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A Frame Analysis of Gynecological Exams

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Betsy Cullum-Swan

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BEHAVIOR IN PUBIC PLACES*

A Frame Analysis of Gynecological Exams

By

Betsy Cullum-Swan

A THESIS

Submitted to
Michigan State University
In partial fulfillment of the requirement
for the degree of

MASTER OF ARTS

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1989

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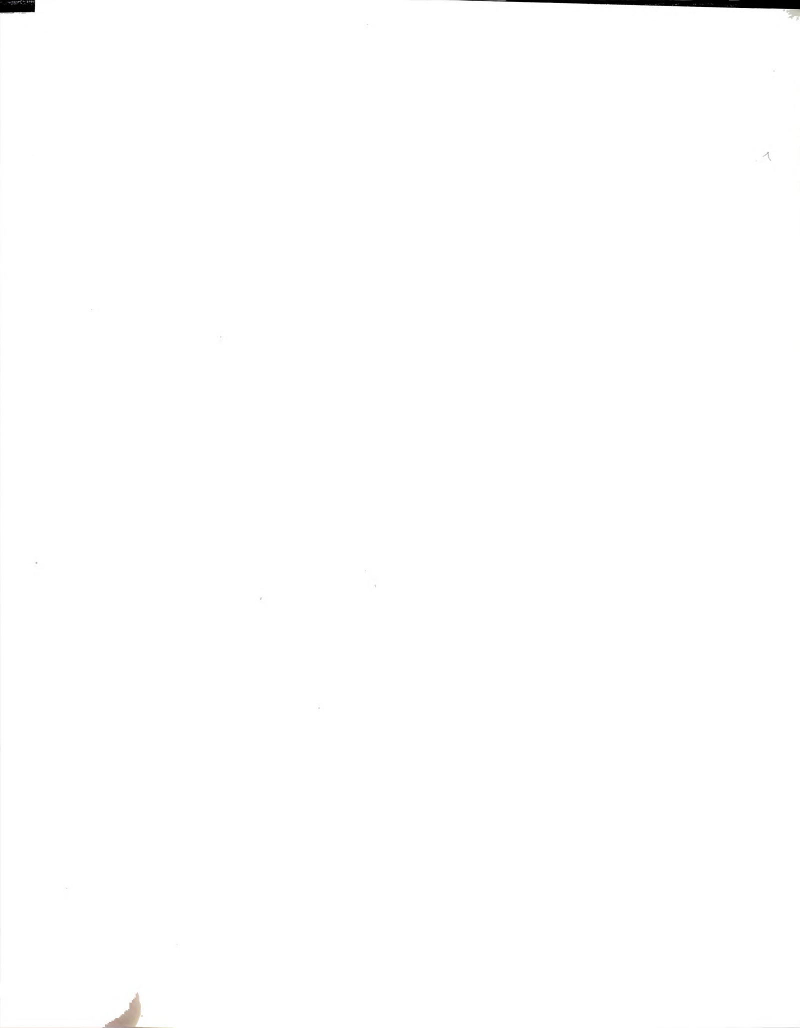
* Unlike James Henslin and Mae Biggs I could not resist Goffman's suggestive title. I think somehow he wouldn't mind.



ABSTRACT

BEHAVIOR IN PUBIC PLACES

A Frame Analysis of Gynecological Exams

By

Betsy Cullum-Swan

It is suggested that frames (Goffman, 1974) help interactants to define situational reality and that all frames are composed of two components, here operationalized as environment and interaction. Patients and physicians frequently disagree on the form and content of the medical frame. The gynecological exam presents a context in which the participants may have divergent definitions of the situational reality.

The study, based upon a sample of young female students (n=36), examines the gynecologcial frame and tests some hypotheses concerning internal consistency between the posited frame components. The effect of gender of physician, upon the patient's experience of the procedure, is also examined. Findings indicate that gender has a differential effect on several features of the exam and that women report generally negative experiences in this context. Recommendations for frame alterations which will not impinge upon task completion are presented.

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> I felt exposed, deteriorated, out of shape and like a piece of meat.-woman interviewed about her experience in a gynecological exam

INTRODUCTION

This quote graphically reflects how many women think and feel about the gynecological exam. Objectification, lack of power, exposure and vulnerability are recurrent emotional themes voiced by women in reference to the experience. The lability of their emotions during the exam is certainly related to their exposed, prone and vulnerable physical position and the unstable definition of reality which lurks in this context. As a result, the reality of a gynecological examination can never be routinized but remains precarious (Emerson, 1970). However, such exams occur routinely and are viewed as a part of a sound health regimen and good female hygiene. Because women do often assume this same position during sexual intercourse, which is private and personal in this culture, it seems likely that the overlap between the features of a sexual experience and a medical experience is at least partially responsible for the problematic nature of the occasion. Do women connect the two? Sociologically, this is a question with profound practical ramifications: how is the routine and non-sexual nature of the exam displayed and maintained over the course of the interaction? Maintenance of a medical rather than sexual definition, through social

consensus and role appropriate behavior, would be necessary in order for the exam to progress smoothly. The participants must be mutually committed to a working consensus to maintain the grounds of the task at hand, the definitional reality, and how their respective parts must be played to produce an appropriate medical interaction.

I utilize Erving Goffman's dramaturgical perspective and basic concepts from Frame Analysis (1974) to examine the phenomenon of the gynecological exam. Perceptions gathered by all the senses will be used to explore how the patient makes sense of and reacts to the experience. Situationally appropriate behavior is examined with a view to how the performance is brought off through proper interdigitation of roles. The interaction is primarily dyadic in nature, although a nurse is typically present as observer if the physician is male. Because the gynecological exam is performed within a confined and staged setting, it is by nature routinized and ritualized. Interaction will be examined within this physically and morally bounded setting, and an analysis of the situational definition of the event will be presented.

FRAMING

According to Goffman, the **frame** holds in and defines the boundaries of the gynecological exam, a dramatic scene

or, metaphorically speaking, oil on canvas. What may appear is historically and contextually determined. The impressionists drastically changed what could be held in the artistic frame. A situation or event defined by specific features may similarly undergo transformation. How we think about and make sense of such occurrences is the focus of Frame Analysis (1974). Goffman's scheme is analogic in nature. Sense making is performed by knowing what features of the frame are similar or not similar to other frames in the same field, and what their meaning is within the particular frame. Knowledge of many frames and their contents helps one to know how meaning will be assigned in this frame and what behavioral expectations exist. The establishment of a primary framework helps to render interaction sensible. It gives features of this situation, which may be present in a variety of frames, a contextual significance.

The concepts of framing to be used in the analysis of the gynecological exam are:

1.Frame: basic elements of the definition of a situation built up in accordance with principles of organization which govern events-at least social ones-and our subjective involvement in them (1974, p. 10).

2.Primary Frameworks: a framework seen as rendering what would otherwise be a meaningless aspect of the scene into something that is meaningful. It allows the user to locate, perceive, identify and label a seemingly infinite number of concrete occurrences defined in its terms (1974, p. 21).

3.Key: the set of conventions by which a given activity, one already meaningful in terms of some primary

framework, is transformed into something quite else (1974, pp. 43,44).

4.Keying: a basic way in which a strip of activity can be transformed or serve as an item-by-item model for something else (1974, p. 45).

THOUGHT, EMOTION AND SELF

A frame analysis utilizing these specific terms is applicable to the evaluation and understanding of situated behavior. The gynecological exam presents such a case. Goffman emphasizes the assignment of meaning within a context to the things people do and how they act. Others and their reactions are necessary to establish situational reality. He speaks in terms of roles, performances and lines, but the link between performance and the response of others is stated in general terms (Goffman, 1956). This approach, however valuable, also neglects the important link between thought and emotion. It is important to understand how performance and response and thinking and feeling are linked in specific settings. Research should investigate how these are integrated. Reflexivity, or the way others' responses to our responses are interpreted, and how we respond to ourselves over the course of a performance, is an important part of the definition of the situation.

> Since frame incorporates both the participant's response and the world he is responding to, a reflexive element must necessarily be present in any participant's clearheaded view of events; a correct view of a scene must include the viewing as a part of it. (Goffman, 1974, p. 83)

We are interested in how others think and feel about us and our actions. We use this information, as we perceive and interpret it, to modify and adjust our behavior to others' and our own expectations. This sort of cue reception and behavioral feedback facilitates interaction. It provides important information for the participants to make sense of the situation. When contents of the frame are somewhat ambiguous, we look to others for sense making help. Interactants may cooperate and negotiate the interaction order and establish the grounds.

However, the role and expectations for behavior in the situation, may be at odds with the individual's self. The self behind the self may be uncomfortable with the role it has to play. Over the course of a lifetime the sense of self distills as we incorporate experiences, places, faces and memories of specific interactions. The self behind the self is the sum total of these unique life experiences and may reject a role if it seems incompatible. Role reciprocity and mutual understanding of others' expectations for behavior may alleviate some difficulty with roles not compatible with the self. Negotiated order may allow temporary assumption of the part, even if the role is problematic, to accomplish a desired goal. The role of patient in a gynecological exam is difficult for many women to accept and must be negotiated between the physician and and patient for successful completion of the task.

During the process of order negotiation, interactants should consider how the other defines his/her self. Participants must accomodate expectations for behavior to other's and their own definition of self and fit within their roles. Thus interactants attempt to define the other's me, and create a phenomenon with which they may interact. Imputation of meness to the other symbolically constructs and transforms others according to our definitions and desire and reduces the sense of risk and uncertainty. Definition of the other's me helps us to know how to act and what may be expected in a situation. This assessment however, must be continually adjusted throughout the interaction, as the grounds may shift and evolve to facilitate a successful playing of the scene.

Self, composed of a subjective I and objective me, as defined in the context of this study, is particularly problematic in constrained situated interactions. The process of establishing a primary frame and our role within it, means we must objectify our selves. We must think about the self behind the self as an object or a me. Differentiation between the I and me is difficult, as anything that seems to represent the I is no more than a masquerading me, an object pretending to be a subject (Rock 1979).

> The "I" in memory is there as the spokesman of the self of the second, or minute, or day ago. As given it is a "me" but it is a "me" which was the "I" at the earlier time.
> (Mead, 1956, p.174)

As soon as we think about or objectify the I, it becomes a me. Thus for purposes of this study, the I is defined as the active perceiving self, and the me is the idea of self as an object or thing unto itself.

Objectification, or perceiving subjects as things rather than in terms of the subject's interests, provides a perspective for observing and defining situational reality. It helps one to attach meaning to particular frames or manifestations of sociation. Sociation is a form, actuated in a variety of ways, that allows individuals to "grow together in a unity and within which their interests are realized "(Levine 1971, p.24). Human existence can be thought of as composed of content, or the actual feeling and experience of being human, and form, the structured relationships and established patterns for interaction within a group which facilitate and determine the acting out of content.

I suggest that a clear relationship exists between form and content and objectivity and subjectivity.

> The opposition between subject and object forms the fundamental constitutive dualism in the realm of culture. Insofar as subjects are creators of cultural objects, they stand opposed to the latter as agents of the progressive forms of life confronted by fixed, objectified products detached from the continuity of life. (Levine, 1971, xxxvi)

Thus individual changes and shifts over time result in needs and "impulses which give birth to culture"(Levine, 1971, xxxvi). The protoforms, or subjective forms of social life,

are goal oriented and products of the individual. However, as soon as a new form appears it begins to become objectified and to oppose and restrict its creator. Thus this objectification restricts the creation of new forms. Such forms may become routinized and objectified within institutionalized structures. Consequently, an individual in pursuit of a desired end, generates forms which will become part of the social life of others.

> The individual is contained in sociation and, at the same time, finds himself confronted by it. He is both a link in the organism of sociation and an autonomous organic whole; he exists both for society and for himself (Levine 1971, p.17).

Generation of cultural objects occurs because of the needs of a developing subjective culture. Once solidified, forms become inflexible and difficult to adapt according to changes in subjective need. Thus tension arises between needs of the individual and the objectified forms. A similar tension exists within frames, which I suggest are analogous to objective forms. The needs and desires of individuals may be at odds with particular frame conventions.

Although form is variable situationally, its particular manifestation may become routinized within a specific setting. Individuals, groups and organizations are equally subject to this phenomenon. The smaller the group, the easier it becomes to replicate the forms. Interaction between two individuals permits routinization to occur

because of the mutual dependency of roles and the limited scenarios and reactions which may occur. Interactional limitations and routinization of procedures complicate the development of a negotiated order within particular forms.

Institutions represent a world of forms in which individual choice of content is severely restricted. Objective culture is, "the world of cultural forms and their artifacts that have become independent of individual experience" (Simmel, 1984, p.6). Tension arises between goal achievement of the institution, which is facilitated through the instrumental function of cultural forms, and maintenance of integrity of the persons passing through the institutions. However individuals may bring a piece of subjective culture to a frame and alter the existing form through interactional negotiation.

A verbally competent patient may initiate any topic of conversation she desires. She may discuss her children or friends she holds in common with her physician. At successive exams this conversation or similar versions of it may be repeated. It then becomes part of the routine grounds and negotiated order within this woman's gynecological frame. Over time, repetition of such scenes may result in changes in the forms of objective culture.

Meaning within an interactional context calls for taking the role of the other (Mead, 1956) and learning to feel as if one were the other person. The adequacy of

this understanding within a frame is assessed through one's thoughts and feelings. Thinking and feeling provide information to the individual concerning the fit between of reality and expectations.

> Emotions function as a messenger from the self; an agent that gives us an instant report on the connection between what we are seeing and what we had expected to see, and tells us what we feel ready to do about it.
>
> (Hochschild, 1983, X)

How we feel about something may be determined by what we think about the matter and how we think about something may give form to our feelings within a specific frame. Thus "feeling is forever given shape through thought and thought is laden with emotional meaning "(Rosaldo, 1984, p. 143). They interact in a complex fashion and jointly serve as motivation for the self insofar as they can be interpreted within a social frame.

The self or unified I and me is at risk during a gynecological exam. The transformation of the patient into a thing, or from subject into object, facilitates doing the exam. Things such as "patients" and "exams," have an objective reality apart from themselves. Perhaps most important is the experience that reality seems to be out there before we arrive on the scene" (Emerson, 1970, p. 75). The pre-established reality referred to by Emerson is not the situational definition of event nor the negotiated interactional order. Rather it consists of women's perceptions of routinized procedures and somewhat

inflexible roles of the medical frame. Lack of a role in creation of the medical setting leads women frequently to to disattend or remove the I from the experience. Not feeling like a person and refusal to think about what is going on, helps to lessen women's embarrassment and discomfort. Because interaction is formalized and relatively non-negotiable in this setting, usual rules of identification and reflexivity do not apply. Emphasis within the medical frame is upon doing the job and serving the patient. Patients' lack of clarity concerning how to feel and think are a function of the overlapping features of the sexual and gynecological frames and the perception of reality they believe exists within the frame. The primary framework isn't always clear. Thus in the medical interaction the patient is cast in a somewhat dependent role and feels she has little input into the definition of reality. She may attempt to prepare and protect the self to fit the role.

SELF, BODY AND ROLE

I intend to adapt frame analysis to analyze how women think and feel about an experience. The primary role of the physical body in this particular frame calls for such a perspective.

> Emotions are thoughts somehow "felt" in flushes, pulses, "movements" of our livers, minds hearts,

> stomachs, skin. They are *embodied* thoughts, thoughts seeped with the apprehension that "I am involved" (Rosaldo, 1984, p. 143).

This quote from Rosaldo suggests that a critical location for examining embodied thoughts is interactions in medical settings. The medical sphere represents a context where the linkage between thinking and feeling and the experience of self and body is particularly salient. The patient and physician must cooperate to circumscribe the limiting features of the existing procedures and setting to deal with the patient's role incompatability. Medical frames seem to be constructed on the assumption that self and role are isomorphic. Impersonality and objectification are not easily accepted by the patient's self. In fact, self and role are always in dynamic tension such that the playing or ability to fit the role depends on the self and visa versa. Selves are cast from past role-performances and how the individual perceives his or her success in the role. Organizational and interactional studies of medical care ignore the place of the self in shaping the process of care delivery. The relationship between self, body and interaction have been similarly swept under the carpet. Emerson notes how the staff attends the patient.

> The staff are concerned with the typical features of the body part and its pathology rather than with the unique features used to define a person's identity. The staff disattends the connection between a part of the body and some intangible self that is supposed to inhabit that body.
> (Emerson, 1970 p. 78)

The body, its presentation, positioning and gesture is a communicational medium for expression of the self and simultaneously a receptor for communications from others.

> As the self is dressed, it is simultaneously addressed, for, whenever we clothe [or unclothe] ourselves, we dress "toward" or address some audience whose validating responses are essential to the establishment of our self.
>
> (Stone, 1970, p. 404)

In everyday life, we have some choice about the self we present, as well as the range of responses available to others' self-presentations. The institutionalized rules for interaction, positioning, dressing and undressing in the gynecological frame, are integral to the patient's self presentation and fit within the frame. Interactional expectations contain an implicit conception of the body and its relevance, e.g., conventions concerning touch, proximity, eye contact and manipulation in time and space. Because the body with its orifices and surfaces is the pathway and conductor for all messages and communication in a setting, a physical exam will stimulate all sensory response modes. This presentation of an embodied self, importantly constrained by lack of physical autonomy and expected to maintain a circumcribed definition of one's self in a specific context, is necessary to fit the frame.

Studies of medical interaction (Paget, 1988, West, 1984) suggest the relevance of talk in these settings, as do studies of the gynecological exam (Emerson 1970, Henslin and Biggs 1971). These studies suggest the differential

relevance of talk and its content to males and females. This study, however assumes that these are interrelated with the frame, and that establishing the frame and fit within it is a crucial negotiated social process that perhaps governs interactions and feelings. Thus, I will examine frame composition in terms of setting and role in order to analyze data on how the respondents holistically experienced the frame.

THE MEDICAL FRAME

Interactional norms and presumptions concerning situational reality are determined by the context or frame expectations. Individuals bring emotional and cognitive baggage to the specific encounter. Past experiences, preformed expectations and one's perception of self, shape and mold the given performance and how it will be received. Patient-practitioner interaction is particularly problematic because of the extremely rigid and asymmetrical roles assigned to the players and the potentially emotional content of the encounter. Physicians hold societally conferred authority to guide persons through crises and changes; they perform liminal yet significant social roles because they are privy to and participate in birth and death scenes. Although a woman visiting the gynecologist does not necessarily believe her life is at

issue, the very act of care-seeking may elicit fear, uncertainty and anxiety concerning her reproductive viability and her feminine self. The woman experiencing physical or mental distress feels a sort of social and emotional stress. She owns feelings about her body and symptoms which the physician approaches with a particular strategy.

But the scene is not merely fleshed out by two autonomous actors, the caregiver and care-seeker, standing for themselves and performing their own roles. They are representative of statuses within the larger cultural and institutional context which share behavioral norms. These are important bases for the authority of the physician and the compliance of the patient.

Nevertheless, the construction and maintenance of medical frames is to some degree negotiated. They are threatened by cues and stimuli and shaped by the expectations which the selves of the interactants bring to the setting. For a typically healthy person, the self and expectations for patient behavior may be at odds. Culture specific rules and adaptations are particularly problematic in the medical field. The new heterogenity of physicians, e.g., women, very young, foreign, has exacerbated the potential for misunderstanding within the medical dyad. The physician's role in the U.S. has traditionally been possessed and defined by white upper class males which

somewhat simplified rules and role expectations as physicians were generic and typified (Hughes, 1964).

Cultural acceptance of medical definitions and medical reality strongly patterned by technology is anchored in American pragmatism and the belief that science and technology are the opiates and salvation of the people. Professionalization of the medical realm rendered physicians' explanations increasingly legitimate. This power was formalized and enacted under the auspices of social and cultural authority (Starr, 1982). Social authority is primarily functional and helps to regulate the actions of subordinates. The physician's status and power are anchored in the structure of the medical institution and inculcated in those lower in the hierarchy. Skill and knowledge, however, do not suffice in the absence of consensus on legitimacy and meaning. Cultural authority allows physicians to construct the form of the medical frame but the contents are still vulnerable to patient input and the establishment of a negotiated order. "By shaping the patients' understanding of their own experience, physicians create an aura of consensus under which their advice seems appropriate" (Starr, 1982, p.14). Therefore, the working definition of the medical encounter and the appropriate frame conventions came under the control of the physician.

The role of the physician has been defined sociologically in terms of neutrality, skill and altruism

(Parsons, 1960). His ability to remain affectively neutral, detached and impersonal is one of the assumptions and cornerstones of proper patient-practitioner interaction. It is presumed to be the basis for efficacious treatment. People viewed as neutral "things" are more easily maneuvered, cured, cut and dosed. This thing-like status results from the institutionalized objectification of the person in the patient role as contrasted with the person or self inhabiting the body.

The physician is assisted in carrying off his performance and in maintaining a desensitized, nonpersonal and objective position through standardized rituals. The repetitive nature of the work combined with the pre-established exam form, facilitates maintenance of the medical frame or a definition of what should be occurring. Enstructuration of the exam in this manner should clearly communicate that this is not a sexual encounter. Although a variety of cues, gestures, postures and verbalizations may be exchanged over the course of the exam, they may be ignored and excluded by either party if they do not fit the medical frame. "Medical talk stands for and continually expresses allegiance to the medical definition...the special language found in staff-patient contacts contributes to depersonalization" (Emerson, 1970, p. 81). Medical talk is not however the only sort of talk present in the medical frame. An assertive and verbally competent patient may

initiate any conversation topic she desires. The physician may attempt to define the relevance of all talk and cueing to the frame but s/he can't control the negotiation of order by prohibiting talk. Thus, the physician's behavior is highly staged, preformed and performed to minimize the probability of deviation from the format. Control of the setting itself, combined with verbalizations and the giving off of cues, facilitates cooperation through which a shared performance and sustained working consensus can be brought off.

It is likely, as suggested in this outline, that patients may view the interaction in a different manner from physicians. This is true because of differences in training: control of the setting, feelings and selves enacted in that setting, and as well as the nature of the procedure of interest here, the gynecological exam.

This study is an attempt to discover the types of problems women experience fitting and performing within the gynecological frame. I suggest that overlapping features of the sexual and medical frames cause women to have difficulty in maintaining the patient role over the course of a performance. Defining specific features of the frame which might be altered, to enable better fit between the patient's self and role, is the function of the study. Thus specific questions concerning features of the exam were constructed to find out how women felt and responded in this

context. A sample of women college students were queried about their last exam experience and if they felt able to fit the frame and patient role. Discovery of problematic frame features, which gynecological patients would like changed, was the primary goal.

HYPOTHESES

This is a study of meanings in context, and is empirical in nature. The goal is to define the content of the medical frame and examine the ability of physicians and gynecological patients to perform their roles to maintain frame expectations.

How women feel about various aspects of the setting and their interaction with the physician will be used to measure reported ability to cognitively and affectively accept and successfully participate in the exam, which is defined as "fitting the frame." I use patients' feelings concerning the experience as a measure of fit, because the procedure is so formatted that few behavioral disruptions occur. Inability to fit within the frame would rarely be acted out since gynecological patients have either voluntarily or because of necessity, e.g., infection, pregnancy, dysmenorrhea, made the appointment. They have placed themselves within the frame, and require the professional services just as the physician must be and is ethically

obligated to serve a patient population. Nevertheless, ability to accept the definition of reality assigned to the medical frame (Henslin and Biggs, 1971 Emerson, 1970) does not mean the patient can properly inhabit the frame and cognitively and emotionally accept the assigned role.

Various explanations can be offered for patients' difficulty with role and frame maintenance. Previous negative experiences in the medical frame may cause the patient to carry excessive fear, dread or loathing of any medical interaction. Unacceptable out-of-frame behavior by the present or a past physician can result in negative interaction. Unusual patient modesty may produce severe frame disruption and actual physical inability to sufficiently relax. Relaxation and cooperation are thought to be essential for a successful exam. Absence of experience within this particular medical frame (no previous gynecological exams) places the patient in a normless situation. It is difficult to pick up cues and perform successfully in a role never played before. Non-routine visits may carry such traumatic connotations that the patient is unable to maintain frame conventions e.g. rape, abortion, hemorrage and severe pain. A generally unpleasant or painful encounter may also result in frame deviations by the patient.

Therefore I suggest that difficulty with medical frame maintenance will result in a negative or out-of-frame

experience for the patient. Behavior which is congruent with the conventions of the medical frame will be defined as maintaining the frame. However, the definition of out-of-frame behavior must be qualified because both physicians and patients may exhibit behaviors, or not exhibit behaviors, which are technically out-of-frame but acceptable because they facilitate the work. For example an unusally modest woman may disattend (Goffman, 1974, p. 202) the activity at hand by daydreaming or pretending to be "somewhere else." She typically does not try to cover up or close her legs. Disruption of the exam does not occur on these grounds, so mental out-of-frame activity is allowed. Patient disattention would only be problematic if the woman patient didn't co-operate or respond to the physician's questions or instructions. Thus I would suggest that patients only think or feel out-of-frame because of their subordinate role and the tightly formatted nature of the exam. Inappropriate actions will be sanctioned and controlled because of the physician's authority within this frame. The physician may likewise perform out-of-frame behaviors which do not interfere with but actually facilitate completion of the exam. S/he may warm the speculum under the tap or tell slightly racy jokes. If this behavior is not disruptive or proves instrumental for the task it may leave the patient with a positive evaluation of the experience.

I assert that frames are used consistently and that all frames have two components which are internally consistent. These components are setting and role. For conceptual purposes of the study, setting or environment is defined as the things or objective features which culturally identify the physician's examination room. The role segment of frame is identified by interpersonal features of interactants or the subjective aspects of the exam. From preliminary interviews and ad hoc discussions, I have concluded that many, if not all, women have or have had some difficulty fitting within the gynecological frame.

I suggest, however, that frame problems are primarily related to interpersonal and role aspects of the frame, not to setting or environmental discomfort. Eye-contact, or lack of it because of positioning, costume, touch and talk are critical in maintaining the asymmetrical nature of the interaction. Therefore, I hypothesize that women reacting negatively to the interaction will react negatively to the environment. Because I assert internal consistency of frame components, I expect similar patterns for neutral and positive respondents. These predictions are based upon my belief that the frame is experienced holistically by the woman.

Because both males and females are physicians, I chose to examine the affect of gender upon the experience of the examination. I wondered if a same sex interaction would

result in less framing difficulties for the patient. If framing problems were related to overlapping features of the sexual and gynecological frames, perhaps gender of the physician could alter the experience of the exam. Respondents were relatively evenly distributed according to sex of the physician, 16 males and 18 females. I suggest that sex of the practitioner will effect ability to fit and perform within the frame, and that women will experience more framing problems with a male physician. I also hypothesize that the relationship between interaction and environment will be intensified for male physicians.

Talk is an important feature of all interactions, but the guiding, reassuring and information-giving talk of the doctor, in particular, may prove relevant to the patient's ability to fit within the frame. Independent of other frame elements, I believe that talk is the least institutionally controlled aspect of interaction. The paper robe, uniform, touch and lying in the stirrups are not negotiable. But talk is by nature, verbal negotiation. Thus I believe if women experience more framing problems with male physicians, they will similarly react more negatively to male physicians' talk than to female physicians' talk.

In sum, my hypotheses are as follow:

H1: Reaction to the environmental component will correspond to reaction to the interactional component.

H2: For male physicians, the relationship between interaction and environment will be intensified.

H3: Women will experience more framing problems with a male physician than with a female physician.

H4: Women will react more negatively to male physicians' talk than to female physicians' talk.

METHODS

Sample

This is a preliminary study, a process of discovery. Practical considerations and time constraints rendered standard sampling procedures impractical. Therefore, brief, three page, questionnaires were distributed to female undergraduate and graduate students in two different sociology classes. I chose this strategy to obtain responses from a larger age range and to locate women having a wide range of experiences with a gynecological exam. Respondents were allowed to take the questionnaire and return it personally or through campus mail service.

There was no way to identify the individual respondent or their class status. Eighty-five questionnaires were distributed and thirty six were returned (42% return rate). Eleven were turned in immediately at the close of the class in which they were distributed. When I read these protocols, I found that four of these eleven respondents reported distressing memories which were brought to mind by

the questions. However, the remaining seven were relatively neutral in response. Respondents who had the questionnaire longer generally gave more detailed answers but the distribution of responses in terms of content did not differ from those handed in after class.

The questionnaire contained primarily open ended questions (see Appendix A). The questions were in the form of sentence completions which asked how the respondents felt about specific features of the exam, e.g. noise, paper robe, talk. Since the attempt was to determine ability to feel and react in a frame appropriate manner, a specific description of the context or frame was constructed. A list of features of the medical frame (see below) was constructed to establish a conceptual basis for coding and to determine fit within the medical frame. Specific features of the frame were operationalized into their respective items on the instrument. This typification of the medical frame is gynecology specific although many features are part of any type of medical interaction.

MEDICAL FRAME FEATURES

Environmental Features

Smell: The examination room will smell clean. A presence of antiseptic odors (alcohol and betadine)

signifies an absence of germs. Body odors are interpreted medically not personally.

Noise: Excessive noise should not be present. Noises present should be soothing. Because of confidentiality telephone conversations should not be overheard by patients. Doors should be closed to maintain privacy of patients.

Equipment: The walls in the room will be a neutral color. The windows will be covered so no one can see in or out. Rooms will have doors which are kept closed. The room should be maintained at a temperature which is comfortable for the patient. The room will contain an examination table. The table will have stirrups for placement of the woman's feet. Instruments or tools will smell sterile and look clean.

Lighting: Overhead fluorescent tubes light the examination area. The woman's pelvic area is illuminated with a special lamp for this purpose.

Interactional Features

Costumes: The physician is dressed. The physician wears professional garb. The physician has tools of the trade. The physician wears gloves to do the exam. The patient's

street clothing are removed. The patient wears a robe or is draped. The patient is exposed only as necessary.

Position: The patient assumes the lithotomy position in the stirrups. The physician is stands or is seated between her legs during the exam. The patient is draped in a manner which makes it difficult to establish eye contact between the patient and physician during the exam.

Talk: The physician does most the talking. The patient responds and does as requested. The talk is impersonal and professional. The talk facilitates doing of the work. The form of the talk is determined by the physician. The physician only asks about things relevant to medical treatment.

Touch: The physician uses medical touching which is called palpation. The physician only touches the patient in the areas relevant to examination, diagnosis and treatment. The patient does not touch the physician. The patient does not touch herself.

Procedure

Respondents were requested to mentally replay their last gynecological exam. They were instructed to remember specific aspects such as setting, physician behavior and how

the scene unfolded. Ideally their feelings, thoughts and sensate registration of this information would emerge. The individual woman was directed to relive her experience as if it were a movie scene. After this mental preparation the questionaire was to be completed.

The first page of the questionnaire contained open-ended questions concerning particular elements of the frame which correspond with the list above and a question establishing the biological sex of the practitioner. Patient's responses concerning their feelings about the features of the medical frame were obtained. Pages two and three contained a series of questions concerning satisfaction with the exam, the talk which ensued before and during the examination, feelings of uneasiness which were not physical in origin, daydreaming during the exam and memories of previous experiences elicited by the exam. For this analysis only page one and the questions concerning uneasiness and talk will be utilized.

The questions concerning daydreaming and memories had been included to provide data on keying. I believed that memories and daydreams might provide a way to discover if common features of the sexual and gynecological frames cause women framing problems, and if women key or connect one frame with the other. Operationalization of the variables combined with clearer conceptualization of the relationship between the medical and sexual frames, rendered

the suppositions concerning keys and keying theoretically incorrect. Although confusion within the medical frame could occur because of the common features of the two frames, it became evident that women do not key or transform the sexual frame into a medical frame. Rather the common manifestations of elements, woman's position, touching of genitals, vaginal lubrication and penetration may cause some women to experience difficulty in establishing the proper definition of the situation. They enter the physician's office however, knowing the primary framework as well as the sexual frame and other everyday frames that are available. It is possible, for example, that women may involuntarily slip into the sexual frame or a different medical frame during the course of the exam.

Thus I supplement Goffman's definitions (above) with one of my own which I feel complements the conceptual scheme of Frame Analysis. Frame is similar to Simmel's idea of form, and is not neccessarily related to its contents. Frames are embedded in a background of information. It is possible for a content, or a particular manifestation of an element to be present in several frames. For example, digital, vaginal penetration may be present in the following frames: 1)consensual sexual; 2)gynecological; 3)rape; 4)child sexual molestation; 5)abortion; and 6)childbirth. It is possible that women may key from one of these frames to another. In effect, the items may serve as a "basic way in which a strip

of activity can be transformed or serve as an item by item model for something else" (Goffman, 1974, p. 45). Playing at rape within the consensual, sexual frame may be be transformed into a real rape (Scheppele, 1987). Such features may be present in several situations and can be placed logically in several different frames. Their presence within several frames may cause "within frame confusion." Yet, the presence of these potentially confusing data do not establish or indicate in themselves that keying or transformation between frames has or will ocur normally.

The complexity of this forced me to extend Goffman's ideas, and to clarify them for the purposes of this research. I suggest that the process of awareness of and identification of features present in more than one frame involves sorting clues, features of frames which may be confusing or multiply codable, and hence a source of confusion or anxiety or uncertainty, from cues, which are seen as fundamental in identifying and maintaining frame. All clues are cues, but not all cues are clues. I use clues here as a pun suggesting that like the entitled game, clues may be misleading. It is clear that interaction and environment contain other "stabilizing" cues such as talk. These serve to focus and to reduce the likelihood of clues being salient in orienting role behavior and feelings. Of course, verbal interaction is the most flexible and readily

available means of cueing to guide and sustain the routine nature of medical reality.

These questions concerning cues or clues were rarely and scantily answered and no testing of hypotheses concerning this slippage could be accomplished. Absence of response to these questions (the only questions uniformly left blank) was interesting. Perhaps the sexual yet non-sexual nature of the gynecology exam renders women confused and unable or unwilling to give responses concerning what is brought to mind in terms of memory or fantasy. On the other hand, the construction of these questions may not have been adequate to abtain the necessary data. This subtle aspect of the problem is difficult to capture in a written questionnaire.

Concepts and Variables

I have stated above that conceptually, the frame is composed of setting and role or environment and interaction. I now wish to further specify the concept, drawing on Simmel's concept of form (Simmel, 1984). Thus emphasizing the determinate character of form in medical interactions. There are at least eight features of the frame, four each for environment and interaction, which I operationalized by asking ten questions. It is possible that there are many others, but these are the most obvious and salient. The concept of environment contains four features of the setting: noise, smells, equipment and lighting. These are

the physical attributes of the room and tools of the trade. Although smell and noise are certainly personally interpreted and assigned meaning, I place them under environment because they remain relatively stable and are setting and situationally rather than interpersonally specific. Although perfume and body odors, instances of content in Simmels' terms, could prove exceptions to this rule, it is assumed for purposes of this conceptual scheme that the odors of medical work will override such personal scents or the interactants will attempt to disattend smells which are not frame appropriate or medical data.

Interaction is related to aspects which are person specific such as dress, talk, touch, and physical positioning. These features are part and parcel of status, role and reflexivity. The contribution of these elements to the frame is interaction specific and essentially different from the concrete features belonging to environment. Although the paper robe and uniform may be apparently and materially the same from exam to exam, it is the wearer, the manner in which they are worn, and how this is interpreted within the frame, that position them conceptually within the interactional category. Two individuals may own an identical piece of clothing and wear it with very different panache and style. Thus the donning of cloth (or in the case of the disposable robe, paper), even if not chosen by the wearer, may present a very different self and image even

within the institutionalized medical context.

The concepts were operationalized into two composite variables. Environment was constituted of noise, smells, equipment, gooseneck lamp and ceiling light. Interaction incorporated touch, talk, stirrups, paper robe, and uniform.

Coding

Responses to the feeling questions were then coded according to frame conventions. It was assumed that a patient accepting the frame and patient role would answer the questions in a rather neutral manner or no response would be elicited by the question. Thus unanswered questions and those responding they felt "O.K., like I was in a doctor's office or nothing," were coded neutral. If discomfort, uneasiness or negativity were expressed the response was coded negative. Feeling "fine, comfortable," or an improvement in feeling such as "better" was coded positive. Since the questionnaire was constructed to discover negative out-of-frame experiences, I controlled for bias by uniformly coding a questionable response in the positive direction. A gain in status was coded positive, a cost or loss, negative.

Original coding on the questions concerning feelings (1-10) was performed poste haste and upon receipt of the questionnaires. Coding assignment was based upon frame conventions established in correspondence with the medical frame definition. These conventions were created and

defined by two coders to institute some check on reliability and validilty. Did the categories in fact represent the frame as conceptualized and were the responses appropriately coded? Concensus was reached on both issues after many theoretical and practical discussions. A discrepancy in some statistical findings caused the investigator to examine the coding scheme and the subsequent computer performed recoding. Since the problem definition, hypotheses and frame content were mentally distilled and more concrete at this point, another check on the original coding of the responses was performed. Twenty four conceptual coding errors were discovered. Seven percent of the data was incorrectly coded. This proved an invaluable lesson concerning the need for clarity on all elements of a study before the coding of open ended data of this type. Consensus on the coding once again was accomplished. Recoding was performed to transform the raw numbers into positive, neutral and negative categories.

The questions concerning talk and uneasiness were analyzed for content and general response categories were created. These results are not used in hypothesis testing per se, but they provide explanation and support for the findings based upon the frame indices. They offer substantiation and insight into framing problems.

FINDINGS

The response frequencies on the composite variables interaction and environment were initially examined. The sample distribution illustrated very similar pattterns for both variables. On the interactional variable, 69% responded negatively, and 31% were in the frame or neutral. No one was positive on the interaction. For the environmental variable 64% responded negatively, 30% were able to fit the frame and 6% were positive.

Hypothesis one tested the posited internal consistency relationship between interaction and environment. I have suggested that women experience the frame holistically and will respond in a similar manner to both frame components. Discussion of hypothesis one is divided into three sections which correspond to the findings concerning the coded values for the variables environment and interaction. Table one illustrates the effect reaction to interaction has upon reaction to environment in terms of the original coded values on the composite items. This table, presenting the relationship between the values on interaction and environment, should be examined representationally to discern if patterns and groupings emerge. Table 1 includes these data presented in percentaged format with computed marginals, chi square and probability included. Table 2 is the collapsed version of Table 1. Here the scores from

Table 1 were recoded and grouped into negative, neutral and positive categories. I collapsed Table 1 to create three distinct response categories which correspond conceptually to the ways women might think or talk about the experience of a gynecological exam. Relationships between numerical values on the two variables didn't relate to the possible responses women might have to the exam, although they do provide some information concerning internal consistency of frame components. For purposes of this disccussion, Table 1 values will be called scores and Table 2 values will be referred to by their recoded response category.

Thus women having a low numerical score on interaction would be expected to have a low score on the environment and this relationship should be replicated for those in the midrange and high score categories. If the hypothesis were supported I would expect to find the major diagonal cells containing the majority of the cases.

For purposes of this analysis, I first examined Table 1 representationally. I interpreted the table in terms of cluster and scatter of responses. The general pattern observed, a skew towards low scores and virtual absence of high response scores, is striking considering a cultural emphasis upon neutrality e.g. "it's important and desirable to maintain health," or even positivity, "I went to the doctor and I'm O.K., I'm taking care of myself."

That women scoring low on interaction will also score

low on environment, is supported by Table 1, which illustrates the relationships between scores on the two variables. Note the distribution pattern and that the majority of cases fall on the major diagonal.

Statistical support for internal consistency, concerning low scores, is found in Table 1. Here is a preponderance of evidence for an overall low score or negative reaction. The direction of Table 1 is as is as expected, and the chi square for this table, is significant. The R square of .71 means that 71% of the total variation in environment can be attributed to its linear relationship with interaction. This is a significant finding. However, because of the small sample, degrees of freedom and number of empty cells, the significant chi square, even after the correction for continuity, must be interpreted with caution.

The data in Table 2 show that 68% of the respondents were negative on both interaction and environment. Thirty-two percent were negative on interaction and neutral on environment. These two findings are consistent with the original frequency distribution of the separate variables as represented by the marginals. No respondents were negative on interaction and positive on environment. However the chi square for Table 2 is only marginally significant as is the probability level. Tables 1 and 2 provide some support for hypothesis one. However more data are needed to better establish the relationship between interaction and

Table 1. **Response to Environment as Affected by Response to Interaction**

Environmental Response Score	Interactional Response Score											
	5	6	7	8	9	10	11	12	13	14	15	
5	1.00	.00	.11	.18	.25	.00	.00	.00	.00	.00	.00	.17
	(1)	(0)	(1)	(2)	(2)	(0)	(0)	(0)	(0)	(0)	(0)	(6)
6	.00	.50	.22	.00	.00	.00	.00	.00	.00	.00	.00	.11
	(0)	(2)	(2)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(4)
7	.00	.25	.22	.09	.00	.00	.00	.00	.00	.00	.00	.11
	(0)	(1)	(2)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(4)
8	.00	.25	.22	.18	.50	.00	.00	.00	.00	.00	.00	.25
	(0)	(1)	(2)	(2)	(4)	(0)	(0)	(0)	(0)	(0)	(0)	(9)
9	.00	.00	.11	.46	.12	.00	.00	.00	.00	.00	.00	.19
	(0)	(0)	(1)	(5)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(7)
10	.00	.00	.00	.09	.12	.50	.00	.00	.00	.00	.00	.08
	(0)	(0)	(0)	(1)	(1)	(1)	(0)	(0)	(0)	(0)	(0)	(3)
11	.00	.00	.11	.00	.00	.00	.00	.00	.00	.00	.00	.03
	(0)	(0)	(1)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(1)
12	.00	.00	.00	.00	.00	.50	.00	.00	.00	.00	.00	.03
	(0)	(0)	(0)	(0)	(0)	(1)	(0)	(0)	(0)	(0)	(0)	(1)
13	.00	.00	.00	.00	.00	.00	1.00	.00	.00	.00	.00	.03
	(0)	(0)	(0)	(0)	(0)	(0)	(1)	(0)	(0)	(0)	(0)	(1)
14	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00
	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
15	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00
	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)	(0)
Chi square = 87.64	.03	.11	.25	.31	.22	.05	.03	.00	.00	.00	.00	1.00
df= 48 P = .0004	(1)	(4)	(9)	(11)	(8)	(2)	(1)	(0)	(0)	(0)	(0)	(36)

Table 2. Response to Environment as Affected by Response to Interaction

		Interactional Response			
		Negative	Neutral	Positive	
	Negative	.68	.55	.00	.64
		(17)	(6)	(0)	(23)
Environmental Response	Neutral	.32	.27	.00	.30
		(8)	(3)	(0)	(11)
	Positive	.00	.18	.00	.06
		(0)	(2)	(0)	(2)
		.69	.31	.00	1.00
		(25)	(11)	(0)	(36)

Chi square = 4.82
df = 4
P = .09

establish the relationship between interaction and environment.

The cluster and overall pattern represented by Table 1 offers general support for the posited relationship between interaction and environment. However, women scoring in the midrange on interaction will score in the midrange on environment, is not clearly supported. Although there is some cluster formation in the cells representing respondents in the midrange on both frame components, 50% of those scoring a 9 on interaction, which in Table 2 is coded as neutral, scored 8 on environment, which in the collapsed coded version, is negative. Thus the relationship between interaction and environment may not be strictly linear but could be graphically represented with an S curve. Internal consistency with regard to midrange scores, is not supported.

Data in Table 2 show that of those having a neutral response to the interaction, 31% of the entire sample, more than 50% were negative on the environmental aspect of frame. This is not indicative of internal consistency within the frame elements. Thus the majority of women not reacting or neutral to the interaction were experiencing negative reactions to the environment. Eighteen percent of those neutral on interaction, were positive on environment. Therefore support for hypothesis one is questionable when looking at the neutral categories.

Women scoring high on the interactional component will score high on the environmental component, was not testable with the obtained data. As indicated by Table 2, no one in the entire sample reacted positively to the interactional component of frame. The total absence of positive interactional responses is very interesting. Only 6% of the entire sample responded positively to the environment, and they all fell into the neutral cell for interaction. These findings and the overall skew towards negativity on interaction and environment would support my belief that women generally have framing difficulty with a gynecology exam. It is also possible that a nonlinear relationship exists between environment and interaction.

Hypothesis two, for male physicians, the relationship between interaction and environment will be intensified, was not supported by the data. Tables 3 and 4 represent the relationship between interaction and environment with the addition of a control for gender. Comparison of Tables 3 and 4 with Table 2 will show the effect of the addition of gender upon the equation. I would expect an increase in the percentage of cases located in the upper left cell, when controlling for the value male, if my hypothesis is correct.

The addition of the control variable does not affect the original relationship as posited. The chi square for both Tables 3 and 4 is not significant. The relationship between interaction and environment is not effected when

Table 3. Response to Environment as Affected by Response to Interaction According to Physician's Gender

		For Male Physicians Interactional Response			
		Negative	Neutral	Positive	
	Negative	.82 (9)	.60 (3)	.00 (0)	.75 (12)
Environmental Response	Neutral	.18 (2)	.20 (1)	.00 (0)	.19 (3)
	Positive	.00 (0)	.20 (1)	.00 (0)	.06 (1)
		.68 (11)	.32 (5)	.00 (0)	1.00 (16)

Chi square = 2.42
df = 4
P = .30

Table 4. Response to Environment as Affected by Response to Interaction According to Physician's Gender

		For Female Physicians Interactional Response			
		Negative	Neutral	Positive	
Environmental Response	Negative	.50 (6)	.50 (3)	.00 (0)	.50 (9)
	Neutral	.50 (6)	.33 (2)	.00 (0)	.44 (8)
	Positive	.00 (0)	.17 (1)	.00 (0)	.16 (1)
		.67 (12)	.33 (6)	.00 (0)	1.00 (18)

Chi square = 2.25
df = 4
P = .32

observe that the relationship between interaction and environment virtually disappears for female physicians, with only 50% located in the negative-negative cell. The addition of a control for gender does not intensify the original relationship between interaction and environment for males, and it reduces the interaction effect for female physicians.

These results prompted an examination of the first order relationships between gender and interaction and gender and environment. The column marginals for Tables 3 and 4, indicate the differential effect of gender upon response to environment. Tables 5 and 6 were constructed to further inspect these relationships. Table 5 demonstrates that the majority of respondents (68%), regardless of gender of the physician, were negative on the interaction component of the frame. The distribution within response categories is virtually identical for male and female physicians and the chi square is not significant. Table 6 illustrates the differential effect of gender upon response to the environmental component. For respondents having female physicians, 50% were negative and 44% were neutral on environment. The majority (75%) of women choosing male physicians, were negative on environment and only 19% felt able to fit within the frame. These findings are very interesting and will be incorporated in the discussion

Table 5. Response to Interaction as Affected by Gender of the Physician

		Gender of Physician		
		Female	Male	
Interactional Response	Negative	.67 (12)	.69 (11)	.68 (23)
	Neutral	.33 (6)	.31 (5)	.32 (11)
	Positive	.00	.00	.00
		.53 (18)	.47 (16)	1.00 (34)

Chi square = .02
df = 1
P = .90

Table 6. Response to Environment as Affected by Gender of the Physician

		Gender of Physician		
		Female	Male	
	Negative	.50 (9)	.75 (12)	.62 (21)
Environmental Response	Neutral	.44 (8)	.19 (3)	.32 (11)
	Positive	.06 (1)	.06 (1)	.06 (2)
		.53 (18)	.47 (16)	1.00 (34)

Chi square = 2.59
df = 2
P = .27

section in relation to several of the hypotheses.

Hypothesis three, that women will experience more framing problems with a male physician than with a female physician, is examined in Table 7. For purposes of this cross tabulation the interactional and environmental scores were added together and coded into very negative, somewhat negative, neutral, somewhat positive and very positive categories. Again there was only one case (5%) located in a positive category. If women experience more framing problems with male physicians than female, I would expect the comparison across columns to show higher frequencies and proportions toward the negative end of the spectrum for males. However this is not the case. Neither the chi square or P value are significant and the responses across cells for males and females are almost identical. Unquestionably, hypothesis five is not supported by the data.

Hypothesis four, women will react more negatively to male physicians' talk than female physicians' talk, is examined in Table 8. This bivariate table represents the relationship between reaction to talk and gender of physician. I would expect a skew towards negativity for reaction to the talk of male physicians, and fewer negative responses for female physicians' talk. This is supported by the data, as one can observe that 38% of respondents reacted negatively to the male physicians' talk, while only 17%

Table 7. Reaction to Frame as Affected by Gender of the Physician

		Gender of Physician		
		Female	Male	
	Very Negative	.22 (4)	.25 (4)	.23 (8)
	Somewhat Negative	.56 (10)	.56 (9)	.56 (19)
Reaction to Frame	Neutral	.17 (3)	.19 (3)	.18 (6)
	Somewhat Negative	.05 (1)	.00 (0)	.00 (0)
	Very Negative	.00 (0)	.00 (0)	.00 (0)
		.53 (18)	.47 (16)	1.00 (34)

Chi square = .94
df = 4
P = .82

Table 8. Reaction to Talk as Affected by Gender of the Physician

		Gender of the Physician		
		Female	Male	
Reaction to Talk	Negative	.17 (3)	.38 (6)	.26 (9)
	Neutral	.05 (1)	.12 (2)	.09 (3)
	Positive	.78 (14)	.50 (8)	.65 (22)
		.53 (18)	.47 (16)	1.00 (34)

Chi square = 2.86
df = 2
P = .24

reacted negatively to female physicians' talk. Thus frequency of negative responses to talk of male physicians was greater than twice that for female physicians 'talk and hypothesis six is supported.

DISCUSSION

Underlying themes and primary assumptions function to weave the fragile thread of ideas into a conceptual scheme. Frame as form, offering a context and the supporting structures or rules to identify and make sense of experience, provides such a basis for this study. Frame as the organizational support for establishing situational reality is constituted of two primary elements, setting and role. I believe this is universal and applies to all frames and their contents. Reality is established through knowledge of the frame, its specific components and their particular manifestations of contents in a context. Thus Frame Analysis offers organizing principals which people use to function in their expected roles in the pre-established primary framework.

The components, here operationalized as interaction and environment, were posited to operate along an internal consistency principle, within the gynecological frame. I believe this assumption is supported by the data. The overall negative skew of reaction to frame, and its specific

components, attests to the fact that women have problems fitting within the gynecological frame although the specific relationship within the categories remains questionable.

The small sample causes difficulty statistically. I suggest that a larger sample would, provide further support for the internal consistency principle, more meaningful statistical analysis and less data distortion by extreme cases.

Questions concerning the coding still haunt this researcher. The reactions of many respondents, as coded, fell into shady areas. A marginal and negatively biased score was so similar in content to one located at the lower end of neutrality, that subtle nuances of the experience, and the meaning of the computed scores as related to the original expressions, may have been diminished through coding. Although the theoretical basis for the coding was rigorous and precise, appropriate coding methodology does not insure that results will reflect the true nature of open- ended responses. However, this is a problem endemic to the use of this type of data and chosen method of analysis. Meaningful discussion of this problem is beyond the scope of the project. Therefore, the discussion section contains many quotations in an attempt to rectify what I perceive as a problem. Here I will integrate the quantitative and qualitative.

In some cases the respondents did not answer the

questions as instructed. Rather they reinterpreted the questions to fit their needs to answer and disclose. An interaction between the person and the questionnaire resulted in some women recalling and reacting to gynecology exams other than the last one. The form of the questionnaire seemed to elicit memories of past negative exams and some women responded according to the stimulus. One respondent circled female as the sex of the practitioner for the last exam, and used a male referent throughout pages 2 and 3. Some confusion existed here concerning which experience the woman was describing. This will be addressed further in the discussion of the nature of the relationship between frame and gender.

Clearly women experience within frame difficulties during the experience of a gynecological exam. Since the frame is defined and created for the purposes of the physician, this is not a surprising finding.

> Gynecological exams are the absolute worst and degrading things I've ever done. I feel like an animal on display with that burning bulb in my crotch. There has to be an easier way.

An interesting Freudian slip is present in this quotation. The bulb is not literally in the crotch, but rather shined on the area for illumination. However, this slip may express something about the unacceptable invasive nature of the examination. Not only the body is invaded but the personhood and self of the woman is invaded.

Because the self is at risk, cues are necessary to

anchor the patient within the frame. We know the <u>cues</u> but are sometimes confused by the <u>clues</u>.

> [The doctor's touch made me feel...] weird, I was confused about whether to "enjoy it or not. Since this sort of thing is normally a sexual experience.

Touch for this woman represented a clue, an element of the sexual as well as the gynecological frame. However the cueing function of talk, helped her to feel more comfortable and confident about her role within the frame.

> [The doctor's talk made me feel...] comfortable. He was talking all the time so that I didn't really NOTICE everything-kind of like a magician. I expected to feel much more uncomfortable than I did-but his whole <u>manner</u> was very soothing and kept my mind off of what was happening.

In an interesting way these quotations represent the necessity for cooperative work within the dyad to establish and maintain the frame. Despite the institutional definition of the frame and the risk status of the patient's self, this dyad worked together to accomplish the task.

Elements of the particular frame components function as cues and clues e.g. paper robe, touch, gooseneck lamp, and equipment, to help the patient identify the frame. I suggest that patients and practitioners do not agree upon the necessity for inclusion of particular manifestations of elements or cues in the gynecological frame. The language and concepts of <u>cueing and cluing</u> provide a framework for understanding women's reaction to these particular indices which are the contents of the frame. The frame components, environment and interaction, will be analyzed in terms of

their cue and clue content. Remember, as previously defined, clues may confuse because they are contained in the sexual and gynecological frame.

The interactional component has two clues, stirrups and touch. Stirrups are not usually contained in the sexual frame. However stirrups stand for the position during the exam, which is like the missionary position assumed by women during intercourse. Both of the clues elicited negative responses from the respondents. Ninety seven percent reacted negatively to lying in the stirrups.

> The fact that I was unclothed except for the drape and having to put my legs on the stirrups, made me feel ugly and in the most ugly position a woman can display her private areas.

> Doctor left me in the room in the stirrups and didn't close the door all the way! Every time someone walked by the door I was worried they were going to come in and [see me] in this vulnerable exposed position.

Others said lying in the stirrups made them feel," like an animal-like a mental patient," "like an idiot, completely vulnerable," "available for everyone to look at," "cheap," and "trapped."

The other clue, genital touching, similarly brought forth negative responses. The doctor's touch made me feel, "weird," "detached, "invaded," "gross," jumpy and tense," "sick to my stomach" and "I wanted to recoil."

> It is just strange to have a person touch you in a completely medical way-when at a different situation it would be exciting or sexual to be touched in such ways.

These women knew they were in the medical frame. However

these clues, position and genital touching were disturbing and confusing because they exist in both frames. Feeling vulnerable to a sexual partner is not at all similar to feeling vulnerable and trapped by relative strangers. Being medically touched is not like being sexually touched. But the distinction between the two may not be clearly made until the exam is well underway or even retrospectively. Ultimately, the changes and new manifestations of these clues, transforms them into cues.

Thus confusion or frame slippage can be managed by the transformation of clues into cues which are combined with other established and standardized cues. Cues of the interactional component are paper robe, uniform and talk. I suggest that we all learn to properly interpret and accept certain institutional cues as part of many frames, whether we like them or not. These cues are present in so many frames they can not be misconstrued as clues. Uniforms are such a cue. They are used in many jobs and professions. We have learned to identify status and profession of the wearer by the uniform. Respondents in this sample were neutral in reaction to the uniform, although women were slightly more negative towards the male physicians' uniform than the females'. I believe the significance of this finding is related to gender of the wearer, and anger concerning prevalence of male authority figures in this culture.

Talk exists in virtually all interactive frames. Even

interaction between deaf persons includes a visual sort of talk known as signing. I believe talk is the best of all cues. It can be easily manipulated and transformed. Talk can clarify the frame because we can modulate and adjust tone, volume, inflection and structure. Verbal interaction is negotiable, versatile and may reduce uncertainty by serving as a guiding force. Both the patient and physician may talk and listen. Talk can be processual and reciprocal.

> I felt he was very easy to talk to, very understanding, very much a listening person. He also explained what he was doing to me-so I didn't have any feeling of him doing more than examining me.

The guiding reassuring talk of the physician is essential in maintaining the fame. It tells us what is going on and what is not. Talk creates and establishes mood and atmosphere. It is the only element of the gynecological frame women reacted to in a positive manner (64%).

> She told me exactly what she was doing, and made jokes so I felt more at ease.

> She explained what she [was] doing in terms of how she was going to touch me, what kind of sensations I should feel, when the speculum was about to be inserted, and how she was going to check my ovaries and rectum.

> I don't remember [what the doctor talked about during the exam]-its been about 6 months-but I know she tried to make me feel comfortable-small talk.

Content and timing of the talk is still at issue. Talk will be more fully discussed in relation to hypothesis six. What you say and when you say it, throughout the sequence of

events, is very important. However, as my female physician said, "you just can't win. If you talk them through the exam, they want to talk about school, if you ask about school, they want you talk them through the exam." Thus how the patient wishes to experience the exam, disattend or understand, is a guiding principle for the content of the talk during the procedure. These two quotes represent women at opposite ends of the spectrum concerning their desired content for the talk.

> Before the actual examination, but while I was in the stirrups with legs spread apart, the doctor was explaining in great detail what she was going to do. Then she talked through the whole examination telling me what was going on. It seemed to drag out the process when what I really wanted to do was get out of there A.S.A.P. ... She, her talk actually made me focus on the examination which made me uncomfortable. I would have rather been reading a sign on the wall.

> I like to know exactly what she is doing all of the time! I ask her to tell me step by step what she is doing and looking at each time I have this exam.

The physician's ability to read the patient and adjust the talk appropriately, appears to be an important skill. Patients must provide some sort of information as to their needs, in this context, to optimize the positive cueing affect of talk. Physicians likewise must be receptive to this negotiation which is instrumental in the establishment of a working consensus for the doing of medical work.

The paper robe is the final interactional cue to be discussed. Women overwhelmingly (94%) react negatively to

the paper robe. The paper robe has a special significance for the patient. Her street clothing, an important part of her presentation of self, has been taken away. Her patient status is clearly established by the wearing of the paper robe.

> [The paper robe made me feel...] uncomfortable being that undressed in front of a stranger.

> I hated it. Rather have something cloth that covered more.

Other respondents felt, "silly," "exposed," "helpless," "ashamed," "naked and cheap." Paper robes, made of the same material as paper towels, are worn primarily for gynecological exams. Their prevalence in this frame has only come about in the last 5 to 10 years. Previously women wore the rear closing, cloth robe which is typically used for other medical procedures, e.g., surgery, x-rays and general physicals. Even chiropractors, clearly on the margins of the medical establishment, use cloth robes. Although, it may be their marginal status which determines use of attire traditionally defined as institutionally correct. Gynecological exams are messy. Stains and betadine, which are very difficult to remove from cloth, are routinely used. It is eminently practical to use paper in this context.

Selves at risk, as in the gynecological frame, do not attend to practicalities. Women already feeling vulnerable and exposed do not want to attire or disattire themselves

with something that makes them feel, "cold," "naked," "huge-it barely covered me," "ashamed," and "not sanitized, and it was needed." This reaction, I posit, is a function of the mutability of this feature. It is not necessary to make women feel humiliated and degraded, in this fashion, to do a gynecological exam.

The environmental component contains no clues but has several institutionalized cues. The overhead fluorescent lights and smells are expected. They elicit neutral or no response from the patients. Noise has a somewhat greater effect, with almost equal response distribution between the negative and neutral categories. I believe those reacting negatively were not responding directly to the absence or presence of noise, but rather to what the noise meant in a particular situational context. One respondent reacted negatively to noises because she was left in the stirrups with the door open and feared the noises signaled the entrance of a person, which would embarrass her. Another attached significance to the noises of the instruments or equipment.

> [The noises in the examination room made me feel...] alone and afraid-the clamor of the gadgets used felt cold lonely and impersonal.

Thus the responses on noise are somewhat difficult to explain. I believe this is a function of the structure of the question and also that noises do stand for other things which are difficult to disentangle when analyzing such

results.

The gooseneck lamp, although present in many settings, is not acceptable to gynecological patients. Seventy five percent reacted negatively to this lamp as did 64% to the equipment.

> [The gooseneck lamp made me feel...] self-conscious and like I was on display.
>
> [I felt] uneasy and uncomfortable. At times the lamp is so bright and feels so hot that I get a burning sensation.
>
> The medical tools used were cold and touches made me feel very uneasy.
>
> Some of the medical equipment made me feel <u>un</u>easy even though this was not my first exam.

Women's negative reactions to the gooseneck lamp and equipment signal their desire to change these features of the exam. Although there exists some intrinsic unpleasantness in this context, which many patients can accept, a different manifestation of the paper robe, gooseneck lamp and some of the equipment would result in less difficulty fitting within the frame.

This discussion of cues and clues, their meaning and distribution is integral to an understanding of the relationship between interaction and environment. Because interaction contains clues, it is simultaneously variable and vulnerable to frame confusion and the establishment of clarity. Thus vacillation and frame slippage may occur. Position and touch confuse, and talk clarifies. Uniform is

institutionally accepted. Paper robe is not accepted as necessary to the accomplishment of the task. However, when the clues are transformed into cues, touching is defined as palpation and position become lithotomy rather than missionary, only one feature is left which may be adjusted to the needs of the patient.

Environment contains only cues. It is composed of fluorescent lights and smell which are institutionalized and accepted, noise which is slightly problematic and gooseneck lamp and equipment which women would definitely change. However, if the environment herein defined, is relatively stable in gynecological offices, why do women react less negatively or fit within the frame much easier with female physicians than with male? I suggest this has to do with some intangible features of a same gender interaction and with other frame factors which may be present when the inhabiting physician is female. The majority of respondents having male physicians reacted negatively (75%) to the "exposure" provided by the gooseneck lamp and only 19% were able to fit the frame on this element. Of those choosing female physicians, 50% responded negatively and 39% were able to fit the frame. Perhaps women feel less modest and invaded when examined by a female and experience less frame slippage. Two respondents, having female physicians, mentioned posters on the ceiling which helped them to disattend. Speculum warmers mentioned in this study were

women physicians. The self may feel less at risk with a female physician who one assumes has experienced the identical patient role.

Female physicians bring a bit subjective culture to the institution (Simmel, 1984). Status inconsistency attests to this cultural anomaly and tells us there is something very different about a "woman doctor." They surround themselves with personal artifacts. Fingerpaintings and flowers are typical in the office of the female emergency specialist on this campus. I do suggest that certain female physicians have an ability to diminish the negative effects of environmental features within the gynecological frame. These are anecdotal observations and suppositions which are not testable with this data.

Interaction allows more patient input, although it calls for more work to maintain the primary framework. It would not be as accessible to affect by gender of physician. Environment is not vulnerable to cluing confusion. It contains more manifestations of elements which patients and practitioners disagree upon, and over which patients have no control. Women physicians do appear to have some ability to reduce the negative effects of the inflexible environmental features. The lack of any respondents positive on both environment and interaction speaks to the need for change in manifestations of these controversial elements. This will be addressed in the final

discussion.

Although hypothesis three, that women will experience more framing problems with male physicians than female physicians, was not supported, one must examine the patient's criteria for selection of a female physician to understand what these results may indicate. Many of the respondents seeking care from a female physician, experienced acute nervous reactions, fear, and embarrassment concerning the exam. They were not able to assume the status of person as object and fit within the medical frame.

> I was really nervous-it was difficult for me to remain relaxed-when a doctor was looking and touching me personally. I knew I would feel like this. It was no surprise for me to feel afraid. I know lots of girls feel like I do. My friends are uncomfortable too.
>
> A person's body is private. When another person touches you in a person's most private parts, you feel exploited.
>
> I HATE HAVING THIS EXAM DONE. It is like I was on display to the doctor and nurse. I don't like strange people to look at or touch me.
>
> I don't like 2 people to see that part of me so close when I don't even know them.

Others made reference to previous negative experiences with male physicians.

> I would never again go to a male doctor--I only did once cause he was the only one in the office at the time. Anyway, something about a man examining me while I'm in such a "trapped," vulnerable position seems wrong--like they have no business there.
>
> For some reason I feel like I'm being violated in some way. This may be why I only go to female doctors for gyn. exams. It's still not <u>great</u> but better. I can't imagine a man

> examining me! I had one once and I was terribly uncomfortable. Again, I feel humiliated by the whole thing.
>
> When I was 18, I had to go the hospital for an STD. I was a virgin and I had never been to an OB/GYN. It was a man, and besides physically hurting me, he made me feel like shit and a tramp. And of course he didn't believe that I was a virgin. I was crying and he was just an <u>asshole</u>! I have learned a great deal about my condition and I know that it was caught through oral sex. I will <u>never</u> go to a male gynecologist again, though.

These quotations were all taken from women indicating their last gynecological exam was performed by a woman. All of their scores on the variable frame fall into the very negative category. Previous negative experience or general difficulty with the frame may be the basis for their choice of practitioner.

They hope for a less negative experience with a female physician. Patients may believe that female physicians can identify with the patient on the basis of their own in-the-patient role experiences with gynecology exams.

> She told me what she was doing and apologized for cold "utensils," etc. I think that, as a woman, she is more comforting since she knows how vulnerable women can feel during these exams.

No respondents cited previous negative exam with a female physician as criteria for selection of a male physician. Women did experience the same sort of embarrassment and nervousness with male physicians as with female physician. They also objected to the necessary presence of the nurse during the male-female interaction.

> This is an embarrassing, violating experience.

> Need I explain further?
>
> The nurse who stands in the room is like an unnecessary bystander.
>
> Because my doctor was male, a female nurse had to be present during the exam and I think this kept the doctor from being as thorough as he could of because he had to worry about this actions being interpreted as sexual.

Generic issues due to the intrinsic unpleasantness of the exam are present with practitioners of either sex. I suggest however, that the frequency of comments and their content on the questionnaires of respondents having female physicians, signifies a more negative preconception of the frame than for those having male physicians. It is probable that some sort of selection criteria other than gender of physician is reflected in the data. Perhaps patients chosing female physicians are predisposed toward frame problems or negative reaction to frame. This preformed expectation of the experience within the frame may not be significantly affected by gender of the practitioner. Perhaps the data should indicate that women experience more framing problems with female physicians. But I posit these problems are not directly related to the gender of the physician, but rather based upon pre-existing negative feelings concerning the frame. This supposition is supported by the previous discussion of women responding to the questionnaire on the basis of other exams. Women may similarly inhabit and experience the frame on the basis of previous experiences, rather than the present exam.

The role of talk as a cue and guide in any interaction has been discussed. I believe the support of hypothesis four speaks to the importance of talk within the medical frame. Women react more negatively to male physicians' talk than female physicians' talk or conversely women react more positively to female physicians' talk than male physicians' talk.

Talk is embedded in a context. If women chosing female physicians are predisposed toward negative experience within the gynecological frame, as previously discussed, talk may have a greater effect upon their interaction, than for women attended by male physicians. Women chosing female physicians may own previous negative experiences or have general difficulty fitting within the frame and would be most vulnerable and liable to react to effective cueing. Their ability to participate in the talk might serve to lessen the pre-existing frame problems they may bring to the encounter.

Talk doesn't stand alone in real life or in the questionnaire construction. The item concerning talk is number 9 of 10 in a series. The stage has been set, so to speak, by the previous questions. The respondent should be mentally in the midst of relieving the exam when she answers the question about talk. Thus her response is not to talk in general, nor is it likely to address talk from another exam. It is situated in this particular experience. The

manner women answered this item further attests to this supposition. Many used qualified adjectives or phrases to describe their feeling about the talk. I felt "better-yet uneasy in a different way," "a little less uncomfortable," "reassured, but still tense," "much better, still nervous," and "a little more comfortable." These responses reflect a positive increment or gain from a previously negative position so they were coded positively. Position in question 8, was lying in the stirrups, so these qualified responses may be reflective of their discomfort in the lithotomy position, which would imply the question order functioned according to the design.

Seventy eight percent of the respondents having their last gynecology exam with a female physician responded positively to the talk. Only 50% of the sample having male physicians responded positively to the talk. Talk is the only interactional element for which significant between gender differences in response were exhibited. Thus I posit that talk, the most important cue of all, functioned in this frame to produce the intensification of the negative relationship between environment and interaction for those having their last exam with a male physician.

In summary, hypothesis one, concerning internal consistency of the frame elements, is supported by the data. More data would perhaps clarify these relationships. The majority of women are clearly negative on both elements of

the gynecological frame but the overall relationship between these variables may not be linear in character.
The relationship between the variables for the neutral value, is not clear from these data. I attribute this finding to the cue content of the environmental element which is particularly problematic for gynecological patients. Consistency concerning positivity could not be examined because no one was positive on the interaction.
The data does not support hypothesis two: when controlling for gender, the relationship between interaction and environment is intensified. The data do offer hints that a larger sample might clarify the significance of the addition of the control and offer support for this hypothesis. The supplementary Tables 5 and 6 do demonstrate the differential effect of gender upon response to the environment. Patients responded negatively to the interaction regardless of the gender of the practitioner. Patients are predominantly negative in response to environment with male practitioners.
Hypothesis four examining women's differential response to talk, according to gender of the physician, is supported.
Women respond more positively to the talk of female physicians than that of male physicians. Hypothesis three, women will experience more framing problems with male physicians than with female physicians, was not supported.
I believe women choosing female physicians have important reasons for selection other than gender of physician which

renders the meaning of this finding rather obscure. Although actual behavioral differences by women physicians and assumptions concerning female traits, may function to diminish the pre-existing negative feeling, concerning the frame, which I posit many of these women own.

Research Issues

Theoretical issues concerning Goffman's conceptual scheme arise as a result of this study. There are also some practical implications that flow directly from an interpetation of these findings. I turn my attention first to the theoretic issues.

Goffman explains, with regard to framing and keying, that the existence of recognizable primary frames may be models for or transformations of others. This appears clear and straightforward. However, it assumes that we know what the primary framework is or, in the case of ambiguity, is :

> ...itself of two kinds: one, where there is question as to what could possibly be going on; the other as to which of two or more clearly possible things is going on. A difference between vagueness and uncertainty. (Goffman, 1974, p 302)

It seems unlikely that we are frequently so confused about primary frameworks that two types of ambiguity exist. How can we go about transforming frames via keys when or if we possess so little knowledge concerning the extant primary frames? Primary frames, after all, set the fundamental grounds for interaction. If we don't know the primary frame

or the available frame options, how can we perform Goffman's defined operations?

I suggest that we are never without <u>some</u> idea of what is going on. We always have a field of possible frames to choose from. In the case of a fabrication or deception, we may be confused or left purposefully without enough information to judge what is going on. We may make an incorrect decision concerning the primary framework. Sometimes we discard a frame after more information is processed and we then know what is not going on. This enables us to disregard a frame and consider others. However, we have some ideas or frames from our experiential bank to draw on. This would be the case with satires and takeoffs which "are meant to be seen as copies and make no sense without this common recognition "(Goffman, 1974, p. 84). Even in this situation we have probable frames to choose from.

I do not believe we are navigating through situations and manipulating or transforming one frame into another, because we have little or no idea about "what the hell is going on here." Rather, we are confused by the combination of the cues and clues in a context and seek to achieve clarity at the level of concerted action. We do this through cue assemblage and sorting, and transformation of clues into cues. This theoretical model for sense making and establishment of the frame does not call for endless

definitions of rare or nonexistant framing difficulties. It is applicable to the real world.

Perhaps a few speculations about the real world, based on this rethinking of some of Goffman's ideas, may be permitted here. Institutions exist in the real world. There appear to be some implications of the negative experiences reported here. Some changes are indicated by the reports of gynecological patients. These, if insitituted, could transform important aspects of the medical frame, here represented by the frame organizing the meaning of the gynecological exam. It may be possible, with a few changes, to make the exam more "patient-friendly." Such changes would address the following kinds of questions. Is a less negative experience possible for the individual woman? Why are women so anxious and distraught over the mere thought or mention of a gynecological exam?

I believe that much of the dissatisfaction with the gynecological frame occurs because of confusing clues present in both the gynecological and sexual frames, and because women are treated as objects in the one and subjects in the other. Saying this does not mean women key from the sexual frame to the gynecological frame nor that they wish for a sexual encounter with their physicians. Rather the similarity of the touching of genitals, positioning of the body, and the exposure of the self causes women to expect and want treatment as a person, not as a thing.

Human beings expose their essential selves rarely, and most frequently perhaps during sexual encounters. Goffman has discussed this in his classic papers about more ostensively "trivial" experiences involving face work (1955) and embarrassment (1956). Sexual contact is powerful and indicative precisely because both the giving and receiving of pleasure and the maintenance of an internal and external dialogue take place. Optimally, we are integrated selves, experiencing cognition and feelings simultaneously. Although men and women may exist as sexual objects, in a caring intimate interaction they are sentient selves for and with each other. The setting and atmosphere are created and sustained by the participants. Both interactants shape, suggest and indicate, and symbolize desired behavior within the frame.

In a gynecological frame, the self of the woman is exposed and at risk. In some ways, this may parallel the experience of the mental patient. All personal belongings are taken away. No indices of the self are left under the control of the woman. She is instructed to undress and position herself and her body is invaded in an uncomfortable manner with foreign metal objects.

> I felt extremely vulnerable. I had no control whatsoever once the equipment had entered my body. What would I do if my surrounding area was suddenly bombed? I wouldn't be able to move with the equipment in me!

The others available to her in this setting treat her as an

object. She is the object of a collusive triad of doctor, nurse and herself. The disposable nature of the paper robe further emphasizes her marginal status and inability to bring anything of her self to the interaction. Assymetrical role relations are maintained by her powerlessness in the setting. In spite of pressure for self conformity, my data suggest that the self of many women is not isomorphic with the institutionally defined role. This degree of selfhood found around the edges of institutions suggests the existential foundations of the self and its maintenance.

Because a patient's sense of self is at risk many attempt to disattend and omit the I from the experience.

> I looked away the the wall and tried to ignore what was going on.
>
> When I have these exams, I do all I can, I turn my feelings off completely.
>
> In this situation you think about anything to take your mind off the discomfort. Not only that, but take your mind off having your legs in the air and someone's face between them.

Because of their powerlessness and the need for disattention, women feel as if they were objects or forms. They become humans devoid of the subjective or the content. The temporary submergence or denial, perhaps even a feeling of loss of self, necessary for many to cope with the negative experience, makes one feel invisible. Women feel an absence of the tools they have developed to manipulate and deal with analogous situations. Clearly, the theoretical question

arising from Goffman's work, and addressed here, is "what is analogous?"

Does medical work essentially call for this sort of patient objectification? Affective neutrality and the ability to make decisons concerning diagnosis and treatment from an informed and objective stance is not the same as equating and treating patients as things. Gynecological patients, like mental patients in institutions, remain multifaceted, feeling and performing beings. They cannot be fully crushed by procedures, nor reified by paperwork. Sense of self is at risk when we interact within insititutional structures. This is clearly the case in hospitals, mental insitutions, prisons and the armed forces. The institution purposefully functions to force all inmates selves toward some median self. This is the malleable institutional self. Does this make patients get well, render the insane sane, reform convicts, or make Marines from a few good men? I think not.

There are some further practical observations I would like to add at this point. I posit that involving women as subjects in an important part of their health care would radically improve the experience. Not only the patients would benefit from this suggestion. Physicians would enjoy fewer tense, nervous, frightened and resistant patients. If the medical establishment continues to emphasize the necessity for regular, preventative gynecologcial care, and

seeks patient compliance on preventative grounds rather than on the basis of presence of pathology, e.g., yeast infection, chlamydia, herpes or unwanted pregnancy, the frame must be changed. This change in perspective calls for alterations which will encourage women to look at the exam as a form of self help, rather than an ordeal. One respondent typified her experience, as a form of sheer survival, rather than a positive contribution to her health or self-esteem, " It's over and I lived through it. [I'm] even stronger than before. Like because of surviving I had grown."

Women needn't feel this way. A different strategy for health maintenance might facilitate women having regular gynecological exams without an assault on the self. Perhaps even a few frame alterations would incur better patient compliance. Some very small changes might radically reshape the experience. Ample cloth robes would definitely be an improvement. Warming the speculum takes little effort, and was greatly appreciated by the women mentioning it. A male physician with whom I spoke stores the available speculums on a heating pad. His only admonition, was "make sure and check they don't get too hot, that can be a problem too!" Use of gynecological chairs, similar to birthing chairs, in which women are gradually tilted back and may view their pelvic area and the physician's actions, are a humanizing innovation.

Technological changes in the environment are not the only alterations called for. Women reacted less negatively to the environment when examined by a female physician. The intrinsic nature of a same sex interaction can't be mimicked. However, incorporation of more women into the institutional structure could facilitate humanization of the exam setting and ultimately the practice of medicine itself. If physicians are educated to treat the patient more humanistically, perhaps the effect of gender upon certain features of the gynecological frame could be reduced. Incorporation of many gender traits traditionally labeled feminine, into the physician role, could potentially transform the experience of medical care and health maintenance for all individuals.

In sum, these changes might alter some of the negative aspects of the experience yet do not impede the exam. Perhaps changes of this kind, would serve to reshape the gynecological frame in a positive direction. The patient could be involved in the exam and learn about her body in the process. These cues and medical role behavior, traditionally features of the gynecological frame, call for transformation.

Future research

Were I to redo the study, I should try to sharpen the instrument to facilitate more precise responses. I would alter several aspects of the questionnaire. It seems to me

that the reasons for seeking the exam and the previous experiences of the person are crucial in setting the context for the experience. (It seems possible, although I cannot determine this from my present data, that respondents were reacting powerfully to past negative experiences when reporting " my last exam.") Gathering data on the stated reason for visit, and information concerning other traumatic exams would have been helpful. I would ask women what they would alter about the experience. I would ask if anything about the setting was different from other experiences and how this affected the respondent. I would ask also how they felt about the lack of eye contact with the physician. I would create separate questions concerning the position maintained during the exam, and the stirrups as a particular type of equipment.

The data taken together support my primary assumptions. I have tried to integrate the humanistic concerns that lie behind the research with the data presented throughout the paper. In my view, my materials undeniably show need for changes in several alterable features of this situated experience. These findings, I suggest, speak clearly to the utility value of frame analysis as an analytic scheme. It does not merely provide a means for investigating how people make sense of situations and establish primary frameworks. Research based on frame analysis has relevance for social policy and for directing attempts to alter the real world.

If we can understand how the layers of experience are built up, in what way we come to understand cues and clues and their combinations and transformations, we can use this knowledge to diagnose incongruent features of a frame. It can be used as an instrument for change. Thus, frame analysis may be transformed from a theoretical conceptual framework into a practical guide for effecting change. This change, however, is only possible if those with the power and authority to alter frames are willing to act on the basis of the evidence.

APPENDIX

APPENDIX

Gynecology Questionnaire

This questionnaire concerns your perception of and feelings about gynecological exams. The first questions deal with feelings about specific aspects of the experience. Do not think deeply, just respond with the first word or phrase that comes to your mind. The next section contains yes/no responses and sometimes an explanation is requested. Try to recall and write down as many details as you can on these questions. If you have comments please write them on the back.

When answering the questions I would like you to recall your last gynecological exam. Think about the doctor and his/her office. Replay the exam in your mind as if it were a scene in a movie. Pay attention to all your senses. In general how did the surroundings make you feel and what did you think about while you were there? With these things in mind please answer the following questions. Thank you for your participation in this study.

The physician I had for this examination was: a)male
b)female

1)The **smell** of the examination room made me feel ....

2)The **noises** in the office made me feel...................

3)The **paper robe** or drape made me feel...................

4)The **doctor's uniform** made me feel.......................

5)The **equipment** in the examination room made me feel .....

6)The bright florescent **ceiling lights** made me feel ......

7)The gooseneck **lamp spotlighting** my pelvis made me feel..

8)Lying in the **stirrups** made me feel.....................

9)The **doctor's talk** made me feel..........................

10)The **doctor's touch** made me feel.......................

11) Concerning questions 1-10, were any of these feelings (either positive or negative) surprising to you?

a) YES b) NO (go to next page)

12) Can you explain what caused this particular feeling or reaction?

13) How did you feel about your reaction?

Circle one response and answer the follow up question if requested.

1) Were you generally satisfied or dissatisfied with the exam?

a) DISSATISFIED b) SATISFIED (go to #3)

2) What could have made this a satisfactory exam?

3) Could anything have been done to make you more satisfied?

4) Did you talk with the doctor before the exam while dressed in your streetclothing?

a) YES b) NO

5) What did the doctor say when s/he entered the room?

6)What did the doctor talk about during the exam?

7)Excluding physical discomfort, did you feel uneasy at anytime during the exam?

a)YES b)NO (go to #8)

8)Why did you feel uneasy?

9)Try to remember what it was like when you were lying on the table during the examination? Did you daydream about anything?

a)YES b)NO (go to #10)

10)What did you daydream about?

11)Did the exam make you recall other experiences or situations, which were not necessarily gynecological exams?

a)YES b)NO (go to 14)

12)What memories came to you and why did it seem similar?

13)Why do you think you recalled this memory?

14)Have you given birth to a child?

a)YES B)NO (go to 16)

15)How many times have you given birth? ____________

16)What is your reproductive status?

a)PREMENOPAUSAL b)MENOPAUSAL c)POSTMENOPAUSAL

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