helena felt like her practitioner was going to treat her external genital warts, “and then everything was going to be fine ... because nothing else was really explained.”

In addition, those practitioners who employed a moral surveillance style of interaction ended up damaging their patients’ psychological perceptions of well-being. Diana remembered holding back her tears until after her practitioner had finished delivering her herpes diagnosis over the phone.

1 let down right after he hung up. I was crying all over the house. I was just a basket case then. I called my shrink and was just hysterical over the phone ... He said, “Well, I think you need to come in tomorrow, and we'll talk about it ... I was just devastated – I was very depressed. I remember getting in the bed, you know, just pulling the covers over my head and not wanting to ever come out.

Helena also left her diagnosis emotionally distraught: “I just came home from the doctor and felt so dirty.” Jamie, an 18-year-old, White, upper middle-class undergraduate painfully recalled that she left her diagnostic
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In contrast to the above scenarios, one patient-centered practitioner turned the diagnosis and treatment for genital herpes into a positive medical encounter and an opportunity to assess the patient's total sexual health. Elle, a 32-year-old white, working-class graduate student, described her female practitioner as having used her diagnostic encounter to make her herpes diagnosis feel more manageable. The practitioner explained to Elle that, while herpes may be incurable, it also may not be forever a symptomatic condition. In addition, Elle's practitioner asked if she wanted to be tested for other STDs. Elle explained that being treated with respect helped her to respect the practitioner's recommendation, and she decided to get the "full screening" for STDs at that appointment.

CONCLUSIONS

The women's illness narratives portray sexual health practitioners most often as agents of health (biomedical model) and social control (moral surveillance model). However, they clearly express a preference for and appreciation of health agents with a holistic focus (patient-centered model). With regard to practitioner sex/gender, the women's preferences for female sexual health practitioners reflect an experiential desire to avoid practitioners who utilize a moral surveillance interaction style. Despite the fact that the women's accounts described only 37.5% of female practitioners as fitting the patient-centered model of interaction style, their overall selection of female practitioners coexists with an expressed preference for more patient-centered interactions. This contradiction of realities suggests that gendered expectations of feminine traits (ones that overlap strongly with patient-centered/holistic traits) may bias female patients' assumptions of female practitioners' interaction styles, thereby affecting their choice of female sexual health practitioners. Further research with a larger sample could help to illuminate the complex relationships between the sex/gender of both patients' and practitioners', practitioner interaction style, patient satisfaction/comfort, perceived interactional constructions of morality, and patient compliance.

There are public health costs of moral surveillance and biomedical interaction styles. First, this study and others have demonstrated that non-compliance with medical practitioners' recommendations for treatment and/or behavioral changes is more likely to occur when a patient feels judged by
their practitioners. Second, patients are less likely to feel comfortable asking questions and getting clarifications about diagnoses or treatment plans when they perceive their practitioners as being judgmental (moral surveillance model) or distant (biomedical model). This can lead to patients not understanding the nature (chronic or curable) or their illness or the ramifications of their illness for others (e.g., modes of transmission). Finally, an interaction with a practitioner who communicates condemnation of a patient based on that patient’s illness can lead to that patient experiencing mental health trauma: for example, anxiety about how others will perceive them or depression over seeing themselves as a bad person who brought this illness upon themselves.

In contrast, there are public health benefits of more practitioners embracing a patient-centered interaction style. The patient-centered model of interaction can produce patients who will be more likely to follow medical treatment plans and modify risky behaviors because they will not only understand their medical pathways toward healing, but they will also believe that they deserve to get well. If promoting health is our goal, then we must protect the moral identities of patients and empower them to get the information they need during interactions with their practitioners.

In practical terms, how might we accomplish this goal? By changing the way we train health practitioners and by adding professional health educators to the medical team. This study shows how practitioner interaction style might introduce stigma and shame into patients’ medical encounters. If public health is our goal, then we must train medical practitioners to interact with patients in ways which protect patients’ views of themselves as “good” people who do not deserve their illnesses. Ideally, the style and focus of medical training would incorporate holistic goals of patient-centered healthcare. Realistically, professional and economic constraints make it likely for the biomedical model of practitioner interaction style to remain dominant. In this case, professional health educators should be added to the medical team. They can educate patients about symptoms and treatment options and also offer psychological/emotional support, complementary to the technical expertise provided by medical practitioners. Research on changing student physicians’ views on authority in physician-patient relationships shows that “humanistic training” is partly responsible for a shift away from the biomedical model of interaction (Lavin, Haug, Belgrave, & Breslau, 1987). In the case of the moral surveillance model, I contend that there are public health benefits, in the form of patients’ emotional well-being and compliance, to eliminating professional and social acceptance of this practitioner–patient interaction style. My study echoes
findings of research on HIV treatment and counseling: safeguarding the moral statuses of patients is vital to achieving compliance (Plumridge & Chetwynd, 1998).

If we are to create effective treatment programs for stigmatized illnesses, then we have to eliminate the moral judgments of medical practitioners and the social constructions of these conditions being “deserved” and caused by “bad” behavior. Brandt (1997, p. 68) warned that unhealthy behaviors “such as cigarette smoking are sociocultural phenomena, not merely individual or necessarily rational choices.” Therefore, labeling a health condition as deviant will not discourage individuals from engaging in high-risk and/or unhealthy behaviors. In the case of contagious illnesses, such as STDs, patient non-compliance can result in others becoming infected. While in the case of non-contagious illnesses, non-compliance may result in stress for caretakers or endanger the general public (e.g., driving under the influence of drugs or alcohol).

A concerted effort to promote the patient-centered model of practitioner-patient interaction can increase the numbers of patients who are compliant (with treatment plans and behavior modifications) because they will better understand the medical pathways toward healing and they will believe that they deserve to get well.

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Practitioner Interaction in the Treatment of Women with Chronic STDs


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