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Ob/Gyn Women in a #Metoo World: Unraveling Agency, Gender Bias, and Gender Inequity in the Workplace

Corey L. Bazemore
University of Central Florida

OB/GYN WOMEN IN A #METOO WORLD: UNRAVELING AGENCY, GENDER BIAS, AND GENDER INEQUITY IN THE WORKPLACE

by

COREY BAZEMORE

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ABSTRACT

This research explores the visibility of women physicians, specifically in gynecology and obstetrics. It focuses upon their perspectives of gender inequity and sexual harassment within their broader profession and individual daily workplace. This study explores the medical and STEM women's awareness and understanding of sexual and gender microaggressions within their professions by interviewing six women physicians. I analyze these narratives in relation to the #MeToo movement and how this movement gives visibility to the voices of women across workforces, including medicine, STEM, and other academic areas. This study shows the ongoing need to develop deeper conversations and interventions about women doctors' experiences with gender discrimination and sexual harassment. This study adds a feminist interdisciplinary discussion of women physicians paving the way for further research across all specialties of medicine where women occupy space. My methods include five telephone and one in-person interviews and review of public statements such as medical professional associations and other public discourses. I analyze the women's narratives alongside how the #MeToo movement has intervened on behalf of women in medicine. My data showed how the women experienced microaggressions whether they realized it or not. From men in positions of power and written rules within hospitals written by men, women were placed at a disadvantage within the workplace. Further research can be implemented to study the intersectional identities along with gender in medical specialties.

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CHAPTER ONE
INTRODUCTION

Aside from pediatric medicine, today gynecology/obstetrics is the only specialty mostly led by active women physicians compared to men.[1] These are immense strides of change in a medical field founded by Dr. James Marion Sims and rooted in the unconsented experimenting on enslaved Black women.[2] It is important to recognize the painful history of gynecology and obstetrics in the world we live in now. Recent statistics demonstrate that more women than men train as gynecologists and obstetricians.[3] According to the Association of American Medical Colleges (AAMC), 23,740 out of 41,619 obstetricians and gynecologists are women and 17,879 are men; and there are more women in residency programs as well.[4] Among the majority of women physicians in gynecology/obstetrics, over half practice in hospital.[5] Women gynecologists and obstetricians routinely interact with a large number of male physicians, healthcare providers, and administrators beyond their private offices.[6]

This is an interdisciplinary project that explores how gender violence and professionalism in medicine manifest in the workplace. “Gender effects” contribute to the experiences of women within an institution and negatively affects them socially, often to deter their professional growth.[7] Gender effects are a result of stereotypes, biases, and inequalities that invade their social culture within the profession. Gender stereotypes and other related social barriers continue to be serious obstacles in the profession, leading to various professional backlashes.[8] Gender discrimination manifests as disrespectful remarks and lack of promotion, resources, and professional mentoring.[9] The resistance from their organizations to report discrimination incidents contributing to worsening the situations.[10] Gender discriminatory incidents must be

addressed with changes to professional organizations' and institutional policies. These policies must increase sexual discrimination education to workers and raise awareness about broader women's issues that impact the workplace.

I would like to briefly address an existing dark of gynecology and obstetrics not a focus to this study. A predatory relationship between physicians and patients that has occurred in multiple medical specialties. A study by physicians in the United States (U.S.) in 2019 reported that these cases are not adequately resolved and physician perpetrators are not adequately disciplined.[11] A recent news article online, from the news website Public Citizen, outlined a few of the incidents from the past decade.[12] The occurrences involved sexual harassment and abuse of women and children patients by male physicians. The silence of sexual misconduct in medicine is persistent towards patients and women physicians greatly contributing to the inequality against women physicians that I examine in this thesis.

At the start of my research, I came across a survey conducted by physicians in the American Association of Gynecologic Laparoscopists (AAGL). This data inspired me to further research the #MeToo movement and gender discrimination within the field of gynecology and obstetrics. According to the AAGL survey, policies and institutional education are shaping medical practices given the heightened awareness emerging from the #MeToo movement.[13] The AAGL survey provokes further investigation into how gender discrimination and sexism "look" in the field. The invisibility of women's struggles with gender discrimination and sexism is too often ignored. The #MeToo movement empowers those to reflect on these interactions within the workplace and to ensue change upon the institution. The AAGL survey is important data to remind us that gender discrimination is a common occurrence in blue-collar jobs, and that healthcare is no different.

In the wake of the #MeToo movement initiated by Tarana Burke in 2006, a social movement that empowered those who felt silenced, training and policy changed within institutions.[14] However the AAGL survey revealed that most incidences of sexual microaggressions or harassment in medicine are not reported, with most victims being women.[15] These incidences are seen as physical and non-physical forms of attempts to hold power over another person. The #MeToo movement empowered some women in medicine to identify occurrences in the workplace and reflect on them with others a part of the movement. While race was not directly addressed in this study, race and sexuality are social factors that significantly contribute to sexual harassment and discrimination in the workplace.[16] The term "intersectionality" coined by Kimberle Crenshaw is critical for analyzing these intersectional identities and the increased vulnerability of these women to racism and sexism beyond this study.[17]

"The Awakening" is a collection of stories from women in rebuttal to an all-male conference at Stanford University.[18] The website documents women in academia as they share their past stories and how the movement has forged the telling of these stories.[19] The "awakening" represents the increase in courageous women coming out to tell their truths. The academics refuse to allow these experiences of sexual harassment to hinder their professional and personal growth. The #MeToo movement requires examining sexual culture of medical institutions as a whole and how the movement may contribute to eradicating gender inequality and violence in medicine. The new institutional policies must be closely monitored in how the roots of inappropriate interactions between healthcare workers and other physicians are addressed according to the participants in my research.

The goal of this feminist study is to highlight the experiences of women as gynecologists and obstetricians and explore their perceptions of sexual harassment in the workplace. It is a feminist approach by centering power relations and institutional power in patriarchal systems such as medicine.[20] I explore interactions that will lead to a broader understanding of the interactions of the women physicians with healthcare workers and within the healthcare institutions. By interpreting gender culture in medicine, I identify ways to recognize gender inequity and violence within the workplace. The gender culture in the workplace is rooted in "cultural beliefs, secondary causes relate to organizational structures, policies, and practices."[21] Gender culture in the medical field being affected by gender discrimination and "gendered family responsibilities" furthers the gender inequity between men and women physicians.[22] This study is important for the field of women's studies to interrogate questions such as how women in predominantly male workforces most fluidly move through these spaces. I analyze as a rising feminist the effects of the #MeToo movement on the agency of the women participants. In order to understand such women's experiences, I consider what gender effects look like for them in their careers in medicine that continues to be broadly male dominated.

CHAPTER TWO
LITERATURE REVIEW

In this chapter, I review the literature in gender inequity and inequality and some of the feminist scholarship, particularly relating to the #MeToo movement. This literature review shows the problems of gender culture of medicine and in other professional workforces. The #MeToo movement allows us to contextualize the agentic and gender issues within multiple fields, including medicine. It also shows the gaps in research to address the similarities and differences across women obstetricians/gynecologists and other women's professional workplaces.

Gender in the Workforce

Gender shapes ideas and images of people and how such are portrayed in society.[1] A man and a woman could display the same attributes, for example, during a speech, but the perception of the speeches and speakers is totally different.[2] Based on research by Deborah Tannen, a woman who displays male characteristics in her speech would be negatively perceived, while a man displaying the same characteristics would be cheered on.[3] If a woman took on qualities of a stereotypical man, she would be referred to having a "psuedomasculine style" and having little tact.[4] As a way to describe these gender stereotypes, a "lack of fit model" is used to depict these women seen in many professions.[5] The model further explores that "gender stereotypes portray men as agentic and women as communal."[6] For example, physicians are given male characteristics to describe them such as being agentic and assertive. However, these characteristics are contradictory to the stereotypes placed upon women. The example of opposing traits in medicine define gender stereotypes and how women are seen as unequal in the

workplace. The literature proposes ways in order to combat the "lack of fit model" such as normalization of women at high ranking positions, providing family planning options for fathers and mothers, and changing gendered culture in the workplace.[7] Dr. Carolyn Skinner adds to the ideas of Dr. Heilman and Dr. Caleo through her book comparing today's professional women to the women in the 19th century. In her introduction she explains, ". . . modern professional women still often find themselves juggling competing expectations for speaking as women and as professionals. . ."[8] The lack of fit resulting from stereotypes women and men are given provide a barrier for women physicians and professionals in the workplace. Women's autonomy and lack of agency is contradictory to the expectations of a woman in society and the medical workforce.

Women across workforces face different forms of gender discrimination and/or harassment. Unfortunately, most incidents are not reported out of fear that their claims will not be heard or believed and fear of jeopardizing their careers or employment.[9] According to the AAGL survey, the number of reported cases of gender discrimination and harassment has been stagnant, which has led me to the conclusion that policies and education systems for sexual harassment have not improved either.[10] Gender discrimination will look differently depending on the profession. Gender discrimination and workplace violence takes place in a wide variety of fields where power structures inhibit the progression upward in female professionals and physicians' fields.

Feminist Studies of Structural Violence in Science, Technology, and Medicine

Feminist theory examines gender through social interactions and power.[11] Gender violence seen through feminist theory looks at topics such as: personal and public spheres of

influence, cycles of violence, and the experiences of the victim.[12] For example, emotional abuse is a form of gender violence according to the literature that manifests across indirect and direct interactions and is difficult to identify.[13] Feminist theory emphasizes the need to take these interactions seriously in order to raise awareness of workplace violence.[14] Feminist Mary Mahowal explains feminism can be useful in counteracting gender stereotypes of women in medicine.[15] Within medicine this applies to looking at how the interactions between male and female physicians with different levels of power in the hospital. Gender inequality in healthcare is shown in the unequal distribution of women and men in the workforce. More women than men work in lower groups of healthcare workers while men make up the majority of the surgical workforce.[16] Gender discrimination and workplace violence takes place in a wide variety of fields where power structures affect female professionals and physicians, inhibiting their progression.

Gender discrimination looks differently depending on the profession. Literature notes how "Maleness is determined not only by the job itself, but by occupation (e.g., the military vs. education), subfields or professional specialties (e.g., surgery vs. pediatrics), academic fields (sciences vs. humanities), and function and level within an organization."[17] The Science, Technology, Engineering, and Mathematics (STEM) fields and medicine reveal the entrenched male dominance through many existing cases of gender discrimination and harassment. The extensive amount of such gender violence also reminds us that women will be subject to these experiences in male-dominated occupations. As it stands, most medical specialties continue to have more men than women professionals. From physicians Dr. Tolbert Coombs and Dr. King's research, they found that gender discrimination is the second largest form of discrimination to impact female physicians.[18] The medical scholarship argues that gender discrimination means

deterring the progress within their profession and will result in punishment and lack of respect.[19] For physicians it suggests that there is ". . . lack of promotion, failure in decision making processes, inadequate research time allocation and deficiency in mentoring."[20] The scholarship will help in understanding the female obstetricians and gynecologists' experiences in the study. During analysis, I will get a better understanding of the big picture of their experiences of gender discrimination and harassment knowing how it will look for female physicians in the workplace.

The #MeToo Movement

The #MeToo movement is a critical public discourse platform and social action tool to connect the women's experiences in the workplace to how women within the feminist movement examine institutional and gender violence.[21] The #MeToo movement sparked many conversations and courses of action to implement institutional and systemic change.

The movement founded by Tarana Burke in 2006 initially aided Black women affected by sexual violence, which led later to the widespread hashtag in 2017 over social media that began the conversation nationally.[22] These public conversations worked to combat the erasure and silencing of many women on a national scale, especially women who are biracial people of color (BIPOC), and in turn, offered many opportunities for healing and transformation to those affected and in silence.[23] As a result, the #MeToo movement now has outreach pathways to empower and educate communities fraught with gender violence.[24] To date, the ongoing conversations, both virtually and face-to-face, are an impact of the #MeToo movement with far reach and institutional change. For instance, in the wake of the #MeToo movement, Maryland passed a gender equity law to enhance the Equal Pay Act in 2017.[25] The new act forced employers to be proactive in assessing deficits in wages among their female and male

employees.[26] The movement provides support for women, education systems, and creating resistance against systems that deter the movement.

The #MeToo movement has brought awareness to the workplace. It has offered renewed or innovated, bold strategies for addressing sexual harassment. A study shows that the #MeToo movement ". . . advocates the need for employers to establish an organization wide culture of respect in which the sexual harassment is not tolerated, with the goal that it simply will not occur."[27] The research suggests how when organizations and institutions take serious responsibility for the prevention and addressing of gender discrimination or harassment, its employees are highly compelled to do the same and adhere to workplace policy. Dr. Stephanie Fortado explains that, ". . . there is potential for #MeToo to become a public rallying cry for changing workplace culture and mobilizing workers around specific sets of demands."[28] In women's studies and feminist professor Dr. Tegan Zimmerman writings she recognizes Twitter as a tool for intersectional feminists and a key factor in Fourth Wave Feminism.[29] This is important for the discussion of the hashtag that popularized the #MeToo movement.

The use of Twitter can spread a feminist movement quicker and further than ever before. There is evidence that #MeToo movement is effecting change toward workplace policies and work culture in STEM. The #MeToo movement allows for a conversation to begin within the medical community about gender violence and to make progress in improving spaces of equality for women in the workplace. I will use agency, gender inequity, and gender bias to analyze the gender discrimination and harassment throughout my thesis. These analytical tools help to interrogate the gender culture of medicine and other workforces.

CHAPTER THREE
METHODOLOGY

In this study, I utilized feminist ethnographic methods to provide an anthropological understanding of gender discrimination and other gender effects within the workplace of female gynecologists. Ethnography is used in the collection of qualitative data in cultural anthropology through observing and recording experiences. *Feminist Ethnography* analyzes gender and power dynamics produced within interactions and relations.[1] I used this text as an ethnographic tool to guide the collection of qualitative data for the study. Semi-structured interviews and observation of the physician outside of patient care were used to allow for discussion around the interview topics. Observations during the interview were recorded and include the setting, behaviors, and physical attributes (how she dressed and presented herself). The observations were limited because only one of my interviews were conducted in person due to the COVID-19 outbreak.

The interview sessions were all audio-recorded to collect detailed field notes. I transcribed the audio recordings and read carefully to decode interview transcripts. During analysis I searched for key words, consistencies, and contradictions within the transcripts of all the interview data. One interview took place at their medical practice and five interviews took place as a phone call. I recruited six women participants of twenty-five to sixty-five years of age, who identified as physicians and "women" mainly in gynecology and/or obstetrics, and work in various settings such as a hospital, clinic, or solo practices within Central Florida. In my data I focus on the gender of the participants and exclude race and ethnicity as criteria for the study. The sample did however include two women of color and I recognize the impact that race and sexuality has for future research.

Some interview questions included: How would you describe gender stereotypes for women gynecologists? How would you describe gender roles in the medical field? How do you define sexism and see it manifest in your field? Do women physicians get treated differently by other physicians or healthcare workers compared to male physicians? Is there women-women conflict within the workplace? Is going into a "female specialty" empowering to women or looked down upon for following a norm? Is there a gender culture and is it a positive or negative impact on collaborating, patient care, or professional development? What established rules and codes are in place to protect women from workplace discrimination in hospitals? What established rules and codes are in place to protect women from workplace discrimination in hospitals? If you have heard of the #MeToo movement, in your professional experience would it benefit women gynecologists and obstetricians to have an alliance with this organization to eradicate gender bias (leading to gender violence)?

The interviews lasted fifteen to thirty minutes and included the participant being audio recorded if they gave consent (which all participants did). These recordings are stored in a secured drive in order to protect the confidentiality of the participant and in order to best interpret the field notes of the women I interview for the study.

Media outlets are relevant sources for my research that provide context and examples of current incidences of workplace violence. I used media outlets such as news reporting (ex. The Chronicle of Higher Education) and social media (ex. Twitter). Media influences the perceptions of harassment in the workplace and the awareness of problems surrounding sexual harassment. Sources such as news sites, movement websites, and articles advocating for the #MeToo movement will be useful to analyze the participants' interview data. The research and analysis

conducted between November to July 2020 includes the participants' interviews and the expansion of my literature review.

Ethics

I inquired into a sensitive subject for women who may have been affected by sexual harassment or know others who have been. I took precautions during my interviews with the participants, as individuals and professionals, such as being respectful and understanding of what and how much of their experiences is shared. I honor the anonymity of these women for the protection of their experiences and identity in their personal and professional lives. As a pre-medical student wanting to be a part of these women's professional world one day, I conducted this research to highlight the injustices and gain insight through the practice of ethnography.

CHAPTER FOUR
GENDER INEQUALITY: FROM SOCIETY TO MEDICINE

Gender inequity in the workforce is still a major dilemma in American society. Men's inappropriate sexist behaviors and boundary breaking interactions remain unaddressed in many workplaces and professions. Microaggressions and overt disrespect were commonly experienced by the participants in the workplace. Furthermore, the pay inequity and limited agency in seeking out leadership opportunities for women physicians were reoccurring issues throughout my research findings. As a biologist studying science as are the women in medicine, I see more clearly how the experiences of their social world within and outside of the medicine field overlap. With this perspective, I analyze the experiences of women in medicine in relation how the social world acts on the participants. I discuss my ethnographic data about the women physicians to show a deeper view of how they experience microaggressions, agency, and gender inequity in the workplace.

Participant Demographics

The physicians worked in different medical arrangements such as having an affiliation with a hospital for surgical privileges, no longer working in a hospital setting, or currently working at a hospital or private office. In addition to the five obstetrics/ gynecology participants, one participant specialized in gastroenterology.

I interviewed Dr. Ryder in person at her private practice. In my interview with her, I formed a connection and created a more welcoming environment to talk about personal details. Over the phone is less personable and created more difficulty in assessing the comfortability of the participants about my questions. Dr. Ryder has been practicing for over thirty years in her solo

practice. Although she works in her own private practice, she performs surgical procedures at a local hospital. Dr. Ryder is a gynecologist who specializes in urogynecology from the Netherlands. She is familiar with treating different organs in the pelvic area and continues to only treat women patients much like an obstetrician/gynecologist. Dr. Ryder dressed feminine with her hair down and medium heels. I could not imagine being in heels all day as a busy physician. I wondered why she chose less comfortable footwear but perhaps it held importance for her to express her feminine gender. Dr. Ryder and all of the physician participants spoke in a confident and assertive manner during our interviews. Similar to Dr. Ryder, Dr. Almond also works at a private practice. However, she also works at the same practice with an obstetrician/gynecologist who is a male. Dr. Almond has been practicing gynecology for twenty-four years and currently works in Central Florida.

Dr. Kelman has been practicing for twenty-three years as an obstetrician and gynecologist. She is the only obstetrician/gynecologist at her hospital location and has a separate office at the hospital to have visits with patients. Dr. Kelman is in the same healthcare group as two other female obstetrician/gynecologists whom she interacts with but not frequently at her current workplace. In Dr. McCloud's case, she works in a larger hospital and has many daily interactions with male physicians. Dr. McCloud has been practicing for twenty years as an obstetrician and gynecologist and works in a hospital in Ohio. Dr. McCloud is a Black woman but did not further explain if her race impacted her as a woman physician. She used to work with a residency program in Central Florida, which is how I got in contact with her. Dr. Tipple has been a practicing obstetrician and gynecologist for thirty-one years. She currently works in the Central Florida area as a residency program director. She has also worked on the board of executives at the American College of Obstetrics and Gynecologists (ACOG) in the past. She provided

additional knowledge on the field of gynecology and obstetrics that the other physicians could not. I discuss her time as an executive board member of ACOG in the next section.

Dr. Sanger is a gastroenterologist from India and has been practicing for thirteen years in Central Florida. She did not expand upon if race had an impact on her as an Indian woman in medicine. My interview with Dr. Sanger gave me an additional perspective on the gender inequity discussed with obstetricians and gynecologists. Gastroenterology is a competitive surgically dominated specialty with the much larger majority of physicians being men.[1]

Discussing the workplaces and demographics of each physician is important for analysis in the following sections. With this information we gain the big picture behind the creation of microaggressions and power struggles within healthcare. The participants' specialty, years as a physician, and places of practice all contribute to the told experiences and analysis of them.

Microaggressions and Medicine

As I explained to each physician the purpose of my research, I received different reactions from them. Some doctors were very supportive and interested in telling their stories. Others were more wary and wanted to distinctly set themselves apart from women who had experiences with workplace sexual harassment. Dr. Sanger and Dr. Almond both lacked an awareness of experiencing any occurrences compared to the other physicians experiencing microaggressions in the workplace. Being a woman in a male dominated industry is challenging because masculinity sets the bar for defining efficiency and success. These characteristics placed on women physicians works against the gender roles experienced by women. This upward struggle will show in their interactions with men and systematically within an institution.

Dr. Kelman felt the pressure to live up to the standards of a male physician or get called a girl. Although Dr. Kelman does not work with male physicians in her office, she faces disrespect by male hospital administrators and faced disrespect of male physicians in residency. Similarly, Dr. McCloud said in residency she had to be, "performing to make sure no one thought you couldn't pull your weight or weren't as smart." Dr. McCloud told me that the residency program she attended stood mostly run by men which greatly impacted the culture and attitude of the program. For example, she stated "[Residency directors] ask only women where asked if they plan on having a family and hire or not hire based upon this." Also, fewer women physicians as attendings (a physician who oversees residents and students of specialty) decreases the chances for female residents to have role higher models in medicine.

However, in the physicians' workplaces today microaggressions appear differently than when these women were residents. The participants also still feel the pressure of having to perform at a higher standard than men just to be seen as equally competent physicians. For example, Dr. Ryder told me that women are viewed more critically than men such as being held more accountable when something goes wrong. Many microaggressions also are shown as a lack of respect towards these women in gynecology and obstetrics. Dr. Almond told me of a time she had to do a procedure early in the morning while sick. Upon arriving at the hospital, she saw that her surgery rescheduled to accommodate for a male physician. She knew that the change in the schedule did not change due to the urgency of the surgery. Her surgery time changed with no notification and so Dr. Almond asked the charge nurse, "I don't understand why you put him first, why because he's a man?" The charge nurse did not argue and gave Dr. Almond her original surgery time. Dr. Almond took the charge nurse's actions as confirming her thought that the male physician's time had preference over her own. Similarly, Dr. Kelman felt her gender

play into interactions with other hospital workers. For example, Dr. Kelman experienced being dismissed after being invited to share her thoughts about at issues at a meeting with other male hospital administrators. She believed that the male administrators would go with their original plan anyway. Dr. Kelman said, "healthcare administrators . . . ask[ed] just to say they did." Dr. Kelman's sentiment is similar to another participant, Dr. McCloud. At Dr. McCloud's hospital, whenever going in for surgery the nurse anesthetist will only address her by her first name where he will use the doctor's last name if they were a man. Dr. McCloud told me she moved on by laughing it off even though this is clearly disrespectful behavior. She also reported experiences of disrespect from male physician colleagues, male administrators, and healthcare workers in the operating room. The microaggressions shown through the participants' experiences are lack of respect and higher standards expected of women.

In some instances, the women would even minimize their experiences with microaggressions as if it they did not hold insignificance. Some of the women have even expressed that they have gotten to a point of not caring what the guys think anymore. Dr. Sanger and Dr. Almond said that they were not aware and deflected or did not answer many questions I had with details. Dr. Almond, similar to Dr. McCloud, said she allowed for remarks said by male physicians to not be important to her. She had an assertive tone in assuring that what she said got across without miscommunication. Dr. Almond also blamed herself for having a more complacent and female personality. She told me, "If people take advantage of me sometimes then that may be one of the reasons." The microaggressions from other male physicians could have been occurring, but the women chose to not process it as such and merely brushed it off. Another reason for this occurrence is that the microaggressions may be normalized for them and therefore would have a lack of awareness in this case.

The other women participants however have heard obstetrics and female pelvic surgery minimized by men compared to other surgical specialties which are dominated by men. The amount of skill and factors that go into vaginal reconstruction and pelvic surgeries is not recognized enough because it is surgery specifically for a woman's reproductive system. Dr. Kelman received a comment by from a male surgeon on being an ob/gyn, "The surgeon said ob/gyn's aren't real surgeons, comparing us to midwives." Dr. McCloud had the same instance happen to her where a surgeon asked her why she didn't want to be a real surgeon. However, some of the participants did not encounter these types of surgeons and did not think of it as a popular standpoint of other surgical specialties.

Despite the interactions with other physicians, the participants are women physicians who want to help other women, and many of them want to be an advocate for their patients. The physicians opened my eyes to issues that need to be advocated for the women that they treat and that there is a systemic issue of not valuing the bodies of women. There is a discrepancy in what surgeries are covered by insurance for men and women, a need for research on how medicines effect women, a need for research on how diseases affect women, and sexual harassment/assault occurring between physicians and their patients.

Most of the participants recognized some sort of microaggression in the workplace from when they were in residency or in their current position. However, two of the physicians said they did not pay any mind to if microaggressions occurred or thought of gender inequity as a problem within their field. All of the gynecologists and obstetricians believed that conditions regarding gender discrimination improved since they were in residency. Dr. Tipple shared an example of her residency experience: eighty to one-hundred hours work weeks and little protected time off or teaching time due to harassment from attendings. The gynecologists and

obstetricians in residency twenty to thirty years ago had experienced microaggressions within their field such as being criticized for showing female characteristics, having a culture of overperforming to be seen as equals, and having to downplay remarks said by male residents or attendings.

Physician Gender Inequity and Motherhood

All physicians shared being mothers while holding down a medical profession; only Dr. Kelman and Dr. McCloud expressed how motherhood made an impact on their career. Both of these women have been practicing for over twenty years and currently hold or have held administrative positions of some kind within the field of gynecology. I realize some of the physicians may not have realized the connection between having a difficult pregnancy or time managing parenthood due to the demanding environment of being a physician and gender discrimination. Their motherhood and career may not have crossed paths, but since my interview did not explicitly ask these questions, I cannot know definitively.

To have a career as a gynecologist and obstetrician will make both work and life balance difficult. The difficulty of work-life balance is true especially for women physicians that take on a second shift after work with home obligations. The second shift, coined by feminist scholar Arlie Russell Hochschild (1989), is an unequal workload put on the woman of a household and can be relatable to refer to it as another job.[2] This occurs because of the unrealistic expectation of women to be the main barer of domestic responsibilities.[3] The long hours and being additionally on-call as an obstetrician is very demanding. Dr. McCloud and Dr. Tipple both mentioned how this is a big factor for women choosing an administrative or executive board position within medicine.

Dr. McCloud said that the lack of women running residency programs and lack of women staff affects the attitude of a residency program. Dr. Tipple saw the obstetrics and gynecology workforce as a complex issue regarding gender. The issue is older male physicians controlling leadership roles and the presence of a large young population of women in residency. This is significant since according to Dr. Tipple, "Male residents from my era and female residents of today have different work expectations. Women are willing to work 80% of what a man will work. Not that they are lazy or don't want to work hard, they just have the right point of view." This is an example of gender inequity attempting to be resolved through amount of work put on each gender. Although, the differing points of view from the men in leadership and women in residency creates a struggle to be respected still today.

Dr. McCloud and Dr. Tipple shared their thoughts on how female physicians who are also mothers have role strain. Especially in an early family, seeking out a leadership role only adds on to the burden of being the primary caregiver for the family. Dr. McCloud said, "Because of a patriarchal society, females who are doctors may already have enough role strain: 'supermom,' breadwinner, primary caregiver, and PTA (Parent-Teacher Association)." As a result, women in medicine may choose to pursue leadership positions later on in their career or not at all. While Dr. McCloud worked at the residency programs, she mentioned how the meeting times worked poorly for the schedule of a mom. She also shared the story of a female general surgeon at the same hospital who adopted a child and had to retire in order to have more time with her child. Dr. Kelman did not only feel the pressure of proving herself as a woman but also the pressure of being pregnant twice during residency. She had to hide her so-called "girl problems" during her pregnancies while also having a male attending tell her to sound less like a girl when giving a

report. Healthcare institutions are not structured to support these women and are built to systematically make it more difficult for women to move up in positions.

The participants portrayed the strength of people who have succeeded in their career despite the seen or unseen barriers society put against them. Hearing the stories from these women inspired me and yet saddened me. The healthcare institution is pitted against women as physicians and works against them. Through limited parental leave, long work weeks, and pay inequity: women need more accommodations in health care to be gender equals. Gender inequity and agentic issues is still in medicine even with the increasing younger population of female residents. There is still more to be done to improve the inequality that exists in healthcare even though so much changed since these physicians were in residency. None of the instances of microaggressions in this chapter have been reported and despite a way to report these instances, they have been all shrugged off and only seen as lessons for being a woman in medicine. I raise the question: Why do women in medicine have to change themselves in order to be recognized as competent physicians?

In Chapter Five, I discuss how my interpretations of participants' views about gender stereotypes in medicine and their perceptions of their gender roles are critical for reimagining social change in medicine. The #MeToo movement is an opportunity for the intervention of that social change. I include the participants' own experiences and knowledge of the #MeToo movement to further analyze the presence of the movement in medicine. But first, we must understand what the movement is and does to image its interventions in medicine.

CHAPTER FIVE
#MEDICINETOO

The #MeToo movement brought people together of different generations, race, gender, and class backgrounds across social media and other public platforms to fight against sexual violence. This social paradigm opened the door for many women to feel empowered and break their silences. The increase of gender violence intolerance is evident on social media websites such as Twitter, blogs, journals, and academic publications. #MedicineToo is a lesser used tag on Twitter that has few posts despite the recent news articles outing perpetrators of sexual harassment and violence in medicine. More work still needs to be done in medicine to improve the gender culture and gender equality. The gender roles and stereotypes of the social world negatively affect the medical world of women physicians. Although women in the workplace are positively affected by the repercussions of the social movement; there is still a lot more change needed to improve their working conditions to be safer from sexual violence in the workforce. The increase in whistleblowers and decrease in tolerance toward men's disrespect of women's boundaries are biproducts of this movement as well as other social actions taken by women at large.

In this chapter, I investigate the ways in which women are impacted by systematic deficits and the ways that these deficits will be made more aware with the #MeToo movement. I show how social movements (the #MeToo and HeForShe movement) affect change for women systematically, socially, and personally. I also explore the current social climate between men and women physicians with the current pandemic taking its toll on healthcare systems. It is important to discuss COVID-19 in the current context of the experiences of my interviews of physicians. Women's accessibility to higher positions in healthcare institutions is valuable not

only to improve hospitals' male-centered policies but to enhance the protection of women from contracting COVID 19 and the role physicians have in this.

COVID-19

The effects of gender bias are evident by how women compared to men are disproportionately impacted during the COVID-19 pandemic. The safety precautions needed for men versus women were assessed by the World Health Organization (WHO) in order to monitor gender equity during the pandemic.[1] The protection of women during virus outbreaks lagged behind what protocols are in place for men.[2] Women are at a higher risk of contracting viruses and diseases than men are due to this fact. For example, during the Zika outbreak in South America women had little autonomy and agency in their homes, relationships, and access to adequate health care leading to an increase in unsafe abortions annually.[3] Not only do women have a higher probability of contracting the coronavirus due to agency issues, but according to the United Nations (UN) seventy percent of the front line health workforce is made up of women.[4] Throughout the COVID-19 pandemic maternal deaths have increased.[5] There needs to be more advocacy and diligence for these women now more than ever to ensure their safety and well-being. To stay striving for the safest working conditions and protection of women in health care and as patients is significant during the COVID-19 outbreak.

The WHO signaled a need for women in policy making to effect change towards the global virus outbreak. The current pandemic reminds us that there is a lack of women in positions of power and influence to address the structural violence in healthcare internationally.[6] The UN Women have recommended some guidelines to the government to aid female front line workers including: supplying feminine products, ensuring paid sick leave, including women in

pandemic response decisions, and including the availability of domestic abuse hotlines as essential.[7] Women who go home after being a front line healthcare worker may still have a second shift, taking on a majority of the household responsibilities.[8] There is a worldwide inequality surrounding the work shared in households where societal gender roles infringe upon relationships.[9] The UN suggests that government officials and decision makers take part in the UN campaign called "HeForShe" to strive for balanced household responsibilities. The HeForShe movement looks at gender inequality as a human rights issue that needs the help of men and women to overcome it.[10]

To find the HeForShe movement from the UN website excited me because it showed how a global organization found this issue of the second shift important as well. Not only does this movement advocate for at home equality, but also workplace equality.[11] The HeForShe movement was founded in 2014 with Elizabeth Nyamayaro as the executive director of the campaign. She explained in an interview how the #MeToo movement and other social movements branching from 2017 for gender equality have expressed to her the need for the HeForShe movement.[12] For obstetricians/gynecologists the movement provides an agentic way to express the need for equality in positions of power in hospitals as well as equality in domestic tasks. I discuss the power dynamics of obstetricians/gynecologists in healthcare and home life in the following section.

The ACOG recently worked on legislation with the similar demands as the UN Women in response to COVID-19.[13] ACOG's legislation also includes securing student loan forgiveness for residents, added financial assistance, and decreased medical insurance rates.[14] The ACOG and UN Women regulations in action across hospitals actively fighting the virus will protect women and front line workers from gender bias and risk of infection.

Female Physicians' Access to Positions of Power

In the Unites States, the Equal Employment Opportunity Commission (EEOC) currently enforces the rules and policies in place regarding sexual and gender harassment for all employees in the U.S.[15] My interviews with Dr. Kelman and Dr. Tipple revealed the known existence of reporting in person to the equal employment office or anonymously at the hospital they worked at. Although, I could not find an employee handbook on the hospital websites where the women worked to confirm their reports. I had difficulty accessing a public record of employee or patient reporting tools for all institutions. Also, I do not know the differences in accessibility or victim reporting between teaching and non-teaching hospitals. My physician informants ensured that the hospitals did not tolerate gender and sexual harassment where they were associated with or worked at. Most participants agreed that the policies in place at their hospitals discouraged harassment, were adequate, and did not know anyone who had needed to use a reporting system.

Yet, Dr. Ryder worked at a smaller system of hospitals and believed the enforcement of equality between all physicians regardless of specialty could be improved. She claims, "Smaller hospitals still function like the 1960s." I saw this as a loss of touch due to older men in power of health administration in the healthcare group she is a part of. She also claimed that the administration of a hospital affects the protection of women in the workplace. This is true for other fields as I have noted earlier and Dr. Kelman, Dr. McCloud, and Dr. Tipple all had the same mindset. These physicians said that more women need to be in the hospital administration in order for the male-centered policies to include women. Dr. Kelman shared a recent event at a meeting with healthcare administrators of the hospital workplace where administrators asked of

her opinion. Dr. Kelman said they ignored her response and chose to follow their decisions and plans without consideration. Dr. Kelman said to me, "and they ask[ed] just to say they did include me in the discussion." As a way to save face the male administrators wanted to show interest in the only woman at the meeting. Dr. McCloud similarly has sat at board meetings but with physicians of other specialties. She said at meetings with men where she is the only female representing her department, the men do not respect her time and "laugh about making it a big deal about punctuality." The lack of respect from other male physicians and hospital administrators keeps female physicians' voices invisible and contributes to why policy may be far behind in some hospitals compared to others.

Some physicians gave me their opinions on why there is lack of women in leadership in gynecology and obstetrics. Dr. Tipple told me, " I believe that women in leadership will come into those roles later due to role strain and second shift in early family." Role strain for women in obstetrics and gynecology is the tension of holding positions in multiple aspects of their lives (medical, social, domestic, etc.). Dr. McCloud and Dr. Tipple said that due to women taking on most responsibilities at home as well as having a demanding job, leadership roles are put off until later in women physician's careers. In residency Dr. Kelman had two pregnancies and felt as though she had to hide her pregnancy symptoms. She would throw up in the bathroom and would not let anyone know she had "girl problems." An ACOG policy on parental leave gives six weeks minimum of paid leave for women and their partners.[16] Dr. Tipple expressed that she used to be on the ACOG board of executives four years ago and associated with a group of those who wanted to extend the minimum paid leave to a recommended twelve weeks. However, she participated on a male dominated board and this extension did not take with the board of

executives. One of the male executive board members rebutted, “Well my staff never comes back after maternity leave after six weeks, they just leave so we should only make it six weeks. I’m not going to go to twelve weeks.” It became clear to me that this present narrow mindset did not include the visibility of women’s experiences and influences.

Dr. Kelman told me about newly enforced patient protection where there is now a strong encouragement from ACOG that gynecologists should have a chaperone.[17] The chaperone could be a nurse or other hospital staff trained appropriately, in the patient’s room during examination.[18] There is an already present power and agency imbalance between the patient and physician. So, in January 2020 ACOG implemented a new committee opinion for gynecologists and obstetricians to have a chaperone monitor physician-patient interactions for every patient or routinely.[19] The chaperone protocol will benefit patients no matter the gender of their physician because of “The difficulties that beset the full achievement of informed consent . . .”[20] The ACOG also says there should be ensured ways for patients who have experienced sexual misconduct to report these events at every medical institution.[21] The patients and doctors who may face sexual misconduct in the workplace both have outlets to let an institution know such behavior is taking place. Although for physicians in the workplace, it will go unreported for a variety of reasons as it does in any workplace.

Effects of the #MeToo Movement for Medicine and Other Professions

Since 2017 when Tarana Burke’s #MeToo movement hit its stride on social media platforms, the conversations have entered different disciplines to discuss gender and sexual harassment. The #MeToo movement is for all genders and is a way to support victims and their stories. Disciplines that have shown increased awareness for the treatment of women in its field

are academia, STEM, and medicine. In this section, I will show examples of the movement's impact in each of these fields through academic journals, websites, as well as Twitter posts.

Within the STEM professions and academia websites have started to share these women's stories to advocate for an end to sexual and gender harassment. The "MeTooSTEM" website does this important work and shares women's stories of all different kinds of positions and what their experiences mean for their futures. One woman told her story about working as an undergraduate in a molecular biology laboratory where a lab tech called her baby and insinuated that he could drug her.[22] As most of the women's stories on "MeTooSTEM" end, she quit and moved on. Even though she reported this incident to the male principal investigator of the lab, it resulted in being shrugged off. These experiences usually involve agency issues: a male with a higher position than the woman and using it against them as a threat. Many of these women were students who lost access to education in order to not live in fear of their abuser. Even when these instances are reported, some of these women's cases are still ongoing or discredited by other colleagues of the men and never go to fruition.

Another site dedicated to women in academia called "The Awakening" gives visibility to women's stories with similar experiences both in STEM and other academic disciplines. Gender inequity between male and female professors is evident by the length of time for promotion, lower salaries, and gender representations in their fields.[23] Not only does structural violence against women affect their positions in academia, but also affects their students and the curricula taught.[24] Dr. Walters says that feminist anthropology would go against the framework of anthropology that is kept in place by male tenured professors in the field.[25] The #MeToo movement forged pathways of courage for women across the United States to tell their stories and to advocate for systemic change of sexual and gender violence.

"The Awakening" is a public article with 30 accounts from women in academia and leadership roles reflecting upon their struggles with their own stories of sexual harassment. They also discuss how the #MeToo movement impacted their personal and professional lives. For example, Anne McClintock, an English professor, disclosed experiencing multiple incidents of "gender harassment" in her words and how the validity of her academic career ended up in the hands of men.[26] She describes the movement as follows, "We are witnessing a monumental reckoning, a seismic shift in attitudes not only to gender violence, but to gender parity, workplace equity, alliances across race, class, and gender, and demands for sweeping institutional changes."[27] The loss of agency to women with prestigious careers deserve respect and change. How many women with painful stories of violation and disrespect will it take to make those institutional changes? Another academic Dr. Martha Jones, a professor of history, asserts that, "#MeToo permits us to see more clearly through the murkiness of awkward and painful pasts. It suggests that we are stronger when we tell our stories out loud and in concert with one another."[28] I enjoyed this quote from Dr. Jones because it proved exactly what the #MeToo movement set out to do. To find a way to support those who have stories of pain and shows the strength that this movement holds. These are only two of the numerous responses shared across university faculty to shine upon women and the agency regained within their stories.

Additionally, "MeTooAnthro" is an anthropology website that shares the stories of academics in this field who are victims of harassment and assault.[29] Established in 2017 in response to the trending hashtag "#MeToo" on Twitter, the website also uses Twitter to share and support the #MeToo movement's message.[30] These hashtags on Twitter and websites including "MeTooAnthro," "MeTooSTEM," and "The Awakening" are wanting to start a

conversation within their field. These websites continue to make it well-defined to me how pressing of an issue harassment and assault is no matter the workplace.

As for medicine, it is still an area that needs stronger advocacy and justice for women. In 2018 the tag "#MedicineToo" began which allowed for victims of harassment and assault to share their voice on a platform. For instance, a female medical resident from Ontario, Canada posted about her sexual assault by an attending physician in 2019. She followed up with an impactful Twitter post on February 6, 2019: "Change is only slow as long as nobody demands that it be quick. Brace yourselves. #MedicineTOO is coming."[31] Women's voices are becoming louder to denounce sexual misconduct and violence. Just this May I stumbled upon a Twitter thread talking about a sexual assault case that occurred five years ago. A female resident physician experienced sexual assaulted by an older male physician who just recently had his license revoked because of it.[32] Gender discrimination and sexual assault happens regardless of the profession and with increased awareness of these women's stories, more women may be open to sharing their stories as well. Websites like Twitter offer a place for professional women to publicly disclose their experiences and at the same time advocate for other women. This act is agentic and empowering for women who have had their expression taken away by gender and sexual harassment.

When talking about the impacts of social media impacts on social movements, I want to include the importance of fourth wave feminism and the #MeToo movement. Fourth wave feminism in a way is equivalent to "digital feminism" as feminist author Laurie Penny put it.[33] The HeForShe and #MeToo movement were both started by Black women and the digital abyss often forgets these identities. It is important to keep in mind intersectionality in feminism and not subdue the feminist voices of BIPOC, Black women, and women of color.[34] Even though this

age in feminism creates a doorway to global movements, the toxicity of the internet and white feminism comes with it.[35] For Black women in medicine and the workplace, it is important to keep in mind the intersectional issues that need to be addressed within feminist movements such as these.

In conclusion, social movements and social media is a refuge for victims and their stories and is an empowering support system that extends to online blogs, Twitter, and workplace institutions. I have gained insight into the culture of workplace power dynamics and the stemming problems that affect the careers of women in medicine. Not only medicine, but academia and STEM fields have been notably accessible to the #MeToo realm. By finding the HeForShe movement along the way allowed me to delve into another area of improving the day to day of women at work, in particular with families. I integrate these ideas to allow for there to be a step toward reaching job equality and equity between men and women.

Narratives of the #MeToo Movement

I also would like to show what the #MeToo movement means to current obstetricians and gynecologists in the Central Florida area to further explore how it is perceived within healthcare. My participants all had different views on what the #MeToo movement meant to them. Although the #MeToo movement is centered around being an advocate for victims of violence and rape primarily, it raised awareness for gender discrimination and gender harassment as well. All of the physicians interviewed had heard of the #MeToo movement and understood its primary goals.

For Dr. Ryder, she told me " I don't really know how much it has really helped to be honest." Dr. Ryder thinks it may have had a negative effect on the level of comfortability men have talking with female physicians one-on-one and things they say being taken out of context.

Dr. Kelman said she thinks that the movement made its way to the healthcare field. She described an example of where the advocacy of the movement could encourage better policies by the ACOG surrounding consent between patients and physicians. Dr. McCloud when asked about the #MeToo movement said, "if you are a gynecologist, you already have an alliance with them. You must be sensitive and be an advocate for protecting rights of women." Dr. McCloud expressed that having respect for women's bodies and promoting women's health is fundamental and the basis of health for a family. Her perspective on the social movement is that '#MeToo' is a fight for human rights and this ideology coincides with those of "#MeTooSTEM" and "#MedicineToo."

However, Dr. Sanger, Dr. Almond, and Dr. Tipple all expressed that they did not see the relevance of the #MeToo movement as well as lacked an awareness for everyday microaggressions and discrimination. Since Dr. Sanger is a gastroenterologist and Dr. Almond is an obstetrician and gynecologist, the field of medicine had no effect on the level of awareness in the workplace. Dr. Sanger stood as the only female she had been aware of to get into her fellowship at the time and represents little role models for the field she entered in to. Dr. Almond said she, "let things go by me because they're not important to me. . . whatever was said was minor." Dr. Tipple even though sharing her stories of gender discrimination, she said that present day in the healthcare system there is already an adequate intolerance against this behavior. These statements raised an idea to me that these women both used survival gear of being oblivious to these microaggressions that may have been there but chose not to acknowledge things said to protect themselves.

This chapter is significant for acknowledging and analyzing movements that are able to effect change in professional institutions. In order to achieve gender equality, gender inequity in

the workplace must be addressed first. The gender culture within medicine has changed little due to the #MeToo movement. However, I hope with the increased awareness of microaggressions in medicine and across professional institutions that changes will be made to create an improved working environment for women.

CHAPTER SIX
CONCLUSION

As I have investigated the effects of gender on women across some medical disciplines, it is apparent that gender inequity, gender bias, and agency are common threads. Gender harassment, microaggressions, and sexual harassment still affect the interactions of women today. Through exploring the experiences of women in STEM, academia, and medicine; their voices on gender issues are becoming louder and louder.

The #MeToo movement in medicine is a helpful social media tool for women to show visibility to workplace misconduct between the genders. The movement has the ability to increas the awareness for workplace issues and activism for women who face gender discrimination, gender harassment, and sexual harassment in the workplace. It also holds people accountable for their actions and brings meaningful awareness for various workforces. However, there is still a deficit in widespread usage of #MedicineToo and action taken by medical institutions. By starting a dialogue about these issues that affect professionals, more meaningful change will be brought about for gender inequity in the workplace.

When I asked the women about their negative experiences in healthcare with male physicians, many stories came from their time in residency. Their stories involved being criticized for having feminine characteristics and working harder to be seen as equal. The participants were in residency 20 to 30 years ago where the environment for residents differed from the residents today. I cannot compare fully the experiences to the residents of today, but I see it as an area of interest for further research.

Not only did female gynecologists and obstetricians in their residency experience gender inequity, harassment, and issues of agency, but still experience it now just more subtly. From my

analysis of the ethnographies from the participants, only some had this awareness for the more subtle sexual and gender microaggressions; and some chose to ignore them. Examples of the microaggressions that the participants experienced were condescending attitudes, disrespect, and lack of professionalism. Today, those microaggressions are rampant and invisible by male physicians of other specialties and in positions of power at hospitals. Some instances seem to be unique to the specialty of gynecology and obstetrics. It is not only a specialty for treating women but also a surgical specialty for women as well. Due to the surgery involving solely women, some obstetricians reported that doing surgery on women had a lower status compared to other surgical specialties in the minds of other physicians.

Future research should focus on the application of intersectionality and analyze both race and ethnicity in addition to gender issues of women physicians. Intersectionality is important because of the compounding issue of gender as well as race discrimination among physicians.[1] The male residents are in a majority female residency population, while the older obstetricians/gynecologists are in the majority of higher positions in medicine. By following the example set by the HeForShe movement, it would be helpful to try to receive support of men to help solve the agency, gender bias, and gender inequity issues within the field. I also think it would be beneficial to compare male physicians from outside this field for a more holistic view of the hospital workplace. Besides workforce issues within medicine, solutions to make leadership positions more accessible to women is needed in healthcare to ensure women's voices are visible. Healthcare institutions also are not built to be accessible to women and need to make having a family and being a physician more manageable, especially for those women who take on unequal amounts of household responsibilities.

Another point of interest within my research is the discrepancy between statistics of patient preference of obstetricians and gynecologists and the doctor's perspective. Multiple participants told me that their patients often preferred women as their gynecologist while research reported by that there is no preference of gender.[2] I am not sure if the physicians are biased or if more research on patient preference and the increasingly younger female workforce in this field could be studied more in the future.

For women physicians during the COVID-19 pandemic, those with families may still have a second shift to come home to. After longer hours and dangerous conditions in a hospital, the work at home may still not be done. The lack of women in administration of hospitals and leadership positions in their specialty adds to the deficit in care for women physicians. This applies to the women physicians working and not working with COVID-19 patients. Women physicians are at a higher risk for COVID-19, mental health decline, and domestic violence during this time. We must do better to protect women physicians.

Through the process of writing and researching for this thesis, I have expanded my knowledge as a feminist and a pre-medical student. My analysis on the social world of women physicians has increased my knowledge of their profession. As an undergraduate biology student, having a strong scientific and social lens will prepare me for my future endeavors. As the physicians are advocates for their patients, I too hope to be an advocate for women.

TABLE OF PARTICIPANTS' DEMOGRAPHICS

Physician's Pseudonyms	Specialty	Years of Medicine Practice	Gender	Race	Origin	Medical School
Dr. Ryder	Obstetrician/ Gynecologist	30+	Woman	White	Netherlands	University of Leiden
Dr. Sanger	Gastroenterologist	13	Woman	South Asian/ Indian	India	Christian Medical College in Vellore, India
Dr. Kelman	Obstetrician/ Gynecologist	24	Woman	Unknown	Chicago, Il.	Catholic University in Ponce, Puerto Rico
Dr. McCloud	Obstetrician/ Gynecologist	20	Woman	Black	Ohio	The Heritage College of Osteopathic Medicine
Dr. Almond	Gynecologist	24	Woman	White	Chicago, Il.	University of Illinois
Dr. Tipple	Obstetrician/ Gynecologist	31	Woman	White	Florida	University of Florida

Table 1. Participants' demographics.

ENDNOTES

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