POWER AND RESISTANCE IN THE MEDICAL ENCOUNTER: A MACEDONIAN CASE STUDY OF THE RELATIONSHIP BETWEEN WOMEN PATIENTS AND MALE PHYSICIANS

By

Elena Anchevska

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Supervisor: Associate Professor Eva Fodor
Second Reader: Professor Judit Sandor

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Abstract

Based on ethnographic research in three gynecological clinics in Skopje, Macedonia and seventeen semi-structured interviewees with patients, this thesis aims to explore the relationship between female patients and male physicians (mainly gynecologists and surgeons) in primary and secondary health care settings in contemporary Macedonia. I examine the ways in which power and resistance underlie and inform both physicians and patients' actions and expectations in the process of treatment management and care, by exploring what women's experiences of medical interactions can uncover about the underlying power relations and possible strategies of resistance. I argue that Macedonian women patients often recognize and accept the power imbalance apparent in their encounters with their physicians; usually they do not challenge the medical authority of their doctors and are aware of their subordinate/passive position (which is commonly attributed to the doctors' specialized knowledge and their self-perceived lack of familiarity with medical information). However, women are not simply passive recipients of care; thus I explore the discrepancies and discontinuities in women's passivity in medical power relations in which they manifest their agency by directly challenging the medical knowledge and advice of the physicians, by opting out or by limiting their exposure to medical interactions, by non-compliance with prescribed therapy and/or use of alternative medicine and by seeking for second opinion or by changing the physician with whom they experienced problematic interactions.

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I dedicate this thesis to my mother, Snezana Anchevska

Table of Contents

Introduction

This thesis is somewhat a personal narrative; the idea for its creation was conceived as a result of my encounters with patients in the role of a health provider, and my experiences with physicians in a position of a patient. My particular research interest in gender and health, and more specifically in women's reproductive and gynecological issues is a result of my engagement as a nurse (mostly as an intern and volunteer nurse) in several gynecological clinics in Skopje, Macedonia, as well as of my own personal accounts of being a patient. As a nurse, I have frequently been engaged in medical interactions with physicians. However, it was a personal problematic experience with a physician long before my interest in pursuing a degree in Gender Studies which prompted me to explore the physician-patient relationship in the context of Macedonian health care from the perspective of women patients. I firmly believe that it is significant to position myself from the beginning as woman coming from Macedonia, a nurse, and a feminist because I am aware that these categories have influenced my way of thinking and the way this research was conveyed and presented in the form of this final thesis. Whether it's menstruation, contraception, fertility or infertility, abortion, childbirth, menopause or another gynecological condition or disease, in the course of her life every woman inevitably faces health issues related to the female reproductive system. During the encounters with patients and physicians it became apparent to me that in the process of providing and receiving medical care the doctor-patient relationship is a central feature which shapes and influences patients' experiences with illness and health care.

Based on ethnographic research in three gynecological clinics in Skopje, Macedonia and seventeen semi-structured interviewees with patients, this thesis aims to explore the relationship between female patients and male physicians (mainly gynecologists and surgeons) in primary and secondary health care settings in contemporary Macedonia. I examine the ways in which power and resistance underlie and inform both physicians and patients' actions and expectations in the process of treatment management and care, by exploring what women's experiences of medical interactions can uncover about the underlying power relations and possible strategies of resistance. I focus on women's lived experiences and their personal accounts of treatment management and care while aiming to reveal the complexities of doctor-patient relationship and women's expectations/demands surrounding it. The analysis extends further from a simple exposition of women's perceptions of their relationship with their male physicians and the power relationship which lies beneath it. Instead, it aims at exploring how medical power relations produce both the compliance and resistance of the patient and influence expectations and participation in treatment decision making, while acknowledging that the doctor-patient relationship does not occur in social vacuum and it is in fact embedded in social context. In the particular case of Macedonia this refers to the country's socialist heritage and its effects on the doctor-patient relationship, more specifically on the paternalistic treatment evident in their interaction, but it also refers to the recent attempts towards creating "informed and empowered" patients according to EU standards, as a result of the enactment of the Law on Protection of Patients Rights.

As many commentators, and most recently Pilnick and Dingwall (2011) have suggested, the doctor-patient relationship has been persistently described as an asymmetric relationship based on hierarchies of power in which the doctor assumes dominant position due to his medical authority and specialized medical knowledge. By examining the physician-patient relationship in a broader context which focuses on the Macedonian health care system and the social, political and economic factors which influence the relationship, I argue that Macedonian women recognize and accept (and on occasions, invite) the power imbalance apparent in their encounters with their physicians; they do not challenge the medical authority of their doctors and are aware of their subordinate position (which is commonly contributed to their self-perceived lack of medical knowledge and information). However, they are not simply passive recipients of care; in their complex responses in the process of receiving care they employ various strategies through which their agency is manifested and which enable them to (re)negotiate their roles and responsibilities in their attempt to secure better treatment and health outcomes.

Although numerous authors have consistently shown that the doctor-patient relationship has a valuable impact not only on patients' preferences for participation in medical decision-making and health care, but also on possible health outcomes, little is known how Macedonian women perceive their relationship with their doctors, nor what possible implications this may have on their participation and engagement in the treatment decision-making, management and care. This thesis aims to contribute to the existing literature on treatment decision making by examining why female patients are reluctant to actively engage in the decision making process, while exploring the doctor-patient relationship in a particular post-socialist context in health care settings in Macedonia. It also engages in exploring the strategies of resistance women patient employ in their pursuit for achieving desired health status.

In the following chapters I first provide the theoretical framework, which informs my study, and I explain how my thesis is situated within a wider theoretical discussion by exploring concepts such as power, resistance and medical decision making. In the methodological chapter I describe how this study was conducted from the initial stage of participant observation and interviewing, to the analysis and interpretation of data, while also reflecting on my position as a researcher. In the third, analytical chapter of the thesis I present an analysis of the interviews and the data gathered during participant observations and I aim to demonstrate how Macedonian women patients recognize and accept the power imbalance in the medical encounter by appropriating a rather passive position in treatment management and care, and the strategies of resistance they use, such as challenging the physician’s expert knowledge in a direct manner, or they employ more subtle forms of subversion, such as non-compliance with prescribed therapy, seeking for a second opinion, limiting their involvement in medical interactions or relying on other forms of knowledge and using non-biomedical (or a combination of biomedical and non-biomedical) treatment, in order to maximize their health status and secure better health outcomes.

Chapter 1: Contextual Background

Macedonia[1] is a relatively young country situated in the heart of Balkan Peninsula. In the past two decades, after gaining its independence, the country underwent political, economic and social changes as a result of the disintegration of Yugoslavia. In order to understand the context in which the physician-patient relationship occurs, a description of the Macedonian health care system is in place. The Macedonian health care system has been subjected to number of reforms in recent history similar to the other countries in the region. Twenty years after its peaceful succession from Yugoslavia, the country is still struggling to establish a suitable and highly functioning health care and health insurance model.

Three crucial periods have marked the development of the Macedonian health care system. First, during socialist times, the health care system was highly autonomous and disjointed. Furthermore, after the independence and the transition towards democracy, a centralized health model was introduced. Finally, recent developments indicate tendency towards decentralization.

As part of Federal Yugoslavia, the health care in Socialist Macedonia was highly decentralized and managed on a municipality level. The autonomous provision of health care services operated by thirty municipalities led to disjoint service delivery and replication of services and facilities. Even though after the independence the health care system was transformed into a centralized management model, the legacy from the socialist health care system still has it effects on the current system, thus the latter is characterized by "overprovision,

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[1] Until 1991, Macedonia was one of the six federal republics and two autonomous regions of Socialist Federal Republic of Yugoslavia. After the disintegration of Yugoslavia, Macedonia declared its independence on 8th of September 1991. With territory of 25.713 km2 and population of approximately 2 million citizens, Macedonia is a multiethnic country with 61% Macedonians, 25% ethic Albanians, 3% Turks, 2% Roma and other ethic groups. 58% of the population resides in urban areas, and out of those 58%, 25% resides in the capital city Skopje.

inefficiency, and duplication of services, capacities and equipment”(Center for Research and Policy Making, 2007). The heritage of inefficiency, a common feature not just in the Macedonian case but also in the other post-socialist countries, lies in the Yugoslavian health care system and the broader context of the political and economic structure (Istenic, 1995).

During socialist times, the state took the role of a parent by establishing and catering to the needs of the citizens-children (Verdery, 1996). In this set of relations, the citizens “were presumed to be grateful recipients- like small children in a family- of the benefits their rulers decided upon them” (Ibid, p.63), a state which Verdery terms as “socialist paternalism”. In regards to the delivery of health care services, the health care system reflected the wider political and economic settings, which suggests that health care services were constitutionally granted to all citizens and were free of charge (or with minimal participation). Thus health care services were distributed as ‘charity’ or even as gifts to the population by the state, and health protection was considered as public responsibility. This, on the other hand, precluded awareness on behalf of the patients for their rights in the medical encounter and created ‘rights vacuum’ uncharacteristic for Western countries with long tradition of rights awareness but typical for socialist countries. On an individual level, the doctor-patient relationship was highly hierarchal with patients “deferring to the ‘professional mystique’ of physicians”, while physicians maintained significant prestige in the society despite their low-income salaries in comparison to physicians in capitalistic countries (Parmelee *et al.,* 1982). Physicians retained higher status in the society in relation to other workers in spite of sporadic campaigns to equalize their status (Ibid). In this respect, the power imbalance in the medical encounter was evident; however, this does not mean that patients were rendered helpless in navigating the medical system. For instance, a common occurrence and characteristic of the dynamics of physician-patient relationship was the use of bribes or payment gratitudes (money or gifts) and ‘connections’ as a manner for patients to “get around the system more easily” (Ibid, p.1392). Furthermore, one way in which state-level bureaucracy was manifested is through limiting the access of health care on a communal level, which meant that each resident was obliged to receive health care specifically in the commune in which she or he resided (Ibid.). However, members of the Communist Party or people with ‘connections’ were able to receive medical care in a place and from a physician of their own preference (Ibid.)

Although the state health sector in Federal Yugoslavia was highly decentralized, with the municipalities having the management and operational power, as Nordyke (2000) suggests, the administration of the municipalities was greatly bureaucratic, “merely duplicating the state-level bureaucracy they were designed to replace” (p. 17) and were subjected to state intervention which was a result of the primary responsibility of the central government in allocation of resources.

After the disintegration of Yugoslavia, the Macedonian Parliament adopted the Health Care Law in August 1991 which provided the legal basis for the establishment of the current health care system. As a result of the necessity for central health planning in the newly independent country, the Ministry of Health was established together with the Health Insurance Fund which enabled strengthening of the centralized health care system. However, in 1996 the need for further reforms was recognized and with the help of the World Bank which provided the funding, the Health Sector Transition Project was introduced, aiming to advance the efficiency and quality of primary health care by increasing the role of the market in health care services.

Additionally, following the Ohrid Framework Agreement[2] from 2001, the Macedonian health care system is going through another process of decentralization. The purpose of the latest reforms, among other goals, is to provide more patient-centered care and to enhance patients' participation. As Kjosev and Nedanovski (2008) state: "the objectives are to improve the population's health by improving access to and quality of basic health services; to increase the efficiency of service delivery; and to improve patient choice within the health system" (p. 73).

In order to improve the delivery of health care services, to increase patient choice and to enhance access to information for the patients, in July 2008 the Macedonian parliament endorsed the Law on Protection of Patients Rights. The law establishes the rights and obligations of patients and health care providers by introducing a system for patient protection according to European standards. The Law on Protection of Patients Rights is the first single law regulating the rights of patients. Prior to the endorsement of the law, the rights of patients were regulated in a number of health care and health insurance laws such as the Health Law of 1970 and the Law for Healthcare of 1983 in Federal Yugoslavia. Subsequent to the independence of the country, patients' rights were more extensively regulated in the Health Care Law of 1991. Nevertheless, the Law on Protection of Patients Rights is the first systemized legislation directly regulating patients' rights (Milevska-Kostova, 2006).

The Law on Protection of Patients Rights defines and regulates the right of the patient to accessible health care; the right to free choice of physician and health care service; the right to participate in decision-making (to consent or to refuse medical intervention); the right to all kinds of information regarding health status, diagnosis, possible options for treatment, positive and negative outcomes of medical procedures and different treatment alternatives. The

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[2] The Ohrid Framework Agreement put an end to the war crisis between government security forces and ethnic Albanian rebels.

information should be provided in an understandable manner for the patient with minimal use of specialized medical terminology. Furthermore, the law stipulates the right to ask for a second opinion; the right of information about the name and credentials of medical personnel performing medical interventions; the right to refuse information; the right to have access to the patients' medical files; and the right to confidentiality and privacy of personal data.

A heated public debate and strong opposition from the medical establishment preceded the adoption of the law. The law is intended to provide better access to information for patients and to increase their participation. However, the Macedonian medical community completely rejected the law because it considered it (and still continues to consider it) as a tool to decrease physicians' power. The law was not perceived as an efficient mechanism to improve the relationship between patients and medical personnel, but instead was seen as a way for patients to contest doctors' decisions and to challenge doctors' authority regarding treatment. As a result, the adoption of the law underwent a complicated and lengthy procedure and was disputed both during parliamentary and media debates (Lazarevik, 2010).

The adoption of the law was a response to the growing international pressure and the activism of the civil sector. It aimed to improve the position of the patients in the physician-patient relationship and to improve access to information and patient participation in the communication with medical establishment. This law was much needed because as Lazarevik (2010) points out: "In Macedonia in the transition years there were number of situations in the hospitals when patient's rights were violated, patients felt unpleasant, and their privacy and dignity was harmed" (p.58). On more than one occasion, patients did not receive the necessary information on various options for treatment and the different possibilities and outcomes of each option (Ibid).

Similarly, according to a study of 282 participants conducted in Macedonia in 2006, 80% of the interviewees were not aware of the rights they have, the benefits from or the mere existence of patients' rights. Furthermore, an astonishing 90.8% of the interviewees expressed their satisfaction (56% very and 34.8% on average) with the services and medical care they received; more then 60% never deliberately went to see another physician or to ask for a second opinion. Moreover, 86.5% of the interviewees believed that the doctor prescribed the best possible medications and therapy for them, and 93.6% followed the advices given by their doctors and complied as much as they could with the physicians' recommendations. Although the right to file a complaint is stipulated in the legislation which regulates patients' rights, 84-86% never had any questions, concerns or complaints about the medical procedures and services they received (Milevska-Kostova, 2006). The study was conducted before the endorsement of the Law on Protection of Patients Rights, and it's not just a descriptive illustration of the level of information and participation of Macedonian patients in the physician-patient relationship, but it also confirms the need for an appropriate, systemized legislation in the field of patients' rights.

Nevertheless, the adequate implementation of the law presents a serious challenge under the circumstances mentioned above. The patients are often not informed about their rights and most of the doctors oppose the law since they see it as threat to their decision-making power. As Lazarevik concludes, the key challenge for the implementation is to find a proper strategy for communication of the law, both to the patients and the medical establishment. As he points out, the implementation of the law would be even more challenging for less educated, vulnerable and disadvantaged groups. Therefore, the process of implementation might last for several more years for the law to be put into practice and for the patients to see the benefits of it (Lazarevik, 2010).

1.1 Reproductive health in Macedonia

The delivery of health care services related to sexual and reproductive health of women is organized on a primary, secondary and tertiary level. Gynecologists and obstetricians provide their services predominantly in the primary health care system, which was subjected to privatization in 2006. In 2008, 308 gynecologists and obstetricians were employed in health care facilities on the territory of the whole country. In comparison to other age groups, women in the age range of 24-35 most frequently require health care services with a rate of 30.4%. According to the 2010 Annual Report of the Macedonian Institute of Public Health, 50% of women's total morbidity rate is as result of genitourinary diseases, 8% of the total number of diagnosis is related to pregnancy and child delivery, whereas 4.8% are associated with neoplasms. The prevalence of malign neoplasms (breast and cervical cancer) is in the rise. In the period of 1995-1997 the number of newly diagnosed women patients with breast cancer increased from 536 to 670. Annually, 66 women are diagnosed with breast cancer and 20 with cervical cancer out of 100 000 women. Macedonia is a country with a high mortality rate linked to breast and cervical cancer, even though there is a possibility for early detection (and with that better treatment) of these conditions.

Situating this research in a broader social context of provision of health care services, while at the same time describing various legal and political factors which influence the dynamics of medical interactions is crucial for understanding the complexities of the physician-patient relationship in contemporary Macedonia. After portraying the circumstances in which the doctor-patient relationship takes place, I turn to examining the scholarship this study draws upon.

Chapter 2: Literature Review

In this chapter I outline the theories and literature, which inform my study. A vast body of literature explores the notion of power and resistance in the context of physician-patient relationship. I mainly draw upon research conducted in Western countries[3] since to my knowledge; the doctor-patient relationship in respect to power and resistance is relatively understudied area in Central and Eastern Europe, and especially in Macedonia.

2.1 Physicians' exercise of power over patients

Power is not a new concept. In fact, it is “as old as (social) science itself” (Davis, 1991, p.7). Starting from Weber's (1978) conceptualization of power, where he defines it as “the chance of man or a number of men to realize their own will in a communal action even against the resistance of others” (p.926), power has been described as “inherently asymmetrical” (Davis, 1991; Turner, 1992; Goodrich, 1991; Lupton, 1997).

What possible explanations provide insight to the existing power asymmetry which impedes patients from achieving autonomy and agency? Some authors perceive the asymmetry in power as necessary and beneficiary since it encourages “the most able to perform the most highly skilled roles” in the interest of both parties of the power relationship (Lupton, 1994; Cash, 1997; Pilnick & Dingwall, 2011) by assuming that that the medical establishment serves in the best interests of patients on the basis of their medical authority. One of the most influential scholars in functionalist theory and its application to medicine, Talcot Parsons, in his classical representation of social roles and expectations in health care introduces the characteristics and

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[3] Here I refer to the literature from the United States, United Kingdom, Canada, Australia and Western Europe.

demands of the ‘sick role’. According to Parsons, an individual affected by serious illness is forced to rely on the assistance and it is impeded from performing the expected social roles (Parsons, 1954). Hence, “people who enter the sick role should desire wellness and seek competent help; in return they are released from usual duties and freed from blame for being sick” (Sinding *et al.*, 2010, p.1094). Following the attempt to receive medical care, the person who appropriates the sick role is expected to place her trust in the medical expertise of her physician and to act in accordance to his directives. Here, the asymmetry of power is crucial in asserting the authority of the physician and in achieving patient compliance (Lorber, 1997). Consequently, medical authority or dominance is perceived as an essential and necessary component and mechanism for maintaining physicians’ control over patients’ health by demanding compliance on the part of the patient and with intent to act and serve in the patient’s best interest (Lupton, 1994; Hayry, 1991).

Some authors argue that power in the medical encounter is achieved and sustained by maintaining monopoly of medical truth claims on the part of the physician (Lee & Garvin, 2003), which, on the other hand, is exercised through control over discourse and the use of medical expert language (Margolis, 1996). By relying on their superior specialized medical knowledge, the medical profession evokes “self-evident epistemic authority” over their patients to legitimize their actions allegedly performed in “the patient’s best interest” (Hayry, 1991). The use of specialized language perpetuates hierarchies of power by positioning the physician as expert and the patient as layperson which reinforces “the expert/lay divide by making useable knowledge unavailable to the layperson and by setting boundaries around knowledge and information” (Lee & Garvin, 2003, p.451). In this respect, as number of researchers have shown, one way in which physicians exercise power over patients is by limiting or restricting access to treatment alternatives by avoiding of explicit mentioning of different treatment options (Gattellari *et al.*, 2002; Braddock *et al.*, 1999). For instance, Gattellari *et al.*, (2002) found that during oncology consultations, less then one in two patients were offered different treatment options, whereas in primary care consultations only 11% of patients were given treatment alternatives. As far as surgical decisions are concerned, in their study of decision making surrounding hysterectomy, Entwistle *et al.*, (2006) reported that between 26% and 65% of women were either not well informed of different alternatives or they weren't given a say in the decision making process.

The extent to which power is exercised in the medical interactions varies upon the model of doctor-patient relationship. Four models of doctor-patient relationships are most frequently discussed in the literature: the paternalistic model, the informative or consumer model, the interpretive model and the deliberative model (Emanuel & Emanuel, 1992; Charles *et al.*, 1997). On the power-scale in medical interactions, the paternalistic model and the informative or consumerist model are on opposite sides of the spectrum. According to Emanuel and Emanuel (1992), in the paternalistic model of doctor-patient relationship, in the attempt to improve the health status of the patients, the physician is entitled to decide what course of treatment is most suitable for the patient, while assuming to be acting in the patient's best interest. Often overwhelmed by illness, patients put their trust in the doctor's expertise because "deep in patients' consciousness, physicians are viewed as miracle workers, patterned after the fantasized, all-caring parents of infancy. Medicine, after all, was born in magic and religion, and the doctor-priest-magician-parent unity that persists in patients' unconsciousness cannot be broken" (Katz, 1984 as cited in Lupton, 1994, p.106). The historical imbalance in power between physicians and patients due the specialized knowledge and skills of physicians created a relationship resembling father treating a child, thus was inherently labeled as paternalistic (McCoy, 2008). Consequently, as Lupton (1994) argues: “the complex relationship between patient and doctor is like that between a parent and a child, with patients relying upon doctors to tend to their physical and emotional needs, to nurture and protect them and to take control of a frightening and anxiety provoking situation” (p.106). Thus the physician is in charge of making the decision in the name of the patient, while patient participation is excluded or almost excluded. Although this model is considered to be outdated in Western countries, it is still considered to be applicable in emergency situations.

On the other hand, in the consumerist model, most of the power in the medical encounter is rendered to the patient because the patient is responsible for making treatment decisions, in spite of doctor’s suggestions and directions, while the doctor’s role is to provide information which will enable and facilitate the decision making process (Emanuel & Emanuel, 1992). From this aspect, the doctor is perceived as a provider of information rather then a decision maker, which ultimately results with lesser power for the doctor. Although some researchers have argued that different models may be appropriate in different clinical settings (Falkum & Forde, 2001) and others (Charles *et al.,* 1999) have suggested that there is uncertainty and overlap in regards to what these models include and how they are applicable on a practical level, the theoretical models outlined above point out to the discrepancy and variety of the degree of power exercised on the part of physicians and patients, depending on which model is predominant in the medical interactions.

The focus on more recent sociological studies which explore the doctor-patient relationship is related to measurement of patients’ satisfaction (for a review of the research see Buetow, 1995) and patients’ preference for involvement in decision making (for a narrative review see Say *et al.,* 2006). Patients’ participation and patients’ preferences for involvement in treatment management and decision making process are important components which shape the power relationship between the physician and the patient. Researchers have shown that diagnosis and health status may affect and influence patients' preference for involvement in treatment management and decision making which may influence the medical power relations. Researchers have noted that patients with more serious, life-threatening illnesses are less like to actively participate in treatment decision making in comparison to less ill patients (Arora & McHorney, 2000; Catalan *et al.*, 1994). In these circumstances, patients are reluctant to actively engage in the process of treatment and care, preferring to place their trust in their doctor, to surrender their autonomy and avoid possible responsibility surrounding the illness. For instance, in their quantitative study of 2197 patients with chronic diseases, Arora and McHorney (2000) found that patients with hypertension are more likely to assume more active role in the treatment process, rendering lesser power and control in the hands of their physicians, in comparison to patients suffering from diabetes or heart problems.

Demographic variables such as gender, age and education have also been reported to be important in establishing patients' preference for involvement. For instance, most of the studies, which explore the relationship between age, education and patient involvement, suggest that younger, better educated people prefer more active involvement (Degner & Sloan, 1992, Buttow *et al.*, 1997). More importantly, number of studies which investigate the association between sex and decision making preference, suggest that women are more likely to prefer an active role in the medical encounter in comparison to men (Arora & McHorney, 2000). By assuming active role in the treatment decision making process women patients may influence the extent to which power may be exercised on that part of the physician. However, when discussing women's preferences for participation it is important to take into consideration that women enter medical encounters and health care systems more frequently than men (Doyal, 1995); their symptoms are more likely to be dismissed or discredited on behalf of the physicians in comparison to men (Werner & Malterud, 2005); and they carry pre-existing vulnerabilities as a result of gender stereotyping (Rogers & Ballantyne, 2008). Thus, feminist scholars of health and gender have rightly asserted that relationships and context in health care perpetuate and reproduce gender and power inequalities (Lorber, 1994; Sherwin, 1996) with the doctor-patient relationship as a central point of inquiry since it is based on inevitable hierarchies of power (Oakley, 1980; Corea; 1985; Roberts, 1996).

By exploring patterns of communication between physicians and patients, in their classical studies Fisher (1990) and Todd (1989) have shown that the “institutional authority of the physicians” not only enables them to exercise power by using specialized medical language, but also contributes to further subordination of women in already existing asymmetrical structure of care. Furthermore, as Smith (1996) points out, male and female patients are differently perceived when challenging the claims of the physician. While men are seen as actively engaged and rational, women are perceived as “hostile, uncooperative and confrontational” (p.194). Moreover, studies have shown that there are “obstacles to clarity” when physicians present information to female patients, with a tendency to express smaller amounts of information when it comes to women of color (Fisher, 1990).

Nevertheless, feminist critics have argued that a careful analysis of gender as a basis and source of oppression cannot neglect or overlook diversity of experience by assuming that women share an essential identity “as women”, thus share same experiences (Lorber, 1994; Doyal, 1995). Thus, it would be wrong to assume that medical professionals treat all women the same solely on the basis of their gender, while being unaware of other categories which shape both medical practices and the doctor/patient relationship. Number of studies have demonstrated how categories such as class and race influence the type and quality of care patients receive. Aiming to show how the doctor/patient relationship embodies and sustains the inequities of the larger system, Fisher (1990) observed that poor women with cervical cancer are more likely to undergo hysterectomies in comparison to more affluent women treated by the same physician. Moreover, while observing doctor/patient interaction in public and private clinics, Todd (1989) discovered that "the darker a woman's skin and/or the lower her place on the economic scale, the poorer the care and efforts at explanation she got" (p.77). Additionally, these women are more likely to be perceived as "difficult" and "to be talked down, scolded and patronized (Ibid.)

The question why women patients may be reluctant actively to participate in the medical encounter and in the process of decision making is rarely addressed. Although the literature on treatment decision making describes patients who are unwilling to assume an active role as overwhelmed by illness or incapable to participate, more recent studies which explore decision making from the perspective of the patient, suggest that women's ambivalence to engage actively in decision making should be understood as "efforts to recast the identities and positions they and their physicians are assigned in the organization of care" (Sinding *et al.*, 2010; Ziebland *et al.*, 2006). Namely, in their study of Canadian women's patients decision-making surrounding breast cancer, Sinding *et al.*, (2010) show how women accept, deflect, reframe and negotiate responsibility for decision making and how their reluctance to take an active role is not as much related to limiting their own responsibility for decision making as it is for achieving a different type of participation on the part of the doctor, by employing strategic efforts to gain more direction from the physician in the context of Canadian healthcare. In their study of how women in Britain who have been diagnosed and treated with ovarian cancer make sense of treatment choices, Ziebland *et al.*, (2006) reported that some women felt that there was no decision to be made in the first place and expressed preference for the physician to be in charge of decision-making, others took more control and asked for second opinion, but still followed their physician's recommendations. Thus, the authors point to the importance of the feeling of certainty and reassurance which women facing life-threatening illnesses seek from their physician when the decision for treatment is rendered to the doctors.

To sum up, this study draws upon Western literature on the physicians' exercise of power over patients in medical interactions which has been contributed to the physicians' medical authority, the monopoly over medical truth claims, the use of specialized medical language, and has been reported to vary depending on the model of the doctor-patient relationship, as well as other factors such as diagnosis and health status, severity of illness and demographic variables. Similarly to Lee and Garwin (2003), Lupton (1994), and Hayry (1991), I show how doctors exercise power by maintaining monopoly over medical knowledge and how the power asymmetry is reinforced by asserting the medical authority of the physician. However, the issue of patients' acceptance and demand for passive role in the medical encounter is rarely addressed and this is where this study aims to contribute. Thus this research is situated within the relatively scarce literature on women patients' ambivalence towards active participation in treatment decision making. Examining why Macedonian women patients might prefer to leave the decisions related to treatment management to their physicians, I show that often they perceive the relationship as based on hierarchies of power with the doctor as medical authority in possession of specialized knowledge and expertise, thus they rely on his expertise and render the treatment-related decision-making to him.

There's a general agreement in the recent Western literature that there has been a shift in paradigm in the doctor-patient relationship and move from this traditional perspective on patient involvement towards a more egalitarian participation of the patient in the medical encounters (Lindebladh, *et al.*, 2005; Noerreslet, Jemec & Trauslen, 2009; Say, *et al.*, 2006; Sinding *et al.*, 2010). It is widely acknowledged that the traditional paternalistic models of health care are outdated, and it recognized that patients should be provided with information and treated as equal partners in the medical encounter (Charles, Gafni & Whelan, 1997). Conversely, I believe that the geographical context in which this study is situated plays a crucial role on medical power relations between patients and physicians. While researchers identify a shift from paternalism towards greater patient autonomy in Western countries, I suggest that the paternalistic model of doctor-patient relationship is still predominant in the process of treatment management and care in health institutions in contemporary Macedonia. Simillary, the few Macedonian authors who implicitly tackle the doctor-patient relationship (Lazarevik, 2010; Milevska-Kostova, 2006) also point out that the paternalistic model of doctor-patient relationship is prevalent in medical encounters. These authors provide a different perspective than the one presented in this study since they are primarily focused on the reforms in the health care sector and patients' rights, and are predominantly gender blind. Thus, my thesis aims to contribute towards acknowledging the gendered dimension of the doctor-patient relationship in the context of Macedonian health care, while striving to make visible women's concerns in relation to their reproductive health through the similarities and specificities of their experiences.

2.2 Women patients' resistance in medical power relations

Earlier feminist critics on doctor-patient relationship have argued that medical dominance during the medical encounter perpetuates gender inequalities and adversely affects women's health, often rendering women patients as passive, victims or powerless (Oakley, 1980; Corea, 1985). Instead of portraying women as passive recipients of care, more recent studies describe women as active participants as they strive to achieve desired health outcomes and maximize their health status (Oinas, 1998; Lorentzen, 2008; Gunson, 2010)

The central debate between these two perspectives revolves around their different understandings of power. Earlier feminist scholars see power as "hierarchal and repressive" (Lorentzen, 2008) because they adopt a traditional (functionalist) perspective on power relations. The main criticism regarding this approach is directed towards the representation of women as vulnerable, passive victims, while at the same time excluding the possibility for their agency (Broom & Woodward, 1996). The more recent approach understands power as "relational/transactional" concept and perceives women as active agents (Oinas 1998, Gunson 2010) following Foucault's conceptualization of power. Feminist scholars representing the latter approach define medical power relations as process of negotiations in which women not only face obstacles but also experience benefits in the medical encounter (Lorentzen, 2008).

One example of how women negotiate their agency in medical power relations is Els Bransen's (1992) study of women's stories of menstruation, where she shows that women do not simply appropriate the dominant medical discourse as a way to describe their experiences, but instead, they construct their own narratives in which they demonstrate their participation, involvement and possibility for agency. Similarly, Oinas (1998) in her account of medical advices in magazines and columns in which young women posed questions regarding menstruation, points out that medical columns and advices served as a channel for the medical establishment to assert and reaffirm their medical authority. Nevertheless she also recognizes women’s capacities and options for agency by showing their ambivalence to engage in medical interaction. Furthermore, Gunson’s (2010) discourse analysis of the public debate surrounding menstruation suppression in Australia, demonstrates similar results and points towards the dynamic responses on the part of women varying from ambivalence, to accommodation and resistance in regards to the medical discourse.

Furthermore, in their attempt to provide typology of resistance in therapeutic relationships by studying working-class mothers and mentally disturbed adolescents, Bloor and McIntosh (1990) described several forms of resistance, such as individual ideological descent, non-cooperation (silence and non-participation) and concealment. They concluded that the most common type of resistance is concealment manifested in form of deviant conformity or ‘no grasping convention’. Lorentzen (2008) on the other hand, in her study of medical power relations and women’s experiences of elective hysterectomy, classified the forms of resistance women demonstrated as active resistance, passive resistance and avoidance. Some women challenged the doctor’s authority and his monopoly over truth claims in a direct, straightforward manner. Others preferred more passive approach, such as ending cooperation with their physicians without direct confrontation by avoiding expressing their dissatisfaction. On the other hand, there were examples when women resisted medical dominance by avoiding medical care altogether, and especially routine check-ups, since they perceived them as ways in which medical establishment tries to discipline their bodies.

Acknowledging the power imbalance in the interaction between physician and patient, feminists have pointed out that the medical encounter is not an isolated personal event. Asserting that “medicine is an instrument of gender oppression” (Roberts, 1996) which serves to “perpetuate unjust social arrangements” (Sherwin, 1996), many feminist authors have emphasized the need to examine the physician-patient relationship in a particular context arguing that this relationship does not occur in a social vacuum. Significant social, cultural, and economic forces influence not just the institution of medicine, but also every aspect of the doctor/patient interaction (Fisher, 1990). As Roberts (1996) points out “medical decisions reflect the social and political context in which they are made” (p.124) and do not rely solely upon the characteristics of the actors involved but in fact are determined by social and political arrangements.

While exploring the physician-patient relationship in contemporary Macedonia, this study attempts to avoid a dualistic approach which renders women patients either as passive recipients of care or as active participants in decision making. Similarly to Gunson (2010), Lorentzen (2008), and Oinas (1998), I show how women occasionally critically engage with the physicians’ attempts to assert truth claims, thus employ various strategies of resistance. This research aim to contribute to the more recent feminist literature which shows that medical power relations are not merely oppressive, but also productive in a sense that produce resistance on behalf of women patients by portraying the complex ways in which women demand, expect and respond to the power and medical authority in the medical encounter. Nevertheless, the analysis extends beyond exposition of the ways in which resistance is produced by engaging in exploring to what extent, under what circumstances, and how categories such as ethnicity, education and age enable or restrict possibilities for resistance. This approach tackles both the complexities and ambiguities of physician-patient interactions and reveals how resistance in medical power relations enables women to achieve desired health outcomes, while taking into consideration the particular context in which the encounter takes place.

Chapter 3: Methodology

In this chapter I describe the methodology I have employed for the purposes of this study. First, I explain how this study was conducted, from participant observation and interviewing, to analysis and interpretation of data. Furthermore, I reflect on my position as a researcher. Finally, I will address the limitations and difficulties I have encountered while undertaking this research. For the purposes of this study, I have conducted ethnographical field work which was divided in two sections: participant observation and seventeen semi-structured interviews. This methodology was chosen since I consider it most adequate to explore my specific topic of interest in order to answer my particular research question of how doctors exercise power over patients and the patients' acceptance and/or resistance of the application of power.

3.1 Doing participant observation in a gynecological clinic

From 1st of June till 1st of September 2010, I conducted 13 weeks-long internship in three private gynecological practices as part of the HRSI/Gender Studies Internship Program. The internship was conducted in Skopje, Macedonia. My activities in the gynecological clinics may be characterized as twofold: my primary task was to provide primary health care services working as a nurse, while at the same time I conducted ethnographic research as a participant observant. In order to gain access in the clinics, I obtained permission from each director, head of department and respective physician in whose offices I interned as a nurse. Before the commencement of the internship, I presented all the relevant documentation in regards to my status as a student, the internship requirements and information from the sending organization (HRSI), as well as, my previous Nursing Diploma. These three particular clinics were chosen because of two practical reasons. First, I have had some working experience in all of the three clinics, both as a nurse trainee and as a volunteer. My previous familiarity with the medical establishment facilitated my access in the clinics and enabled my presence during consultations and exams. Second, the gynecological clinics where I conducted the research where situated in municipalities consisted of patients from different ethic, religious, and class background and where chosen on purpose in order to provide a diverse sample of study participants. All three gynecological practices are located in and are part of Health Institution (Zdravstven Dom Skopje, opstina Gazi Baba) which cover area of four municipalities and a population of 120 00 citizens. All three gynecological practices were privatized in 2006, as part of the health reforms which enabled decentralization of health services.

From a technical perspective, my duties encompassed regular nurse activities, which were mostly focused on administrative tasks such as keeping charts, registering new patients, delivering and sorting test results and occasionally, I had to assist the doctor during the gynecological exams or to administer intramuscular injections (this, however, happened on a very limited number of occasions).

From a researcher’s point of view, the crucial factor which influenced this study was my full access to the consultations between the doctor and the patients and to the gynecological/pelvic exams. Besides the permission from the doctor, every patient was informed about my presence and the reason for me being in the office, and was asked permission for me to be present at the exam. Nevertheless, I always tried to emphasize that the patients are not required to allow me to be present and that there will be no repercussions if they do not. When the patients gave their consent for me to be present during the consultations, I mostly focused on taking notes of the data I found relevant to my topic of interest, or if the doctor needed my assistance during the procedure, I took the notes after the exam and recorded them in my field notebook. I took the role of observer as participant (Burns & Groove, 2005) because the purpose was for me to observe how doctors and patients would interact if I were not present in the office. However, occasionally I was also engaged to some extent in the activities taking place in order to better understand the situation while trying not to call too much attention to myself. The study participants were informed about my dual role both as a researcher and as a nurse, even though my main focus was primarily on observing, and my engagement as nurse during exams was less frequent. On one hand, the reason for my rather passive role was for my presence not to alter the behavior of the study participants (as mentioned above), so I could observe how these actions and relationships occur in my absence (Polit & Beck, 2004). On the other hand, during gynecological exams and consultations (at least in the clinics where I conducted the internship), the physician is in charge of diagnosis and treatment, whereas the nurse usually is not present in the examinations room and even if she is, her activities are limited to administering therapy.

After collecting participant observation data, the notes that were taken were expanded into a descriptive narrative from the encounter with as many details as possible. Approximately four hundred encounters between doctors and patients were recorded. These encounters represent a diverse sample of Macedonian, Albanian, Roma, Turkish, Serbian, orthodox, Muslim and catholic women from various social classes, belonging to different age groups, treated for several diagnosis and conditions, with different marital status and educational level. After the preliminary analysis of the date gathered through participant observation, my general inquiry in the relationship between male physicians and female patients was narrowed down to a more focused research question dealing with the workings of power in medical encounters and the possibilities for resistance on the part of the patients which was further investigated in the interviews.

3.2 Conducting interviews

In December 2010 in Macedonia, I conducted seventeen semi-structured interviews with female patients with different gynecological conditions. The interviewees were recruited by using snowball sampling method. Two Albanian, one Roma, one Serbian, one Turkish, one Macedonian-Muslim and eleven Macedonian women were interviewed. Ten of them identified themselves as orthodox, five as Muslim, one as catholic and one as atheist. Ten women have received high-school education, six women hold university degree and one has elementary education. Nine of the women are currently working, three are retired and five are unemployed. The age of the respondents varies from 27 to 61. Nine women were diagnosed/treated with breast cancer, five women were diagnosed with uterine myomas, three with cervical cancer and one was diagnosed with advanced stage of Cervical intraepithelial neoplasia (CIN3). One of the interviewees was seven months pregnant at the time when the interview was conducted.

The questions in the interviews were focused on women's expectations surrounding treatment and care and their involvement in the decision-making process. The interviews started with general questions in order to map out key events of the process of diagnosis and therapy. Furthermore, women were asked to think back at the time when they were first diagnosed, whether they were provided information and explanation about their condition, if they were offered choices in treatment, how did they make the decision to undergo treatment and what was involved in that, what did they have to do and what did they expect from their doctor. Each interview lasted approximately one hour. The interviews were transcribed and translated into

English. The next step was coding of the interviews and identifying themes. The last step of the process was the analysis of the interviews.

3.3 The researcher-respondent relationship

In this study I speak from the position of white middle-class Macedonian feminist woman. I am fully aware that my position has influenced my way of thinking, the way this research was conveyed, how the analysis and interpretation were conducted and how these categories shaped the relationship between me and the research participants. A crucial aspect of the researcher-respondent relationship is the issue of power inequality which is embedded in the essence of the relationship (Portelli, 1995) and can be particularly emphasized when the researcher is a nurse. The merging of the two roles raises important concerns for obtaining truly informed on the behalf of the patient and refers to the ambiguity of who does the research participant gives her consent to, the nurse or the researcher? (Robley, 1995). The power inequality may be further exacerbated when the nurse/researcher is also the care provider of the patient. In such instances, it may be problematic to establish voluntary participation on the part of the patient and precluded limited capacities for refusal since the patient may feel obliged to consent to participation (Archbold, 1986). In regards to my position as a nurse and a researcher in the gynecological clinics where I conducted participant observation and my relationship with the research participant, the power inequality was less evident due to my student status. Although each patient was acquainted with my nurse/researcher role before the commencement of the exam and was familiarized with general information regarding my pursuit in graduate degree in Gender Studies, patients often perceived me as nurse trainee (on a high school level) and considered their consent to participate in this study as significant input and aid in my learning experience. While some patients were aware of presence, included me in the interaction between them and the doctor and made an effort to help my "process of learning" (as some of them phrased it) usually by indulging in detailed description of their symptoms and other medical information related to their condition, other patients, after providing their consent to participate in the study completely disregarded my presence and focused on exclusive interaction with the physician. This, on the other hand, enabled me to observe how the interaction between them and the gynecologist may occur in my absence.

The dynamics of my relationship with the interviewees was relatively different from the one with the participants in the clinics since with the interviewees I presented solely as a researcher and not as a nurse/researcher. Although initially most of them expressed their surprise in my interest in their relationship with male physicians, frequently they articulated their willingness to participate not just to facilitate my learning process, but also as a chance for their stories to be heard and their experiences to be validated. Once again, I was primarily perceived as a student and less as a researcher.

3.4 Limitations

First and foremost, this thesis does not explore the relationship between male patients and their health providers; it exclusively focuses on women's experiences with the medical establishment, more precisely with their male physicians. The main reason for this particular focus lies in my research interest related to women's gynecological health, even though I acknowledge that some aspects of the analytical section, in which I discuss my findings, may be applicable for men. Furthermore, this thesis does not strive to propose an "ideal" model of doctor-patient relationship, or to suggest that any of the already established models are most suitable in the context of Macedonian health care. Instead I provide empirically based research, which suggests that the findings of this study are more empirical and less analytical.

Moreover, although I refer to the research participants as Macedonian women the study is not limited exclusively to ethnic Macedonian women since women from other ethnic groups were also included. However, the majority of the participants are ethnic Macedonians which constitutes a bias in itself not only as a result of the smaller number of participants from other ethnic groups, but also because of the ambiguity on the behalf of those women patients who didn’t give their consent to participate in the study which points out to the inability of their experiences to be taken into consideration.

The limited number of research participants and the predominant participation of ethnic Macedonian women in the sample draws attention to the incapability to make “grand generalizations” (Stake, 2003, p.156) in relation to women’s experiences of their interactions with male physicians. Although I acknowledge the differences (not only ethnic, but also religious, educational, and in regards to age and marital status) among the women who were studied in the attempt to avoid treating women as homogeneous group, this limitation opens up space for greater risk of essentializing women patients’ experiences. On the other hand, as Stake (2003) points out, the limited number of case studies may present an incentive for “further investigation, as well as helping to establish the limits of generalizability” (p.156). Therefore, my study may potentially present a suggestion for further investigation on the subject of doctor-patient relationship since it is especially understudied in Macedonian and South-European context.

3.5 Ethical considerations

Several major ethical concerns related to doing participant observation in a clinical setting are associated with the dual role of the nurse/researcher, obtaining informed consent and preserving confidentiality and privacy of the research participants (Robley, 1995).

In order to address the above mentioned ethical concerns, all of the women patients were familiarized with my position both as a researcher and as a nurse, with my role as a researcher being particularly emphasized. Verbal consent for my presence during consultations and exams was obtained from each and every one of them (as outlined above). Furthermore, although majority of the interviewees gave their consent for their real names to be used in this study, in order to protect their identity and to provide consistency with the respondents from the participant observation whose real names won’t be revealed, I assigned different name for each and every participant whose narratives and live stories are discussed in this thesis in order to provide anonymity and protect their privacy. Moreover, in the process of conducting, analyzing and interpreting the data I acknowledge my privileged position as a researcher (Sangster, 1998). However, in order to alleviate the possibilities of misuse of the data, each research participant was informed how their narratives will be used in the form of this final thesis, also that the thesis will be available online on the CEU website and the CEU library and was offered to obtain a copy of it.

Chapter 4: Data Analysis

In this section of the thesis I provide the analytical chapter in which I elaborate on several interesting observations which I came across during the ethnographic research on how Macedonian women perceive their relationship with their male physicians. In the following chapter I argue that Macedonian women often recognize and accept the power imbalance apparent in their encounters with their physicians; usually they do not challenge the medical authority of their doctors and are aware of their subordinate/passive position (which is commonly attributed to the doctors' specialized knowledge and their self-perceived lack of familiarity with medical information).

Furthermore, in the second analytical chapter I argue that they are not simply passive recipients of care; in their complex responses during the process of receiving care, they employ various strategies through which their agency is manifested and which enable them to (re)negotiate their roles and responsibilities in their attempt to maximize their health status.

Following the structure of my argument, this chapter will be organized as follows: first I describe women's acceptance of their subordinate position due to the superiority of the medical authority of the doctor; and second, I elaborate on the strategies women employ through which they manifest their agency and renegotiate their position as patients.

4.1 Women patients' acceptance, expectations and demands for a rather passive role in medical interactions

In this section I show that frequently women patients not only recognize and accept, but also invite physicians' exercise of power over them, by assuming rather passive position in the medical encounter and preferring to render the decision-making in the hands of the respective doctor. Relying on the physician's expert knowledge and placing their trust in him is perceived as one way of achieving desired health outcomes, which alleviates the responsibility of diagnosis and treatment decision-making.

4.1.1 The doctor knows best

In mid July 2010, on an extremely hot summer day, a Macedonian woman in her mid-fifties presented in the doctor's office where I was conducting participant observation, visibly distressed and alarmed due to heavy bleeding in menopause. After few hours spent in the crowded waiting room with no air conditioning, Marija finally got the chance to have consultations with the doctor. She was last in a line to see the doctor because she was a patient of another physician[4] who was working a different shift that day. After some disapproval and grumbling on the part of the doctor he agreed to see her in his office due to the seriousness of her situation. During consultations, Marija explained her symptoms and the doctor offered several possible courses of treatment, to which she replied:

"I don't know anything…. Don't ask me for my opinion about what therapy I want because I really don't know. You are the doctor, tell me what to do and I will do it. You know best."

This particular encounter between the patient and the physician reveals several important notions about the doctor-patient relationship and the Macedonian health care system in which the

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[4] In Macedonia each patient has her own gynecological doctor and in the clinic where I was doing the internship doctors usually do not agree to see patients of other doctors.

medical encounter took place. The patient, Marija, was clearly overwhelmed by symptoms of the condition she faced and sought guidance and aid from the physician. The underlying demand for the physician to take charge over the decision bearing is linked with her inability and/or unwillingness to engage in active management of her own health. Thus, she relies on the physician's expertise; since 'he knows best' regarding what treatment would be most suitable. Although she was given the opportunity to participate and to decide which course of action she prefers in terms of therapy and treatment, she showed reluctance to actively engage in the process of treatment management. Instead, she explicitly demanded and expected the physician to make a decision for her, privileging the doctor's expert knowledge over her own. Similarly, as Sandra, one of the interviewees and a thirty-four years old breast cancer survivor, explained:

"I consider the doctor as an authority figure… I can't make a decision on my own… I'm not familiar with medical things at all. So that's why I think that the he [the doctor] is the one who should tell me what to do, I alone… I'm not sure if I'm capable of making a decision on my own… I need to hear his advice; I need to him to tell me what the best option is. "

'The doctor knows best' and the 'doctor is an authority figure' are common themes which emerged in the findings of this study. All but three of the interviewees described the doctor as authority figure; his words are to be respected and his opinions valued and acted upon. It is apparent from these narratives that women themselves perceive and construct the relationship with the physician as based on hierarchies of power, with the doctor being the dominant, superior medical expert, whereas the patients often place themselves in a passive, subordinate position. Here it is important to explain what this passive position actually means. It refers to their demand and expectation to be told what to do, to be taken care of, to render the decision making to the doctor, as he is the medical expert in possession of specialized knowledge, whereas most of the participants (as shown in the narratives of Marija and Sandra) perceived themselves as lacking the capacity or knowledge to make informed medical decisions. Therefore, their demand to take more passive role in the medical encounter does not necessarily represents an impediment, since this position makes them feel safer, it offers a sense of security in terms of obtaining better health outcome.

From the responses of the research participants it is evident that they occasionally manifest expectations for the physician to be in charge of treatment decision making and care because of the medical authority of the doctor based on trust in his medical knowledge. Thus, they not only accept and recognize the dominant position of the physician in the medical encounter, they frequently demand for application of power due to the undisputed medical expertise of the physician.

In their narratives, the research participants frequently associated their respect of the physician's medical authority to the notion of trust, which they contributed to the physician's medical expertise. There is an extensive body of literature on the issue of trust in medical interactions. It is commonly defined as "the optimistic acceptance of a vulnerable situation in which the trustor believes the trustee will care for the trustor's interests" (Hall *et al.*, 2001, p. 615). Thus, trust can be understood as a voluntary action involving dependency on another person and possible risks of negative outcomes. It refers to the expectations of individuals (in this case, patients) of how others (physicians and medical professionals) will behave on their behalf. As Gilson (2003) suggests, "trust involves an element of risk derived from one individual's uncertainty regarding the motives, interactions and future actions of another on whom they depend" (p.1454). From one point of view, trust is a strategic behavior based on expectations and risks about the actions and behaviors of another person (Gambetta, 2000). As Coulson (1998) points out, from this perspective trust has instrumental features and it means "that you are prepared to make yourself vulnerable, to run a risk that the other partner will exploit you, and to build up credit by doing more than the minimum necessary in the hope that, if you have problems yourself, your partner will help you in return'' (p.4). From another point of view, trust has altruistic or moralistic value, since it is based on the expectations on how one should behave (Gilson, 2003; Mansbridge, 1999). Consequently, from this perspective ‘‘one trusts the other more than is warranted, as a gift, for the good of both the other and the community'' (Mansbridge, 1999, p. 290). In this part of the analysis, I explore trust both as a strategic and altruistic behavior by examining how patients link their expectations from the physician to act in their best interest with the trust they place in the doctor-patient relationship. Or in the words of Slavica, one of the interviewees:

“I’ve understood that when the doctor says that something should be done, then it surely should be done. I’m not afraid of what could happen and how would things go, because I simply have trust in them (doctors) to do the right thing.

From Slavica’s response, it is clearly noticeable how she links doctors’ medical authority and knowledge with the trust she has in him to represent her interests and act accordingly. This is a common finding for most of the research participants in this study who revealed that the notion of trust in the physician to act as a beneficiary in the best interests of the patient is one of the fundamental factors because of which they show reluctance to actively engage in treatment management and care. According to the most research participants in this study, the doctor occupies a position of an expert, medically knowledgeable and competent, and willing to act in a good will in the name of the patient. The patient, on the other hand, is a person in need of medical care, a person who needs to be taken care of. In their narratives, the research participants show that trust is constructed and manifested as both strategic and altruistic behavior, resulting in both benefits and limitations. Furthermore, the medical competence of the doctor and the trust patients put in the relationship are two concepts which are significantly related. When asked for which reasons she trusts the doctor to do what's best for her, Vesna, one of the research participants responded:

"The doctor spent years and years studying and practicing medicine, so how can you compare his experience and knowledge with mine?"

Thus, in her response, Vesna not only privileges the physician's medical knowledge over her own, she also shows how these two notions of trust and medical competence are related and mutually constructed. For women patients, trust is an especially valuable feature in the medical encounter, since they enter in interactions with medical professionals more often than men, their bodies are regulated and monitored especially in relation to their reproductive capacities, suggesting that they are more frequently exposed to the ''clinical gaze" of medical establishment, which might result with both gains and vulnerabilities. The benefits and the dangers of placing trust in the medical competence and knowledge of the physician, while expecting/demanding from him to act in the patients' best interest will be further elaborated in the following sections of the thesis.

Nevertheless, relying on the doctor's expertise and guidance for some women may be the only viable solution. For instance, in June 2010, a Macedonian woman in her mid-thirties presented in the doctor's office. While she was waiting for the doctor, who at that moment was out of the clinic, I and she got the chance to talk about her condition which brought her to see the doctor. She was nine weeks pregnant with her fourth child and wanted to have an abortion. Nobody knew she was pregnant, not her husband, not her family, nor her colleagues at work. She had three daughters, and although her husband desperately wanted to have another child (preferably a boy); she decided not to notify him about her pregnancy nor consult him about her decision. She said that he would insist on keeping the baby, while ignoring her wish not to have it, because as she said, she felt too old to raise another child. Instead, she took a few hours off work, telling her supervisor that she's going to meet her daughter's teacher, and planning to go back to work immediately after the procedure was over. In this situation she decided to completely rely on the doctor's judgment; he was supposed to take her to the clinic where they perform abortions and he was supposed to take her back to her work place. She didn't even know where this clinic was or what was the name of the clinic, all she knew is that her doctor was going to take care of her, he was taking her there, and then he's going to bring her back when it's over.

It is noticeable from this narrative that on this occasion the patient felt safer when she received advice and guidance from her doctor. This does not suggest that she would manifest the same behavior and expectations under different circumstances, or that every woman reacts in similar manner when facing similar situation. Nonetheless, under the circumstances discussed above, where the patient makes an effort her pregnancy to remain concealed from her family, friends and coworkers, her physician appears as the trust-worthy figure, with adequate medical knowledge on which she can depend. As she reported, her physician has been treating her since her pregnancy with her first daughter. Therefore, they have established long-term relationship, which as she described is based on trust. The patient apparently had no one else to turn to, thus she placed her expectations in her physician to act as a beneficial agent on her behalf, and to "take care of what needs to be taken care of" (in this case, this refers to the unwanted pregnancy). She expected from her physician to make an appointment at the other clinic where the abortion was to be performed, to be the one to provide the transport to and from the clinic, while holding her during the whole procedure. Here, the physician is not to be mistaken for an individual guided purely by altruistic motives; he received monetary exchange for his services. Thus, he was not acting in a selfless manner, but he was working for his own benefit.

Nevertheless, he responded to the patient's demands and assumed the responsibility for her treatment, providing her with a sense of security and relief, because as she said: *"I know that at the end of the day, he'd do what's best for me."*

On the other hand, Daniela, one of the research participants who was seven months pregnant at the time when the interview was conducted, described a situation when she was in contact with a child with chicken pox, got concerned for the well-being of her baby and the possible consequences of the exposure, so she referred to her doctor for advice:

> *"I was really scared and I called my doctor immediately. I'm not sure if he was busy or just not in the mood, but his answer was really rude. He said something like do you want to abort the baby now? That really pissed me off. I'm just a patient and I don't know if the exposure is dangerous or not, I think that it is his responsibility and his duty to tell me what to do"*

By framing the issue as "*the doctor's responsibility and duty*" to provide not just his opinion but also his strict guidance and by positioning herself as "*just a patient*", Daniela's example shows how she deflects her own responsibility to undertake any action without his advice and how she expects him to do the decision-making. For Daniela, who is a twenty-seven year old graduate in E-Business, clearly fluent in electronic technology and the use of Internet, relying on the doctor's advice might not be the only possible solution to her problem. When she encountered, what she refers to as 'rudeness' or unresponsiveness on the part of the doctor, she could have searched for other options such as, to search for information on the Internet, to ask for a second opinion from another doctor, or to seek advice from a friend or relative, since exposure like hers is not uncommon. Instead, she preferred not to take any action without supervision and approval from her physician. When asked what was her response and how she handled this situation, she stated that she told her sister what happened and her sister (who is also a patient of the same doctor) immediately called the physician and demanded for his opinion and his advice. The reluctance of the patient to seek for alternative solutions reasserts the physician's monopoly over medical truth claims, which went unchallenged in this particular medical encounter. Without the reassurance on the behalf of her physician, Daniela limited the scope of her possible actions and decided not to engage in active seeking for other possible options. Instead she sought reassurance from her physician, as the only way to achieve the above discussed sense of security, as the only way to make her feel safer about her baby's well-being.

Although describing different encounters, what these narratives have in common is the supremacy of the physician as the medical expert by positioning the patient in a relatively passive stance. The medical power relations in these two encounters point to the superiority of the physician as the competent medical figure of authority, and the demand on the part of the patients for him to treat them in this manner.

Researchers have shown that patients usually expect and demand to be provided with medical information on diagnosis and treatment, which suggests that patients mostly want to be informed. This is consistent with the findings in my research: the majority research participants expressed their desire to be fully informed (by this they usually referred to their expectations for the doctors to elaborate on their diagnosis, to suggest possible treatment options and alternatives and provide efficient post-treatment care). However, what became apparent in the narratives of the interviewees is their feeling of discontent with not being provided with the necessary amount of information (here 'necessary' refers to the amount of information they felt is needed in order to make an informed decision related to their own health and well-being) on the part of medical professionals.

As Lorentzen (2008) points out, the knowledge resources in possession of the patients have crucial importance in shaping the medical power relations during the medical encounter. For those women who felt uninformed or not enough informed, relying on the doctor's expertise might be the only option for securing a better treatment and health outcome. Nevertheless, even when women consider themselves as medically knowledgeable and in possession of all the relevant information regarding their condition, they still consider the doctor as figure of authority who should be respected and whose advices should be accepted. In the words of Liljana, a fifty-seven years old layer who was diagnosed and treated for breast cancer:

"Because I am an intellectual, and also both my mother and father died of cancer, I have read a lot and I think that I know a lot about the disease… but still, I myself, and I believe most of us, see the doctor as 'higher power', as God in those moment…"

Or similarly, as Velida, a forty-nine Macedonian-Muslim also diagnosed and treated for breast cancer elaborates:

"I've watched TV, I followed the breast cancer awareness raising campaigns, I knew how to perform self-examination and after I was diagnosed I read a lot…. But I always respect and listen to those superior than me, and that goes for doctors especially. This isn't a minor disease… it is cancer."

Although they consider themselves as well-informed in regards to diagnosis and treatment, they still assert the doctor as main actor and decision-maker, the one who should decide what course of action should be pursued in the patient's best interest. It is evident in their descriptions that they posses a certain level of both embodied and emphatic knowledge (Abel & Browner, 1998), as caregivers for the ill elderly parents, from their own experiences with illness or information from the media. Nevertheless, priority is given to the medical truth claims of the physician, in contrast to their own experimental, authentic knowledge.

The seriousness and the severity of the illness plays a crucial part in how much power women patients render in the doctor's hands. A vast body of literature shows that patients with less serious diseases and conditions are more likely to take active participation in treatment decision making and care, in comparison to patients facing more serious illnesses (Arora & McHorney, 2000; Catalan *et.all* 1994). Similarly, the women participants in research who faced life-threatening conditions, such as cancer, were more likely to expect and demand from the doctors to act in their best interest, while relying on their expertise and knowledge. On the contrary, patients with less severe conditions were more likely to exhibit greater participation in treatment, and also, to challenge the physicians' medical truth claims (which will be explored in detail in the following chapter). When describing her experiences and expectations of the physician who diagnosed and treated her with breast cancer, Lenka, a sixty-year old retired teacher, stated that under the circumstances and the illness she combated at that particular moment, she believes that: "*Every patient sees God in the doctor, a salvation.*" Paradoxically, when she described her experiences with hypertension treatment and her relationship with physicians she elaborated how she self-managed the therapy and disregarded doctors' advices (which will be discussed in detail in the following chapter).

Additionally, these excerpts also point out to the evident power inequality in the doctor-patient relationship, where the doctor on occasions is even perceived as God. By assigning deity attributes to the physician in charge of their health, the position of the doctor as superior in the medical power relations is accepted and reaffirmed by most (but three) of the women patients who participated in this research, in particularly those treated with life-threatening illness and older, less educated patients.

The acceptance of the physician as a figure of authority in possession of medical competence, worthy to be trusted and relied upon is linked with the expectations and demands some women occasionally manifest when they prefer to engage in the process of obtaining desired health outcomes in a rather limited manner, by rendering their agency and capability for participation and treatment decision making in the physician's hands. For some women, opting for such decision might be the only viable solution to their situation. The interactions between the patients and physicians, as outlined above, result with both benefits and limitations the patients face. In this set of relations, the women gain the much needed sense of security, direction and reassurance for which they are willing to leave the treatment management and decision making in the doctor hands. The other benefit for the women patients is alleviating the responsibility which comes with active participation and decision making. When the physician is the one who makes the decision for the patient, the patient does not have to assume responsibility for the actions and possible negative outcomes. Or in the words of one research participant:

"I leave everything up to him [the doctor]. I trust in him… but God forbid that some complications arise… In that case, we usually blame the doctors…"

The negotiation of responsibility over treatment choice and participation in management of care portrays the occasional expectations and demands of women in regards of securing better health outcome. Nevertheless, the appropriation of this perspective brings upon certain limitations. The limitations of this rather passive approach of the patients opens up space for greater patient's vulnerability, as it will be further elaborated.

4.2.2 Vulnerability of women patients in the medical encounter

The dangers of relying on trust in the medical authority and knowledge of the physician to act in the patients' best interest exposes the patient to certain vulnerabilities and limitations which will be discussed in this chapter of the thesis. be As outlined in the previous section, trust is considered to be a crucial feature of the doctor-patient relationship, since it eases access and provision to health care services, while providing reassurance against possible negative health outcomes. Patients trust their physicians to act as beneficent agents in a competent manner. However, some patients, as a result of their gender, age, ethnicity, disability or poverty, are more vulnerable than others, which might result with abuse of power in the medical encounter with possible negative consequences for the patient. In addition to the expectations placed in the physician to act in the patient's best interest, as Rogers and Ballantyne (2008) suggest, putting trust in the physician can increase pre-existing vulnerabilities of patients. This is particularly true when female patients are in question because women enter medical encounters and health care systems more frequently than men (Doyal, 2000); their symptoms are more likely to be dismissed or discredited on behalf of the physicians in comparison to men (Werner & Malterud, 2003); and they carry pre-existing vulnerabilities as a result of gender stereotyping (Rogers and Ballantyne, 2008).

Rogers and Ballantyne (2008) define patient vulnerability as "the inability to protect one's interests" due to both "intrinsic and extrinsic features of individuals or populations" (p.50). "Extrinsic vulnerability is due to *external circumstances*, such as lack of socio-economic power, poverty, discrimination, or lack of education. Intrinsic vulnerability is due to features of the *individual*, such as mental illness, intellectual disability, severe illness, or the extremes of age (young children and some elderly)" (Ibid). In the context of this study, patients' vulnerability refers to their inability to actively participate in managing their own health as a result of abuse of power on behalf of their physicians.

Situated in a crowded waiting room at the Institute of Radiotherapy and Oncology in Skopje, Stanche- a fifty-three year old breast cancer survivor who had a surgery a year ago, while waiting for her turn to see the doctor and get her therapy, vividly explained her experience with breast cancer treatment and care, from diagnosis to post-operative care and therapy. Recalling at the moment when she was first diagnosed and how did that particular encounter with the physician go, she points out:

> *"I wasn't asked if I wanted to have the surgery, I was simply told that surgery needs to be done and that was the end of the story. Everything happened so fast… I had the surgery in three*

days… and before the surgery nobody explained anything to me… I wanted to know what was wrong with me… I was freaked out of my mind, I didn't know that they would take out my whole breast, I was expecting just a small cut, but when I woke up from the anesthesia I realized that my whole breast is gone. Later on the doctor told me that had to be done in order to save my life, but I just wish he had told me that before the surgery so I could be prepared".

In her response, Stanche reflects on several crucial points. First, it is noticeable in her description that the decision to have the surgery was not in her hands because the doctor made that decision instead of her. Second, she points to the fact that she wasn't given sufficient/any information regarding the surgery, which on the other hand is related to the third point of her vulnerability as a patient when she discusses her fear before the commencement of the surgery and her surprise when the surgery was over.

As research participants in this study described their experiences with treatment and care, they drew attention to their perceptions of their reluctance or even inability to make an informed decision due to their perceived lack of capacity or lack of knowledge which they intrinsically relate to their respect for the doctors' authority to make the decision for them and to act in their best interest. The notion of informed decision is based on the assumption that patients are in possession of the necessary information related to their medical condition and are capable to act upon it. It is safe to assume that if they have acquired medical knowledge they would be more actively engaged in the decision-making process. Two crucial concerns arise in the particular context of the doctor-patient relationship in Macedonia. First, very often Macedonian patients feel that doctors do not take the time to explain, and even if they do, often they use specialized medical language which patients find difficult to understand. Second, usually patients rely exclusively on the information and advice their physicians provide and rarely express interest to obtain information elsewhere. As an illustration, results from a study on patients' rights conducted in Macedonia, show that 60% of the interviewees never intentionally went to see another doctor or asked for a second opinion (Milevska-Kostova, 2006).

Although physicians are legally obliged to provide information on a level accessible to the patients, in practice, doctors either provide explanations using medical terminology or if the perceive the patient to understand her medical condition, often they don't provide any information. During the thirteen weeks I spent as a participant-observant in the clinics, I have witnessed this occurrence on more than one occasion. Furthermore, most of the research participants in my study expressed their discontent for not being provided with the necessary amount of information; they felt like they weren't given enough explanation about their condition, thus they weren't in a position to make an informed decision and actively participate in treatment management and care.

The ethnic belonging of the patient is an important factor, which may increase feelings of vulnerability. For Roma women[5], for example, it might be more difficult to challenge the doctor's authority since they are discriminated and marginalized, very often have limited access to health care, and on occasions are victims of the stereotypes and prejudices of physicians. According to the CEDAW Shadow Report on the situation of Roma Women in Macedonia from 2005, Roma women are often victims of racial discrimination, they frequently excluded from provision of state health care services as a result of lack of health insurance which prohibits access to basic health services, and even those women who have access to state health care, often encounter financial difficulties to afford participation in medical examinations. All of these factors have detrimental impact on Roma women's health.

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[5] Difficult to generalize, since not all Roma women are less privileged, other categories shape their position as patients.

These is one of the many examples which demonstrate the obstacles women face when they try to acquire medical information due to the refusal on the part of their doctors to provide the explanations they require. Therefore, the lack of information may be the reason for the women's perceptions that they lack the capacity to make an informed decision which points out to their vulnerable position as patients. Under these circumstances it is difficult or maybe even unrealistic to expect from women to act as informed decision-makers since a crucial obstacle omits them from acting as such – the inadequate or lack of information physicians provide. The inability to take active measures and participation in their own treatment demonstrate women's vulnerability in the medical encounter, by showing how exploitation of power on the part of the physicians may exacerbate feelings of vulnerability.

4.3.3 Concluding comments on women patients' acceptance and demand for physicians' exercise of power over decision-making

The analysis of the interviews and the participant-observation data shows that the doctor-patient relationship is a complex and to a certain extent ambiguous relationship; it portrays women's expectations surrounding treatment and their reluctance to actively participate in decision-making, and it shows how this connects to their respect for the doctor's medical authority. At the same time it points out to the demands of the women to take a more passive stance in treatment, by exploring what benefits and limitations they encounter as a result of it. Additionally, in the next chapter of the analysis I aim to demonstrate that although they might be accepting of their subordinate position, they are not passive observants who have completely rendered their agency; they exercise their own strategies of resistance and empowerment as ways to reassert their agency with an ultimate goal: to secure better treatment and health outcomes.

4.2 Resistance in physician-patient medical encounters

In this chapter of the thesis I aim to uncover how resistance can be produced and manifested in medical power relations by examining Macedonian women's lived experiences of the doctor-patient relationship. Furthermore, I aim to show how women construct and negotiate their demands, roles and responsibilities, the ways in which they navigate their expectations and participation, and the strategies of resistance women employ during the medical encounter. I use the term 'resistance' to signify the discrepancies and discontinuities in women's passivity in medical power relations by using biological essentialisms associated with women's reproductive capacities and motherhood, by privileging forms of knowledge other then specialized, medical knowledge, or by resorting to more subtle actions (strategies) which did not necessarily include direct confrontation, all of which serves to an end goal: maximizing health status. However, it is also important to take into consideration that some women may prefer one sort of resistance, while other some different way of resistance, while third women may employ a combination of the strategies outlined above, varying on the circumstances and preference of the women patients in question.

4.2.1 Challenging the physician's medical truth claims

While most of the women who participated in this research frequently perceived the relationship between them and their physician as mainly unproblematic, some of them were able to identify instances in which they confronted the authority of the physician, by questioning and resisting his attempts to assert medical truth claims they found harmful or felt uncomfortable with.

In this section of the analytical chapter, I show how relying on biological essentialism which renders women primarily as reproducers, some women challenged the doctor's privileged medical knowledge and managed to put forward their own truth claims and preferences in order to achieve desired health outcomes. The idea to connect biological essentialism with women patients' strategies of resistance was inspired by Elizabeth Dunn's argument in "Ideas of Kin and Home on the Shop Floor" in *Privatizing Poland* (2004) in which she discusses how the women workers used kinship metaphors and relied on strategic essentialisms to negotiate their position, expectations and demands in the existing power relations in post-socialist Poland, and argues that these strategies were useful as a manner of resistance towards global capitalism.

Biological essentialism refers to the prioritization of the reproductive capacities and kinship roles of women, which enables viewing women's health primarily through the lenses of their childrearing functions. Biological essentialism has disregarded women's health problems which are not directly linked to their reproductive abilities and has led to marginalization of other women's health issues (Rogers and Ballantyne, 2008). Medicalization, on the other hand, is a process opposite to biological essentialism since it has contributed to "hysterization of social problems" assigning social problems women encounter as objective disorders of the reproductive organs (Waitzkin, 1991, p.113). Feminist critics has perceived biological essentialism in health care in a pejorative sense, due to its tendency towards gender blindness which has led to neglect of the importance of sex and gender in relation to other health conditions such as heart diseases or depression (Kaiser, 2005), but it has also resulted both in under treatment of women and their exclusion from clinical research (Rogers & Ballantyne, 2008; Dresser, 1992). Nevertheless, in this section I use the term biological essentialism to refer to the reproductive capacities of women which enable them to become mothers, and show how the women participants in the study used biological essentialism which renders them as reproducers and mothers in their advantage, by evoking potential or existent motherhood in order to challenge the physician's knowledge and expertise and gain his compliance for their preferred course of treatment.

In order to understand how these women achieved their desired health outcomes, a brief explanation of the Macedonian context is in place. It is important to notice that motherhood is a valued social status in Macedonia (Thiessen, 2007) Even more, a woman is not considered to be "complete" if she hasn't experienced the "bliss "of motherhood. Thus, womanhood is highly associated with motherhood, since it is considered to give meaning to women's existence, a purpose and goal in women's lives[6] (Bubevska & Hoxha, 2006). The particular Macedonian context in which the medical encounters took place has shaped not only women's perceptions and expectations of their appropriate role in society, but it has also "helped their cause" when challenging doctor's expertise by indicating their preferences either to preserve their wombs so they could become mothers, or by removing the womb so they could avoid possible negative outcomes in order to be able to be "*good mothers*" and provide their existing children with "*normal childhood*" (as explained by the interviewees in this study).

Slavica is a forty-three-year-old chef in a prominent restaurant in Skopje. She is not married, although has been in an intimate heterosexual relationship for more than a decade. I chose her to participate in this study because of her extensive experience of interactions with medical professionals. In the past five years she underwent two surgical procedures for removal of breast cysts and one operation of fibroid uterine tumors. As a result of her conditions, she was exposed to frequent relations and contacts with the medical establishment. Even though (similarly to most of the women in this research) she described the relationship with her

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[6] This statement does not apply to all women, since some of them might choose not to conform to this behavior, or might not be able to, for example, if they are reproductively challenged.

physicians (both her gynecologist and the surgeons that performed operations on her) as unproblematic, she depicted one particular event when she directly contested her surgeon's medical truth claims and managed to negotiate desired health outcome. Namely, because of the number and the size of the tumors, the primary treatment suggestion made by the surgeon was a removal of the uterus (hysterectomy). On the grounds of Slavica's age (43), the surgeon made an assumption that she already has children and that her intentions for further reproduction are non-existent (since forty-three is considered a late age for a woman to procreate in Macedonia). Thus, he recommended hysterectomy as the most suitable treatment. However, Slavica found his advice problematic, and as she explains:

"I looked at him straight into his eyes and I told him: Look, doctor, I don't agree with complete removal of my uterus. You see, I still don't have kids, but I hope to have them one day… and if you take out my uterus, you will take away my chance to be a mother… so I asked him if there was another option and after discussing it, he agreed to perform the surgery in a manner that he'd remove the tumors but leave my uterus intact."

When illustrating the process of diagnosis and treatment of her uterine tumors, Slavica elaborates in great detail and with great level of emotions on her efforts to preserve her uterus by persuading her physician to respect her desires. In her narrative, she shows how she achieved compliance on the behalf of the physician and preserved her uterus, which provided her a chance to have biological offspring. Although contrary to his previous suggestion for treatment, her demands weren't met with resistance and disapproval from the physician. Instead, he granted her wish and acted in accordance with her preferences. This particular encounter confirms Waitzkin's (1991) argument that "the patient's reproductive role in childrearing overshadows all other concerns" (p.118). Additionally, he claims that the medical encounter reinforces ideologies of women's appropriate role in the family (Waitzkin, 1991). The following excerpt will demonstrate that point:

Sonja is a thirty-seven-year-old elementary school teacher, married and a mother of two children, living in a small town in Eastern Macedonia. At the age of thirty-four, she was diagnosed with Cervical intraepithelial neoplasia (CIN) stage 3, which is the most severe form, considered as potentially malignant and often referred to as cervical carcinoma in situ. After her medical team established the diagnosis, her gynecologist suggested cervical conization, a surgical procedure in which cone-shaped part of the cervix is removed. However, Sonja was not satisfied with his recommendation. Instead, she demanded a more radical treatment and insisted on hysterectomy as therapy. Her demand was met with opposition on the behalf of the physician since he deemed such invasive approach as unnecessary. Nevertheless, in her own words, Sonja "won the victory" by persuading the doctor that hysterectomy was the only and the best treatment for her. When asked how she achieved that, she stated:

"I put on my most serious face and I said that I won't consent to any other forms of treatment. I told him that I have two kids at home who were age 7 and age 9 at the time. I said that I don't want my kids to be orphans, so I asked him to do it (hysterectomy) for them, so they can grow up with their mother by their side and have normal childhood".

What made Sonja so frightened about her life is her genetic predisposition towards cancer (as she explained, she lost her mother to breast cancer, her father to prostate cancer and her sister also had hysterectomy due to an advanced stage of CIN 3). She expressed her concerns to the physician without hesitation but in her understanding, it wasn't her medical argument which convinced her doctor, as much as it was the importance of mentioning her children in the discussion and her role as a mother. Although at the beginning her physician was reluctant, eventually he respected his patient's wishes and agreed to perform the hysterectomy. After the surgery, Sonja goes to regular check-ups every six months and so far there haven't been any abnormalities in her results.

What Sonja's and Slavica's narrative have in common is the apparent effort on their side to be heard and to be taken seriously by the physician (for instance when they say: *"I looked at him straight into his eyes"* and *"I put on my most serious face"*). However, in contrast to Slavica's case where she evokes the possibility, her inclination and even the necessity for biological motherhood, Sonja introduces her already existent children in the treatment negotiation process by emphasizing her desire to live in order to be present in their lives so she could provide, as she states, a "*normal childhood*" to them.

Additionally, most of the research participants (and especially those who were diagnosed with life threatening illnesses) frequently mentioned their children as the primary reason which motivated them to subject themselves to invasive diagnostic procedures and to endure painful and exhausting treatments. Thus, the notion of motherhood is central for understating how women patient articulate their preferences for treatment and how they construct their "patienthood" in negotiations with physicians.

Similarly, while conducting participant observation in a gynecological clinic in Skopje, I witnessed an encounter between the gynecologist and a patient in her late twenties, who at the time was four months pregnant and reported unusual pain and cramping in lower abdomen. Although the physician conducted an ultra-sound (on a relatively out-dated ultrasound machine), and established that there were no reasons for concerns since there were no irregularities in the results and that the baby seemed in a perfect condition, the patient insisted for a referral in the main gynecological clinic since it is better equipped with diagnostic technology. The physician stated that undertaking such an action won't be necessary but didn't openly object to her requested and gave her the referral she asked for. After the patient left the office, the physician mentioned that even though he felt offended that she didn't rely on his expertise (since as he explained, the technology might be old but he had extensive experience of twenty years), he simply couldn’t refuse to accommodate her wish because he didn’t want to contribute for additional stress of the mother, and with that to risk the well-being of the baby. This particular encounter points to the acknowledgment of the value of motherhood for women patients on the behalf of the physicians and their acceptance of women’s preferences for diagnosis or treatment when related to their offspring.

The examples mentioned above show how women confronted the physician in a direct manner and made a conscious effort for their preferences to be heard, respected and acted upon. Furthermore, the examples describe how the interviewees achieved compliance on behalf of the physician by revoking either their status as mothers or the very potentiality to become mothers in the future. This points out to the possibility of using biological essentialism which basically discriminates against them, for purposes which would advance their health status in a manner desired by them.

Nevertheless, the cases where the women patients directly challenge the medical authority of the physician represent more of an exception than a rule in regards to the participants in this study. Women’s capacity for resistance in the medical encounter varies upon different variables such as ethnicity, class, age, education and knowledge resources (Lorentzen, 2008) such as, access to medical information and/or embodied or emphatic knowledge (Abel & Browner, 1998). Slavica, for example, is economically self-sustained ethnic Macedonian living in the center of the city with easy access to health care services. She’s able to navigate the medical system since she’s in a possession of certain attributes which enable her to assert her own truth claims. As explained in the previous chapter, for women from other ethnic groups, and especially Roma women who often face limited access to health care and are discriminated and marginalized, it may be more difficult to resist physicians' exercise of power.

Apart from the ethnic belonging of the patient, education and resources of knowledge also play a significant role in shaping the patients capacities for resistance in the medical encounter. As researchers have previously shown, better educated patients prefer more active involvement in treatment management. However, in regards to their capacities for resistance, better educated patients are in a more privileged position to make certain claims and to put forward their preferences. This also relates to their better access to medical information or the possibility to search for medical advice outside of the physician's office. During an informal conversation with one of the patients in the clinic who is graduate student in political sciences, she explained that the reason for her visit to the gynecologist is a result of her dissatisfaction of her current method of contraception; more precisely with the contraceptive pills she was prescribed. She described that although her doctor didn't explain the possible side-effects of the pills, she read carefully the leaflet in the package of the pills where her symptoms were not stated. When she noticed changes in her usual mood and her psychological state of mind in general, she used the Internet and searched for additional information, not only medical information but she also visited various blogs in which she got acquainted with other women's experiences with this particular form of birth control. She said that it was revelation for her to see those women's stories and to realize that it might be the pills which caused her emotional instability. Furthermore, she also pointed out to her discontent with her physician's avoidance to mention that the pills might provoke mood swings. During consultations, she requested change of the birth control method and was meticulous to reveal all the possible side-effects. This encounter uncovers how the access and resources of knowledge influence the patients' abilities to undertake certain actions for improving their health.

As several feminist scholars have argued, although health care providers are characterized and perceived as medical experts of the body, they do not posses "monopoly over truth claims-medical or otherwise" (Lorentzen, 2008), because patients also have access to medical information, such as advices from people who had similar experiences (Abel & Browner, 1998), medical books and leaflets with information for patients, information from the media, and most recently the Internet (Andressen, 2011). In contrast to the physician's expert medical knowledge, studies have shown that women occasionally privilege other forms of knowledge under different circumstances (Davis; 1988; Bransen, 1992; Oinas, 1998; Abel & Browner, 1998; Gunson; 2010). In their study of women's experiences with prenatal care and family care, Abel and Browner (1998) point out to two forms of experimental knowledge-embodied and emphatic, upon which women rely on when making health related decisions. Similarly, Bransen (1992) argues that when describing their experiences with menstruation, medical knowledge is not privileged over other forms of knowledge. Instead, women employ different discourses (or 'genres' as she labels them) which are not necessarily medicalized, but present a mixture of both medical knowledge and other forms of knowledge. On the contrary, most of the women in my study usually gave supremacy to the medical knowledge of their physician over their own authentic knowledge (and the exceptions are discussed in detail in this chapter).

Lenka's narrative from the previous chapter is an adequate example in which she stated that although she perceives the physician as God, when talking about her experiences with hypertension treatment and her relationship with the doctors who treated her, she says:

"Who knows where I would have ended up, if I listened to what my cardiologists advised me… I've been struggling with high blood pressure for years… One of them [doctors] prescribed one therapy, the other one different therapy, and the third one something else…but none of them were able to regulate my blood pressure as I did on my own. I found out what therapy suits me the most, and now my blood pressure is normal and I've been living like that for four years already."

It is apparent in Lenka's description that not every woman and not always prefers to be a passive participant in the medical encounter. Furthermore, her example also shows how women (re)negotiate their roles under different circumstances and depending on the severity of the illness. Moreover, Lenka's story of her self-management of hypertension is one instance of how women rely on their embodied knowledge instead of the medical knowledge of the physician. She reported that the therapy prescribed by her physicians was making her "feel sick" and often incapable to perform her daily activities. With experimentation with different "cocktails" of medications and relying on her bodily responses, she managed to treat herself in spite of doctors' advices. Therefore, her narrative is a perfect example of how complex and often ambiguous the doctor-patient relationship is, and especially women's perceptions and responses in the medical power relations.

Class is another important variable which contributes to the availability of resources and possibilities for resistance. However, the research participant in the gynecological clinics and the interviewees belong to a middle/lower-middle class. Thus, critical analysis of class as a factor in patients' resistance strategies would not be included in this thesis because of the lack of participants from other class backgrounds.

4.2.2 Opting out (or minimizing the use) of institutionalized health care

Some women contested the physician's medical truth claims in a direct manner by clearly stating their preferences and by using various tactics (for example, by relying on biological essentialism related to motherhood, as discussed above) to achieve their goals. Other women demonstrated more subtle forms of resistance such as opting out (or minimizing the use) of institutionalized health care or non-compliance with prescribed therapy and/or use of alternative medicine.

For some women the diagnosis came as a surprise, they didn't have any symptoms of the disease or any suspicions that their body is going through pathological changes. Although this might vary depending on the diagnosis, various women from different diagnostic groups stated that they "*knew something was wrong*" long before they decided to seek medical care. For instance, Velida, Jagoda, and Liljana, all reported that they have suspected *"something out of the ordinary"*, they noticed unusual bodily symptoms, and through their narratives they pointed out to the fact that even before they were diagnosed somehow they intuitively knew what was happening to their bodies. When asked why they postponed medical intervention, some women attributed their "negligence" to their busy professional lives. Jagoda, for example, stated that although she was bleeding from more then three months, she consciously made a decision to prioritize her work over her health because at the time she simply couldn't afford to distract her focus of her busy schedule since she worked three jobs when the vaginal bleeding first occurred. On the other hand, Jagoda cervical conization was performed on her five years before she manifested symptoms of bleeding, and as she reported, due to that experience she had even greater reasons for concern but she suppressed them by focusing on her work. As a result of her previous diagnosis and encounters with the medical establishment, she accumulated certain level of embodied knowledge which made her alert to the abnormalities she was facing due to her latter condition. Although she didn't recall any problematic interactions with her medical team while being treated for her former condition, the experience of illness itself contributed to her negligence and made her reluctant to seek medical help the moment she noticed irregularities in her bodily functions. She remembered how helpless she felt when she knew that she couldn't do anything for herself except to rely on the expertise of the medical establishment. For her, entering the system of medical care signified not only a sense of a loss of control which implied rendering her well-being in the hands of medical professionals, but it also meant acknowledging a point of no return, which she desperately tried to avoid and postpone, or as she explained:

> *"You hope it will go away by itself that it will get better… but once you go see the doctor, once all the tests are made, suddenly it all becomes real… and then you have to deal with it…"*

Instead of "dealing with it" in a straight-forward manner, she chose to preoccupy herself with her professional duties and disregarded her symptoms for a period of three months. The amount of time which took her to accept and address her discomforts points out to the efforts she made to avoid entering institutionalized health care.

Similarly, Velida (who had a breast cancer surgery six years ago) reported that although she was aware of the lump on her breast for quite some time, she delayed the visit to the doctor to the point where the cancer had progressed to the stage where it was visible on the surface of her skin. Or as she explained: *"I knew what was wrong and I didn't want to go see the doctor, and when I eventually went there it was almost too late*", to which her doctor said: "*Why did you wait for so long woman? Did you come from the mountain? Don't you know how serious this is? You immediately need to go to surgery!*" However, unlike Jagoda, Velida contributed the postponement to seek treatment, or as she explained, in her opinion she's not an isolated case but

Balkan women in general have tendency for delay which according to her is a result of the "typical mentality of Balkan women, there's always something more important which comes first, whether is the children, or the husband or a sick parent… you get occupied with other things so you don't have to deal with your own problems".

Additionally, when reflecting on the specific moment when she was first diagnosed, Slagana stated that even though she noticed the changes in her breast, she waited for more than a year to schedule her appointment with the doctor. She explained that at the time when the lump on her breast appeared she was under a lot of stress related to the loss of both of her parents (her father passed away in a car accident and shortly after that her mother had a heart attack). When asked why she postponed medical examinations, she said:

> *"I was sick and tired of hospitals and doctors. Just remembering how my parents suffered and how painful it was for me to see them bed-ridden made me feel sick in the stomach. I didn't want to go through that again; I didn't want my kids to see me like that".*

Therefore, she made a decision to avoid seeking medical care, and instead preferred to be in a denial of the pathological changes in her breast. In her narrative she renders hospitals not only as spaces of suffering and pain, but also places of exacerbated vulnerability, which she tried to evade in order to protect herself and her children.

Although they state different reasons for their attempt to avoid seeking medical care, Jagoda, Velida and Slagana make conscious efforts to reduce their interactions with the medical establishment. Unlike the examples mentioned above, Stanche described her willingness to minimize her involvement in formal medical settings as a result to a problematic previous experience where prior to the operation she wasn't informed about the extent of the surgery and where during surgery her whole breast was removed. Stanche reflected on this occurrence with great disapproval and rather emotionally since she felt like her bodily integrity was impaired without her consent. She depicts this particular event as a reason for her distrust in medical professionals which impelled her to limit her interactions with the medical establishment to the minimum, to only *"absolutely unavoidable situations"*. Or as she points out: *"If I can do anything to prevent it [to seek medical care] then I would do it without a doubt"*.

The examples outlined above describe various stages of involvement or, to be more precise, limitations for engaging in medical interactions. Whether they mention previous problematic experiences or other reasons for postponing seeking medical care, what these narratives show is the discontinuity of passivity women demonstrate and their reluctance to accept medical power to be exercised on them.

4.2.3 Seeking for second opinion or for a more compliant physician

Instead of excluding themselves from the system of health care, when dissatisfied with the physician's treatment some women navigated their actions within institutional health care, either by seeking second opinion from another physician or by changing the physician who was not responsive towards their demands, for a more compliant one. Once again, I would like to point out that these cases represent an exception from the general responses of the research participants of this study.

Seven years ago, a month and a half after her normal PAP smear test, Jasna[7] noticed unusual vaginal discharge. After all the required examinations were conducted, her physician diagnosed her with CIN 3. His recommended course of treatment included folic acid (vitamin B9) and regulation of the diet (healthy diet regime), since as Jasna remembers, he said that: *"It's nothing scary, we'll treat it with vitamins"*. At the time Jasna was twenty-four and had given

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[7] Jasna is a thirty-one year old, Macedonian tailor from Skopje, a wife and a mother of two.

birth to her second child a year ago before the irregularities in her results. During a family gathering she showed the results to her godmother, who is general practitioner and she sent her immediately to another gynecologist in the main clinic in Skopje. Three days after she got the results a cervical conization was performed on her. As Jasna described this experience, on several occasions pointed out that it was her godmother who saved her life because of her rapid reaction, since if she didn't consult with her about the pap results, the pre-malignant changes might have progressed to become cervical cancer. In her narrative, Jasna demonstrates how she disregarded the prescribed therapy of her gynecologist and sought for a second opinion from another physician. The familial connection (with her godmother) in this case facilitated and encouraged her demand for second opinion. Regardless of the reason, Jasna challenged her physician's truth claims, and relied on the expertise of another physician. However, she didn't end the relationship with her gynecologist. In fact, she reports that even though he didn't acknowledge the seriousness of her condition at that time, she is still very satisfied with his services and continued her cooperation with him. She explained that she and her physician have long-term professional relationship, and interpreted the wrongful diagnosis as a one-time error.

Sonila[8], on the contrary, when experienced similar situation in which she felt as her physician discounted her symptoms, or as she says: "*he didn't take me seriously, he didn't pay enough attention*" she ended the relationship and found another physician who treated her in a satisfying manner. In her example, Sonila reflects on her active efforts to behave as credible patient (Werner and Malterud, 2003), and when her attempts failed, she engaged in search for a physician who would acknowledge her symptoms and demands. Jasna's and Sonila's cases,

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[8] Sonila is a thirty- two years old ethic Albanian lawyer from Tetovo (predominantly Albanian city in north-west Macedonia), married with two children. She discussed one particular encounter in which her physician disregarded her strong ovarian pain and didn't perform tests or prescribed therapy, but instead, told her that there's nothing wrong with her, that she has to be more patient and the pain would go away on it's own.

although different in content, since one of them demanded a second opinion and the other changed her physician for a another, more compliant one, both indicate to the activities women undertake in their pursuit for achieving desired health status and outcomes. This on the other hand, suggests that women are not simply passive subjects upon which medical power is exercised, but instead, according to their preferences and resources for resistance, they undertake various forms of strategies in their attempt to receive the care they require. Or as Liljana[9] elaborates:

> *"It's my right as a patient to get the treatment I deserve and which is best for me, both as a human being and as a citizen of this country whose rights are guaranteed by the law. I don't see why I would stay with a physician I'm not satisfied with…there's an abundance of them [laughs]…I could always find a better one…"*

Although she evokes legal discourse (available to her as a result of her profession) in explaining her rights to choose a physician, Liljana rightfully points out to the possibility of every Macedonian citizen to choose a physician of her preferences as it is stipulated in the Law on Protection of Patients' Rights (a right which is not frequently exercised by patients as noted in the study (Milevska-Kostova, 2006) on Patients' Rights in Macedonia). The findings of the study show that 60% of the patients never deliberately went to see another physician or asked for second opinion.

4.2.4 Non-compliance with prescribed therapy and/or use of alternative medicine

Unlike the women from these examples which opted out or minimized their participation in the system of institutionalized health care, some of women who participated in this study resorted to different measures and strategies which weren't directly related to challenging the

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[9] Liljana is a fifty years old lawyer and breast cancer survivor.

medical establishment itself (and physicians in particular) but were more associated with challenging the biomedical models of treatment and privileging other forms of therapy (alternative medicine), or even no therapy at all (depending on the seriousness of the illness). A young female patient presented in the doctor's office due to symptoms of irregular and painful menstrual cycles. During consultations, the gynecologist prescribed contraceptive pills as a method for stabilizing menstrual periods and alleviating symptoms of pain and discomfort. Although the patients didn't express her discontent with the assigned therapy during her interaction with the physician, in an informal conversation in the waiting room, she revealed to me that she has no intention of using contraceptive pills since she perceives them as "*artificial hormonal bombs, unnatural for the body*". Thus, she disregarded the physician's advice and opted for another option, which meant receiving no treatment at all.

On the other hand, Barda, a fifty-year old Albanian who was diagnosed with uterine tumors thirteen years ago, was advised by her gynecologist to undergo surgical procedure for removal of the tumors. Nevertheless, such surgery was not performed since she employed a different method of treatment by using alternative medicines, such as herbs, tea and other folk remedies, which enabled her to keep the growth of the tumors under control. Furthermore, she didn't report a conflict between her and the physician in regards to what course of treatment should be undertaken. In fact, she was given a chance to decide whether to have surgery or to abstain from it, and instead to report for regular check-ups every six months. She decided not to have surgery since perceived it as unnecessary: "*why go under the knife when you can find other options, which can be even more useful and less painful*".

Barda's example is an exemption in terms of relying solely to non-biomedical treatments. Nevertheless, most of the women in this study reported using alternative medicine, on most occasions with the knowledge and approval, and in some cases with the encouragement on the part of the physician. When it comes to matters of self-preservation, for most of the women seeking alternative treatment other then the one recommended by the physician seemed to be almost a requirement. Or, as Nadire[10] explained:

> *"I know the name, address and phone number of every healer in town… in the country, to be more precise. I've tried every tea, aloe vera, every herb, everything there is to try. Some things I found more helpful then others… Sometimes I traveled from one part to the other part of the country just because I heard about some women who was making "potions" for the thing [breast cancer] I had… It was tiresome on occasions, but I had to do it… I simply needed to know that I did everything I could to survive".*

In her narrative, Nadire reflects to the lengths a patient would go in order to maximize their health status, by using a combination of biomedical and non-biomedical treatment. The intent to survive prevails all other concerns and encompasses engagement in all sorts of treatments, whether approved by the physician or not. Most of the research participants explained that they have increased the intake of vitamin supplements, included healthy diet, and used folk remedies and other sorts of therapy and medications which are not associated with biomedical forms of treatments. Or, as Marina explained:

> *"Even if my doctor didn't encourage me, which he did, I would still have looked for every possible way to improve my health, irrelevant whether is a healer in some village or that tea they advertise on TV every day, you know the one that's supposed to make you live longer… [laughs]… you can never know what your cure can be, it might be chemo that will save you, but it might be even that tea… how know… you have to try everything… "*

By using both biomedical and non-biomedical, or relying solely on alternative treatments, the women participants in this study manifested their involvement in seeking ways to improve their health, which on the other hand, points to inadequacy to perceive women patients as passive recipients of care, with no agency on their own, subjected to the application of power on the

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[10] Nadire is a fifty-four years old breast cancer survivor from Ohrid, who was diagnosed and treated for breast cancer three years ago.

behalf of the physician in the medical encounters while neglecting their possibilities for resistance.

4.2.5 Concluding comments on women patients’ resistance in medical interactions

In this section of the analytical chapter I elaborated on how women patients articulate the discrepancies and discontinuities of their passivity in medical power relations, in which they engage in challenging the physician’s expert knowledge in direct manner, or they employ more subtle strategies, such as non-compliance with prescribed therapy, seeking for second opinion, limiting their involvement in medical interactions or relying on other forms of knowledge and using non-biomedical (or mixture of biomedical and non-biomedical) treatment. The strategies outlined above, reflect on women’s agency in achieving desired health outcomes and maximizing health status. This shows how medical power relations produce resistance on the behalf of women patients, which confirms my argument that they cannot be perceived simply as passive recipients of care.

Conclusion

In this thesis I explored the relationship between female patients and male physicians in gynecological health care settings in Macedonia. My argument is two-fold. First, I argued that women patients often accept and invite exercise of power on behalf of the physician in regards to decision making on health, by expressing their preferences to occupy a rather passive position in the medical encounter. However, they also engage in employing strategies of resistance varying from directly challenging of the physician's medical authority to non-compliance with prescribed therapy as a manner to optimize their health status and achieve desired health outcomes. In contrast to West-centric literature which points to the shift from paternalism towards greater patient autonomy and more egalitarian participation of patients in the medical encounter, I suggest that the paternalistic model of doctor-patient relationship is largely prevalent in Macedonian health care settings. The specific historical, political and social background of the country is crucial for understanding the physician-patient relationship and the paternalistic treatment which characterizes it. I believe that Macedonia's socialist legacy has a significant impact on the dynamics of contemporary medical interactions. During socialist times, health care services (and not only those) were delivered as 'charity' by the "parent-state" (Verdery, 1996), free of charge and supposedly with equal access to all citizens. Physicians occupied highly prestigious status in the society and established hierarchical relations with patients who were presumed as grateful recipients of their services. In this set of relations, awareness for patients rights was precluded, unlike in Western countries with longer tradition and culture for respect and consciousness of human rights in general, and the concept of patients' rights in particular

(Babic-Bosanac *et al.,* 2007). Conversely, in Macedonia[11] patients are rarely informed and educated about the existence of their rights and the legislation which protects them as such. Thus they infrequently seek legal aid in cases when their rights as patients have been violated, as a result of long and complicated legal procedures. On the other hand, health professionals are also under-informed about the rights of the patients and frequently oppose the concept since they consider it as a mechanism for undermining their decision-making powers and authority. Therefore, patients are rarely seen as equal partners in medical interactions and are often treated in paternalistic manner (Milevska-Kostova, 2006).

As Waitzkin (1991) points out, the embeddness of the individual in the social context affects the doctor-patient relationship, since it is reflected and reproduced in the medical encounter. I suspect that those forty years spent under socialism has shaped and influenced women's perceptions in regards to their roles and responsibilities in the medical encounter. Although twenty years have passed and the regimes have changed, I believe that one of the possible explanations for Macedonian women's preferences for a rather passive involvement in the medical encounter is linked to the country's socialist heritage and the lack of awareness for patients' rights. The naturalized and internalized respect towards authority, a feature highly valuable for socialist regimes, still has it effects on an individual level and it influences the perceptions of women patients of their relationship with male physicians in the context of Macedonian health care.

In regards to the gender dimension of the relationship between male physicians and female patients, it is important to take into consideration that gynecology in Macedonia remains segregated profession mainly dominated by men, even though there is significant demand for

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[11] Similarly to other former Yugoslavian countries (for instance see Babic-Bosanac et al., 2007 as an example from Croatia)

female gynecologists on behalf of the patients. For instance, in one of the gynecological clinics were I conducted participant observation, if the male gynecologist had approximately 2000 patients, the female gynecologist had 5000 patients. Because of the sensitive and intimate nature of the gynecological exam, women often prefer female gynecologists, especially in a country such as Macedonia where the position of women in the society is predominantly hierarchical with patriarchal values and women's sexuality is still considered a taboo (CEDAW Shadow Report for the Republic of Macedonia, 2005). As an example, if a woman is not married or is divorced, she should avoid seeking gynecological care in order to prevent to be dishonored in the society or in her community – a belief particularly hold by Roma women, but also relevant for women from other ethic groups (Ibid). As previously discussed, the position of being a patient presumes certain level of vulnerability which is even further increased if the woman belongs to marginalized group, such as Roma women or rural women. Thus the power asymmetry in the medical encounter is evident and points to women's vulnerability as patients. Under these circumstances, this thesis presents one of the few (if not the only) studies which take into consideration women's stories of their experiences with medical interactions in which they openly speak about dynamics of their relationship with male physicians in the context of Macedonian health care.

Nevertheless, one of the main limitations of this study is that is exclusively focused on women patients' experiences of treatment management and care. Both male patients and physicians are excluded from the research since my main inquiry deals with women's reproductive health. However, the limitations of this study open up possibilities for further research. I believe it would be insightful to include the physicians' perspective in the analysis in order to obtain more complete understanding of the complexities of the doctor-patient relationship. Moreover, I think that it would be interesting to see and compare whether the predominant paternalistic treatment is applicable to men (which I suspect it is), and to establish to what extent, what are the similarities and differences of female and male patients’ experiences on a national level, and possibly on a regional level among the countries which share socialist heritage.

References

Abel, E. K., & Browner, C. (1998). Selective Compliance with Biomedical Authority and the Uses of Experiential Knowledge (M. M. Lock & P. A. Kaufert, Eds.). In *Pragmatic women and body politics*. New York: Cambridge University Press.

Andreassen, H. K. (2011). What does an e-mail Address Add? - Doing Health and Technology at Home. *Social Science & Medicine, 72*, 521-528.

Archibold, P. G. (1986). Ethical Issues in Qualitative Research. In W. C. Chenitz & J. M. Swanson (Eds.), *From Practice to Grounded theory: Qualitative Research in Nursing*. Menlo Park, CA: Addison-Wesley.

Arora, N. K., & McHorney, C. A. (2000). Patient preferences for medical decision making: Who really wants to participate? *Medical Care*, 38, 335–341.

Bransen, E. (1992). Has menstruation been medicalised? Or will it never happen. *Sociology of Health and Illness*, 14(1), 98-110.

Bloor, M., & McIntosh, J. (1990). Therapeutic Communities and Health Visiting (S. Cunningham-Burley & N. P. McKeganey, Eds.). In *Readings in Medical Sociology*. London: Tavistock/Routledge.

Babic-Bosanac, S., Borovecki, A., & Fishter, K. (2008). Patients' Rights in the Republic of Croatia: Between the Law and Reality. *Medicinski Glasnik, 5*(1), 37-43. Retrieved June 1, 2011, from http://www.ljkzedo.com.ba/medglasnik/vol51/M8_7.pdf

Bubevska, A., & Hoxha, M. (2006). *Ženskata Strana na Prikaznata: Lični Prikazni za Krizata vo Makedonija, 2001*. Skopje: In-t "Evro-Balkan"

Buetow, S. (1995). What do General Practitioners and their Patients want from General Practice and are they Receiving it? A framework. *Social Science & Medicine*, *40*(2), 213-221.

Buttow, P. N., Maclean, M., Dunn, S. M., Tattersall, M. H., & Boyer, M. J. (1997). The Dynamics of Change: Cancer Patients' Preferences for Information, Involvement and Support. *Ann Oncol*, *8*, 857-863.

Burns, N., & Grove, S. K. (2005). *The Practice of Nursing Research: Conduct, Critique, and Utilization*. St. Louis, MO: Elsevier/Saunders.

Cash, K. (1997). Social Epistemology, Gender and Nursing Theory. *International Journal of Nursing Studies*, *34*(2), 137-143.

Catalan, J., Brener, N., Andrews, H., Day, A., Cullum, S., Hooker, M., & Gazzard, B. (1994). Whose health is it? Views about Decision-making and Information-seeking from People with HIV Infection and their Professional carers. *AIDS Care*, *6*(3), 349-356.

CEDAW Shadow Report: On the Situation of Romani Women in the Republic of Macedonia, 2005. Retrieved 20 May, 2011 from: http://www.errc.org/cms/upload/media/01/97/m00000197.pdf

CEDAW Shadow Report on the Republic of Macedonia, 2005. Retrieved 1 June, 2011 from: http://www.esem.org.mk/Root/mak/_docs/Izvestai/Izvestai%20vo%20senka.pdf

Center for Research and Policy Making. (2007). *Rationalization of Healthcare Services in Macedonia* (Vol. 4, Policy Study). Skopje: Center for Research and Policy Making. Retrieved from: http://www.crpm.org.mk/Papers/KnigahealthENG1.pdf Accessed on: 20.05.2011

Charles, C., Gafni, A., & Whelan, T. (1997). Shared Decision-Making in the Medical Encounter: What Does it Mean? (or It Takes at Least Two to Tango). *Social Science & Medicine*, *44*(5), 681-692.

Charles, C., Gafni, A., & Whelan, T. (1999). Decision-Making in the Physician-patient Encounter: Revisiting the Shared Treatment Decision-Making Model. *Social Science & Medicine*, *49*, 651-661.

Corea, G. (1985) *The Mother Machine: Reproductive Technologies from Artificial Insemination to Artificial Wombs*. New York: Harper and Row

Coulson, A. (1998), “Trust and contract in public sector management”, in Coulson, A. (Ed.), *Trust and Contracts: Relationships in Local Government, Health and Public Services*, The Polity Press, Bristol, pp. 9-34.

Davis, K. (1988) *Power Under the Microscope*. Providence, RI: Foris Publications.

Davis, K., Leijenaar, M., & Oldersma, J. (Eds.). (1991). *The Gender of Power*. London: Sage Publications.

Degner, L. F., & Sloan, J. A. (1992). Decision Making During Serious Illness: What Role Do Patients Really Want to Play? *Journal of Clinical Epidemiology*, *45*(9), 941-950.

Deveaux, M. (1994) ‘Feminism and Empowerment: A Critical Reading of Foucault’, *Feminist Studies* 20, 223–47.

Doyal, L. (1995). *What Makes Women Sick: Gender and the Political Economy of Health*. New Brunswick, NJ: Rutgers University Press.

Dresser, R. 1992. Wanted: single, white male for medical research. *Hastings Center Report 22*, 24–29.

Dunn, E. C. (2004). Ideas of Kin and Home on the Shop Floor. *Privatizing Poland: Baby Food, Big Business, and the Remaking of the Polish Working Class* (pp. 130-161). Ithaca: Cornell University Press.

Emanuel, E. J., & Emanuel, L. L. (1992). Four Models of the Physician-Patient Relationship. *Journal of the American Medical Association*, *267*, 2221-2226.

Entwistle, V., Prior, M., Skea, Z., & Francis, J. (2008). Involvement in Treatment Decision-Making: Its Meaning to People with Diabetes and Implications for Conceptualisation. *Social Science & Medicine*, *66*(2), 362-375.

Falkum, E., & Forde, R. (2001). Paternalism, Patient Autonomy, and Moral Deliberation in the Physician–Patient Relationship: Attitudes among Norwegian Physicians. *Social Science & Medicine*, *52*(2), 239-248.

Fisher, S. (1990). *In the Patient's Best Interest: Women and the Politics of Medical Decisions*. New Brunswick, NJ: Rutgers University Press.

Gambetta, D. (2000). Can we trust trust? In D. Gambetta (Ed.), Trust: Making and breaking cooperative relations (pp. 213–237). Electronic edition, Department of Sociology, University of Oxford, http://www.sociology.ox.ac.uk/papers/gambetta213-237.pdf.

Gilson, L. (2003). Trust and the Development of Health Care as a Social Institution. *Social Science & Medicine*, *56*(7), 1453-1468.

Goodrich, T. J. (1991). *Women and Power: Perspectives for Family Therapy*. New York: Norton.

Gunson, J. S. (2010). "More Natural but Less Normal": Reconsidering Medicalisation and Agency through Women's Accounts of Menstrual Suppression. *Social Science & Medicine*, *71*(7), 1324-1331 .

Hall, P. A. (1999). Social capital in Britain. *British Journal of Political Science*, 29(3), 417–462.

Hayry, H. (1991). *The Limits of Medical Paternalism*. London: Routledge.

Institute of Public Health of the Republic of Macedonia. (n.d.). *Health Care and Health Protection of the Population in Macedonia* (Annual Report of the Institute of Public Health-Skopje, Macedonia). Skopje, 2010: Institute of Public Health of the Republic of Macedonia. Retrieved from: http://www.iph.mk/images/stories/PDF/izvestaj_zdravje.pdf Accessed on: 20.05 2011

Istenic, M. C. (1995). Slovenia. In N. Johnson (Ed.), *Private Markets in Health and Welfare: an International Perspective*. Oxford: Berg.

Kaiser, J. 2005. Gender in the pharmacy: Does it matter? *Science* 308 (5728), 1572.

Kjosev, S., & Nedanovski, P. (2008). Health Care System in the Republic of Macedonia: Current Situation and Development Perspectives. *Revista Tinerilor Economisti (The Young Economists Journal)*, *1*(11), 71-77.

Lazarevik, V. (2010). Policy Interventions to Tackle Health Inequities in Macedonia: Patient Rights and Reference Pricing of Pharmaceuticals. *Macedonian Journal of Medical Sciences*, *3*(1), 57-60.

Law on Protection of Patients' Rights. Retrieved from: http://www.miahealth.mk/dokumentacija/80_648801981.pdf Accessed on: 21.05.2011

Lee, R., & Garvin, T. (2003). Moving from Information Transfer to Information Exchange in Health and Health Care. *Social Science & Medicine*, *56*(3), 449-464.

Lindbladh, E., Lyttkens, C. H., Hanson, B. S., & Ostergren, P. -. (1998). Equity is Out of Fashion? An Essay on Autonomy and Health Policy in the Individualized Society. *Social Science & Medicine*, *46*(8), 1017-1025 .

Lorentzen, J. M. (2008). I Know My Own Body': Power and Resistance in Women's Experiences of Medical Interactions. *Body & Society*, *14*(3), 49-79.

Lorber, J. (1994). *Paradoxes of Gender*. New Haven: Yale University Press.

Lorber, J. (1997). *Gender and the Social Construction of Illness*. Thousand Oaks, CA: Sage Publications.

Lupton, D. (1994). *Medicine as Culture: Illness, Disease and the Body in Western Societies*. London: Sage Publications.

Lupton, D. (1997). Consumerism, Reflexivity and the Medical Encounter. *Social Science & Medicine*, *45*(3), 373-381.

Lupton, D. (1997). Foucault and the Medicalization Critique. In A. R. Petersen & R. Bunton (Eds.), *Foucault, Health and Medicine*. London: Routledge.

MacLeod, C. and K. Durrheim (2002) 'Foucauldian Feminism: The Implications of Governmentality', *Journal for the Theory of Social Behavior* 32(1), 41–60.

Mansbridge, J. (1999). Altruistic trust. In M. E. Warren (Ed.), *Democracy and trust.* Cambridge: Cambridge University Press.

Margolis, H. (1996). *Dealing with Risk: Why the Public and the Experts Disagree on Environmental Issues*. Chicago, IL: University of Chicago Press.

McCoy, M. (2008). Autonomy, Consent, and Medical Paternalism: Legal Issues in Medical Intervention. *The Journal of Alternative and Complementary Medicine, 14*(6), 785-792.

Milevska-Kostova, N. (n.d.). Patients' rights in Southeast Europe. *Policy Documentation Center*. Retrieved May 20, 2011, from http://pdc.ceu.hu/archive/00002707/

Noerreslet, M., Jemec, G. B., & Traulsen, J. M. (2009). Involuntary Autonomy: Patients' Perceptions of Physicians, Conventional Medicines and Risks in the Management of Atopic Dermatitis. *Social Science & Medicine*, *69*(9), 1409-1415.

Nordyke, R. (2000). *Privatization of Health Care Provision in a Transition Economy: Lessons From the Republic of Macedonia* (Doctoral dissertation, Rand Graduate School, 2000) (pp. 1-133). Santa Monica: Rand Corporation.
Oakley, A. (1980) *Women Confined: Towards a Sociology of Childbirth* . Oxford: Martin Robertson

Parmelee, D., Handerson, G., & Cohen, M. (1982). Medicine Under Socialism: Some Observations on Yugoslavia and China. *Social Science and Medicine*, *16*(1), 1389-1396. Retrieved June 1, 2011 from http://deepblue.lib.umich.edu/bitstream/2027.42/24155/1/0000412.pdf

Parsons, T. (1954). *Essays in Sociological Theory*. Glencoe, IL: Free Press.

Pilnick, A., & Dingwall, R. (2011). On the Remarkable Persistence of Asymmetry in Doctor/Patient Interaction: A Critical Review. *Social Science & Medicine, accepted manuscript*, 1-38.

Polit, D. F., & Beck, C. T. (2004). *Nursing Research: Principles and Methods*. Philadelphia: Lippincott Williams & Wilkins.

Portelli, A. (1995). Research as an Experiment in Equality. In *The Death of Luigi Trastulli and Other Stories: Form and Meaning in Oral History*. Albany-New York: Sunny Press.

Roberts, D. (1996). Reconstructing the Patient: Starting with Women of Color. In S. M. Wolf (Ed.), *Feminism & Bioethics: Beyond Reproduction*. New York: Oxford University Press.

Robley, L. (1995). The Ethics of Qualitative Nursing Research. *Journal of Professional Nursing*, *11*(1), 45-48.

Rogers, W., & Ballantyne, A. (2008). Gender and Trust in Medicine: Vulnerabilities, Abuses, and Remedies. *International Journal of Feminist Approaches to Bioethics*, *1*(1), 48-66.

Say, R., Murtagh, M., & Thomson, R. (2006). Patients' Preference for Involvement in Medical Decision Making: A Narrative Review. *Patient Education and Counseling*, *60*, 102-114.

Sherwin, S. (1996). Feminism and Bioethics (S. M. Wolf, Ed.). In *Feminism & Bioethics: Beyond Reproduction*. New York: Oxford University Press.

Smith, J. F. (1996). Communicative Ethics in Medicine. In S. M. Wolf (Ed.), *Feminism & Bioethics: Beyond Reproduction*. New York: Oxford University Press.

Stake, R. E. (2003). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of Qualitative Inquiry*. Thousand Oaks, CA: Sage.

Thiessen, I. (2007). *Waiting for Macedonia: Identity in a Changing World*. Peterborough Ontario: Broadview Press.

Todd, A. D. (1989). *Intimate Adversaries: Cultural Conflict between Doctors and Women Patients*. Philadelphia: University of Pennsylvania Press.

Turner, B. S. (1992). *Regulating Bodies: Essays in Medical Sociology*. London, England: Routledge.

Verdery, K. (1996). From Parent-state to Family Patriarchs: Gender and Nation in Contemporary Eastern Europe. In *What was Socialism, and What Comes Next?* Princeton, NJ: Princeton University Press.

Waitzkin, H. (1991). *The politics of medical encounters: how patients and doctors deal with social problems*. New Haven: Yale University Press.

Weber, M. (1978). *Economy and Society: an Outline of Interpretive Sociology* (G. Roth & C. Wittich, Eds.). Berkeley (Calif.): University of California Press.

Werner, A., & Malterud, K. (2003). It is Hard Work Behaving as a Credible Patient: Encounters between Women with Chronic Pain and their Doctors. *Social Science & Medicine*, *57*(8), 1409-1419.

Ziebland, S., Evans, J., & McPherson, A. (2006). The Choice is Yours? How Women with Ovarian Cancer Make Sense of Treatment Choices. *Patient Education Counseling*, *62*(3), 361-367.

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