CHARLES UNIVERSITY

FACULTY OF SOCIAL SCIENCES

Institute of Sociological Studies

Department of Sociology

Master's Thesis

2024 **Samina Nørgaard**

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Women's experience of gynecological examinations: embodiment and malpractice in care

Master's Thesis

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Year of the defence: 2024

Declaration

1. I hereby declare that I have compiled this thesis using the listed literature and resources only.
2. I hereby declare that my thesis has not been used to gain any other academic title.
3. I fully agree to my work being used for study and scientific purposes.

In Prague on 29.07.2024 Samina Nørgaard

References

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Abstract

This thesis examines women's embodied experiences of pain and discomfort during gynecological examinations which has been an underprioritized topic within ethnographic and sociological research on women's reproductive and sexual health. Most ethnographic studies on this topic have focused on women who suffer from pathological conditions in their genitalia or on racialized violence in reproductive healthcare. This study contributes to ethnographic research on women's experiences of pain and discomfort during gynecological examinations by focusing on women who in biomedical terms are considered to have "healthy bodies". It questions the routine practices within gynecology including doctor/patient interactions at local hospitals in Prague, Czech Republic. Through in-dept interviews with women in Prague and participant observation at two gynecological wards, the study demonstrates how lack of emotional care and gentleness from gynecological practitioners and the design of gynecological equipment contributes to a normalization of pain and discomfort in relation to gynecological examinations in a European context. The study argues that allowance of unnecessary suffering in gynecological practice is an expression of structural violence against the female body in medicine. Consequently, this means that women refrain from seeking medical advice on reproductive and sexual health issues and that they stay away from gynecological check-ups. To decrease pain and discomfort in relation to gynecological examinations, the study suggests improvements in gynecological practice through more attention to emotional care, better designed gynecological equipment and prioritization of communication skills in medical training.

Keywords

gynecology, healthcare, pain, embodiment, reproductive health, medical violence, ethnography, medical anthropology, feminist research

Klíčová slova

gynekologie, zdravotní péče, bolest, ztělesnění, reprodukční zdraví, lékařské násilí, etnografie, lékařská antropologie, feministický výzkum

Title

Women’s experience of gynecological examinations: embodiment and malpractice in care

Název práce

Zkušenosti žen s gynekologickými vyšetřeními: embodiment a problematická péče

Acknowledgement

I would like to express my gratitude to the women who participated in my study and shared their private stories about expereinces of pain and discomfort during gynecological examinations – and in their intimate lives. It takes great courage to come forth with such private and vulnerable stories about the most intimate aspect of our lives, and I know that many of these women hope that the current state of gynecological practice will improve with higher levels of comfort and more bodily autonomy, and that the sharing of their personal stories might contribute to this.

I would also like to express my gratitude to Mgr. Ema Hrešanová, Ph.D. who has been the most supportive and helpful supervisor to me during this thesis study and whose ethnographic work on women's reproductive health has served as a great inspiration in my own ethnographic training.

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Introduction

> *I was 19 years old when I had my first gynecological check-up at our family doctor in my hometown in Denmark. It happened not long after I'd had my first sexual intercourse and I wanted to make sure that everything looked fine down there. I don't remember if the doctor had explained to me how the examination would go, but I remember the sensation of cutting pain as something entered my vagina. The speculum. It was the maximum of pain I had ever experienced. I was in so much pain that I feared I would faint, so I cried out: "This really hurts!". With a calm, unbothered voice my doctor replied: "Yes, that is because you're tightening your muscles." as he continued the examining of my vagina, now with two of his fingers. By the time the examination was over the pain took up my entire consciousness and I could hardly focus on anything he said. If I hadn't known any better, I could almost have sworn that he had stuck knives inside of me, but when I checked my panties at my next bathroom visit there was no blood to be seen. How come no one had ever talked to me about how painful this examination would be? Or was it just me? Was there something wrong with my body since it had been that painful?*

The vignette above is a personal account of my own embodied experience of extreme pain in relation to my first gynecological examination, and it reflects several of my experiences with gynecological examinations in the time after as well. For years, I thought my experiences of pain in my vagina during gynecological examinations was due to some physiological malfunctioning since none of my female friends could recognize the amount of pain I felt during these examinations. However, as I made new friendships with women throughout my twenties and as conversations would turn to topics about intimate life, I learned that I wasn't the only one with this experience of pain during gynecological examinations, after all. I still did not understand though, why several of the doctors making the gynecological examinations on me did not recognize my suffering with pain, and it was difficult to find answers to my suffering online even. It occurred to me, that this was an area of female reproductive and sexual health which has been given too little attention in medical- and social research, which is something I hope to change with this master's thesis study.
Unlike most research within medical anthropology, this study on women's experiences of

pain and discomfort in relation to gynecological examinations is dealing mainly with women who from a biomedical perspective are considered to have *healthy* bodies – that is, bodies that doesn't have a pathological condition in their genitalia which is identifiable in biomedical terms. When women's experiences of discomfort in relation to gynecological examinations previously have been studied within social sciences it has often been with a focus on women with gynecological conditions or in relation to birth care. A study about US women's suffering of vulvar pains by cultural anthropologist and former nurse Christine Labuski (2015) is one to be mentioned. She did her research on how these women deal with this disruptive aspect of their physical and social lives. From a critical feminist stance, Labuski investigates how the women navigate in their search for treatment to their conditions within heteronormative discourses about healthy female genitalia and dominant cultural attitudes towards heterosexuality and sexual intercourse. Her findings suggest that vulvar pain becomes problematic to these women (and their partners) especially due to such discourses as much as by the physical suffering itself (Labuski 2015:5,6,7).

In many other cases, studies within social science on women's experiences pain and discomfort in relation to gynecological (vaginal) examinations have been conducted within maternity care from which the term *obstetric violence* referring to a particular kind of structural violence against women has been developed as an entire research field on its own (Perera et al. 2022:2). For instance, Michelle Sadler et al. (2016) did research on overuse of interventions on women's bodies during childbirths from a global perspective and with data from different countries and in different parts of the world to address what they consider to be rooted in structural violence against women worldwide. In their study they found that despite human rights reports calling for women's rights to bodily autonomy and to make decisions according to their personal needs in maternity care, which includes the right to refuse medical interventions, women continue to be excluded from decision making in relation to childbirth worldwide. Defining this tendency as non-dignified and dehumanizing treatment the authors conclude that non-evidence-based interventions are continuously high in rates both in high-, middle- and low-income countries within birth care (Sadler et al. 2016:47,48,49,50).

Obstetric violence has been a popular topic among feminist scholars who have conducted their research from intersectional perspectives, shedding light on racial and LGBTQ+

violence within gynecological- and maternity care. Nessette Falu (2023), for instance, has investigated black lesbian women's experiences of gynecological examinations within Brazilian healthcare. With personal accounts from black lesbians in Brazil, she brings attention to a medical system fraught with systematic racism and lesbophobia[1] which generates violent acts against these women within healthcare and gynecology in particular. Falu expands on the normative definitions of *gyno-trauma* (gynecological trauma) – usually referred to as injury resulting from surgical procedures or sexual trauma - to include the affective injuries that comes from intersectional prejudice and other abuses of power. Talking about gyno-trauma then becomes a matter not only of genital injury but also a wider range of bodily and subjective experiences which includes emotional and social trauma relating to violence occurring in the gynecological encounter (Falu 2019:47,52,54).

This study's contribution

This study contributes to the field of research on women's experiences of pain and/or discomfort in relation to gynecological examinations within social science, and in particular medical anthropology, as it questions the routine practices of gynecological healthcare providers – not only in terms of the emotional contact between practitioner and patient, but in terms of the very *touch* by the examiner and the approach to female physiology in the vaginal and pelvic area within Western medicine in a European context. The study takes place in the Czech Republic and mainly in the capital city, Prague, where I have been following Czech gynecologists in their daily work in two different out-patient clinics. I have conducted interviews with both expat- and Czech women about their embodied experiences of pain and discomfort during gynecological examinations from which I have made conclusions by comparing the personal accounts of the women and their experiences with gynecology from different healthcare systems, mainly within Europe. As such, this study contributes to this field of research with a layer of interculturality.

I have sought to understand why and under what circumstances I and other women can experience severe pain in relation to vaginal/pelvic gynecological examinations when in theory everything "looks fine down there". Based on my findings and other similar research,

[1] Homophobia of lesbians

I argue that violent approaches towards the female body have become normalized in the daily practices of gynecology within Western medicine. In line with feminist scholars, I aim with this study at bringing attention towards structural violence against women within medicine on a global level and suggest adjustments within gynecology as to how we can establish a more caring and appropriate approach to the female body particularly within women's reproductive and sexual health.

Throughout this master's thesis I will be referring to gynecological examinations where the internal[2] parts of the female genitalia are examined as *gyno-vaginal* examinations in relation to my own ethnographic data. I find it important to specify this distinction in gynecological examinations from the personal accounts of the women who participated in this study as their experiences of pain and discomfort in relation to gynecological examinations, which I will be analyzing, are particularly related to these parts of female genitalia and has a defining meaning in my conclusions.

In the first chapter of this thesis, I will go through my methodological approach and ethical decisions in my collections of- and work with data from the study. In the first analytical chapter: *1. Gynecological examinations: when, why, how* I situate the current status of guidelines for gynecological examinations within Czech healthcare policy and within Western medicine in general. In chapter *2. No body is the same: When gynecological examinations are painful* and chapter *3. Medical expertise before emotional care* I analyze the personal accounts from the women who participated in my study and compare them with my observations of local gynecological practices at clinics in Prague. In chapter *4. When medicine is violent to the female body* and chapter *5. Must women feel pain at the gynecologist* I analyze women's experiences of pain and discomfort in relation to gyno-vaginal examinations within a theoretical frame of medical violence and discuss what measures must be taken in order to decrease pain and discomfort within gynecology. In the concluding chapter I sum up my main argument and give suggestions as to how this topic might be further explored in future ethnographic research.

[2] The vaginal canal and pelvic area

Methodology and ethics

To understand why women experience pain and discomfort during gyno-vaginal examinations I have used the ethnographic methods *participant observation* and *semi-structured in-depth interviews*. In this chapter I will describe how I collected the primary data for my thesis through ethnography, how I got access to the field, and my reasoning behind the chosen methods.

Participant observation

To understand the principles of care and the approach to the female body among Czech gynecologists when they perform gynecological examinations, I did participant observation at two outpatient wards at two hospitals in Prague. The care and treatment offered at both hospitals are part of the public healthcare in the Czech Republic. I also tried to get access to three different gynecological clinics within the private healthcare sector as private clinics and hospitals usually have larger economic resources to compose the treatments and care offered to their patients, which means that patients going to gynecologists within the private sector in Prague might have slightly different experiences than those seeking medical advice and treatment in the public healthcare. Unfortunately, I never heard back from any of the clinics I reached out to, and on my follow-up phone calls to the clinics, it was impossible to get in touch with someone in charge who could meet with me regarding my fieldwork proposal.

During my participant observation I paid attention to how the doctors would greet their patients both in terms of verbal greetings and in terms of body language when receiving them at the clinic. I paid special attention to if doctors would look at the patients when speaking to them, what mood and facial expressions they would have when talking to the patients, how they would guide the patients into the gynecological examination (what clues they would give to the patient when it was time for the examination), and how they would interact with the patient during the examinations – verbally and physically. By getting insights into how gynecological doctors receive, care for, and interact with their patients at these two gynecology clinics in Prague, I hoped to better understand what it is in the gynecological encounter between doctor and patient that might lead to women's experiences

of pain and discomfort by comparing these observations with the personal accounts from the women who participated in my study. This kind of ethnographic insight has been described by James P. Spradley (1980) as how to grasp *tacit knowledge* which are those parts of social situations that an interlocutor may not be able to express directly in words when questioned about their daily customs. As such, by listening to the personal accounts of the women who participated in my study and by observing the doctor's attitudes and behaviors and their interactions with their patients at the clinics in Prague, I have been able to make analytical conclusions about patterns within gynecological practice by comparing particular interactions described by the women with similar interactions that I have observed during participant observation (Spradley 1980:11).

I conducted participant observations at the two hospitals in Prague during a total of five sessions all lasting between 1,5 and 3 hours. During my participant observation I was observant about what customs within gynecological healthcare might be particularly local and which might characterize more global customs within gynecology, especially in a European context. Being a woman myself I have gone through several gynecological examinations in my home country Denmark (and once in Sweden) so naturally there would be parts of the gynecological practices that I was observing during my fieldwork in Prague that would be recognizable to me from my own personal experience with gynecology. As Denmark is also a European country, I assumed that many of the customs within gynecology would be the same. However, this is not something that should be taken for granted, which is why after every consultation with a patient I would ask questions to the doctors about their reasoning behind interventions and discussions with the patients about their health. This was my attempt to get answers to which customs were particularly local and which were more universal within gynecological medicine. Of course, as hospital culture can vary a lot even within the same city or local area I would compare my observations at the two clinics in Prague with each other and with other ethnographic studies about gynecological- and obstetric healthcare conducted in Prague to make conclusions about patterns in gynecological practice which may have a local character to it.

Access to the field

Both of the two clinics, where I did participant observation, I got access to through a friend who has been studying medicine as an international student at an English-speaking program at a university in Prague. Through his advice, I contacted one of the chair members of the program's educational activities within gynecology, Prof. Novák, M.D., Ph.D in gynecology, who agreed to meet with me at his office prior to my fieldwork. He then put me in touch with M.D. Svobodová, an English-speaking Czech female gynecologist working at the gynecological ward at Nemocnice Centrální (*eng: Central Hospital*) in Prague. The secretary of the medicine program for international students, Mrs. Dvořáková, at the faculty of medicine at the same university also put me in touch with M.D. Kopecký, a Czech male junior doctor in gynecology working at the Department of Gynaecology in Staroměstská Nemocnice (eng: *Old Town Hospital*) in Prague. As such, my medical student friend, Prof. Novák, and Mrs. Dvořáková were my gatekeepers in this study.

At Nemocnice Centrální I conducted participant observations during three sessions in October and November 2023. This hospital consists of special clinics for patients with complicated conditions referred by their own doctor and at the gynecological ward it is mostly surgical clinics that perform small, simple surgical procedures daily. Dr. Svobodová sees about 20 patients a day and the patients treated at her clinic are mostly patients who she has seen for years and who go for regular check-ups at her clinic. She explained to me that many of her patients are working as health staff at the hospital and that their regular gynecological check-ups at her clinic is a special arrangement made for the staff at the hospital because many of them live outside of Prague. It can be difficult for the staff to schedule an appointment with a gynecologist outside of Prague in the smaller cities because it will take much of their working hours to go all the way home for such an appointment. Additionally, there is also not constant access to a gynecologist in the smaller towns and villages as they work on several different clinics in the same area, so it can be difficult to schedule an appointment that fits the schedules of the employees at the hospital.

Dressing into the white lab coat

Each of my sessions with participant observation at Nemocnice Centrální happened on regular working days and lasted between 1,5 and 3 hours each time. I would arrive at 9:00 am when Dr. Svobodová had finished her morning meeting with other staff members at the gynecological ward. On my first day at the clinic Dr. Svobodová gave me a white lab coat to wear during the consultations with patients and I was showed to a small chair in the back of the examination room half behind the back of the gynecological chair, from where I could observe the examinations and take notes in my little notebook. I asked Dr. Svobodová if she was going to introduce my presence in the room to the patients and ask for their consent of me observing the examinations, but with a calm and indifferent tone she assured me that: "No patients will question why you are here because you are a woman, so they will not feel intimidated. Probably if you were a man, it would have been something different".

It became clear to me that with a white lab coat on and with my presence in the background from where I would sit and quietly observe and take discrete notes in my notebook small enough to fit into my lab coat pocket, I gave the impression of a medical student who was there to watch and learn from a senior colleague, or as an assistant or nurse who was ready to assist Dr. Svobodová if she would need it. In fact, my presence on the chair in the back of the examination room seemed to be almost invisible to most of the patients visiting the clinic on those days. Some of the patients barely seemed to take notice of me when they entered the room even though I always made sure to look in their direction and greet them with a: "Dobrý den" (*eng: "Hello"/"Good day")* right after Svobodová had greeted them both to announce my presence in the room but also out of respect. This was common for all of my fieldwork activities at Nemocnice Centrální which means that the character of my participation at Dr. Svobodová's clinic was mostly passive as I would mainly sit from my "observation post" in the background and record in my notebook what was going on at the clinic (Spradley 1980:59).

At Staroměstská Nemocnice I conducted participant observation during two sessions which lasted 2 and three hours at one of its clinics in gynecology and obstetrics where patients can be treated for conditions within the subspecialties, perinatology, urogynecology and gynecological oncology. Both sessions took place on regular working days and on the first day of participant observation I arrived at 9:00 a.m. and on the second day I arrived at 8:30

a.m. right before Dr. Kopecký would receive his first patients. Just like at Nemocnice Centrální, Dr. Kopecký offered me a white lab coat to wear while being in the examination room as to blend in with the environment at the clinic. His office and consultation room is located in the outpatient ward at the hospital where he treats patients with medical issues within urogynecology. The examination room contains two examination chairs – the common gynecological chair with the stir-ups and another chair for the mammography which is similar to the classic gynecological chair except that it doesn't have the stir-ups and that the patient would lie down flat on her back opposed to the classic gynecological chair where the women would be in a position of half sitting half lying on her back. As the examination room of this clinic was quite small, I did not observe the examinations from a permanent spot. Instead, I would move around in the room according to where Dr. Kopecký and the patient were in the room as to not stand in the way but at the same time being able to see what was going on.

On my first day with participant observation at this clinic, there was another doctor from Dubai, who was also there to observe the work of Dr. Kopecký. During the gynecological examination of the first patient in the clinic that day, I kept myself a bit in the background with my notebook and the other observing doctor, Dr. Stevens, stood right behind Dr. Kopecký as he performed the examination. At some point Dr. Stevens turned around to look at me and waved me over as an invitation to come closer and participate in the *seeing* of this patient and her gynecological issue. It was then I realized that I had been positioned in a more active role of a medical student at this clinic compared to my presence at the clinic in Nemocnice Centrální. Even though I had already explained to Dr. Stevens that I was there as an anthropology student to observe the interactions between the doctor and the patients, I assume that he interpreted my distance as shyness and not because it was actually something else I was there to observe than the biomedical character of the examination. In this sense, my participation at Dr. Kopecký's clinic became what Spradley (1980) has described as *moderate* participation (Spradley 1980:60). I could of course never participate completely at the same level of an actual medical student, but as medical students also learn from just observing, my semi-active role as a pretend medical student seemed to make my presence more natural opposed to when I kept myself mostly in the background to begin with.

Language barrier

One research barrier to my participant observation activities at the two gynecological clinics in Prague was the fact that I do not speak Czech – except a few greetings and simple phrases. This means that the inferences I made about the customs and daily routines with patients at the clinics are based mainly on the body language of the doctors and patients and the few words of Czech that I do understand combined with questions I would ask the doctors about the patients they were receiving on that day and the gynecological examinations I observed in the small breaks between the consultations. Though it would naturally have been beneficial to my data if I was able to speak Czech and would understand all verbal communication between the doctors and patients, I learned that there were other opportunities in my lack of local language skills during my participant observations. According to Spradley (1980) the *less* familiar you are with a social situation, the more you are able to see the tacit cultural rules (Spradley 1980:62). In that sense, my lack of local language skills made me more external to the situation at hand during my participant observations at the clinics, even though I have gone through gynecological examinations myself, as I would often have to ask the doctors questions about their practice between their consultations. They would have to express quite explicitly in words to me their perceptions of the patients and their reasoning behind doing things in a certain way when helping me to understand the social situation I had just been observing. The doctors' answers might have been less explicit if I actually understood what was being said between the doctors and the patients during the examinations as they might have felt less obligated to be explicit in their answers to me. This gave me access to their knowledge about the local Czech medical system and their reflections about their own profession and practice.

Ethnographic interviews

To learn and understand the women in my study's prior knowledge and experiences with gynecological examinations shaped by their local backgrounds and how this affected their experiences with discomfort and/or pain during gynecological examinations in the context of being an expat in Prague I conducted semi-structured interviews with expat women in Prague who have gone through at least one gynecological examination in the Czech Republic. Being an expat in Prague myself gave me natural access to expat communities in

the city both within my own social network but also on social media where one can find online communities such as Facebook groups for expats.

In total I conducted nine semi-structured interviews between September 2023 and March 2024. The interviews lasted between 45-90 minutes. Seven of the women who participated are expats living in Prague. Eventually I also included two Czech women among my interlocutors, both living in other cities in the Czech Republic. My decision of including also Czech women in my study was motivated by a desire to build a bridge between my participant observations at the gynecological clinics in Prague and the personal accounts from the expat women. I was interested to know to which extent the expat women's experiences of discomfort/pain could be related particularly to local medical practice within a Czech context and to what extent women's experiences of discomfort and pain in relation to gynecological examinations are more universal and perhaps characteristic to Western medicine in general in a European context. The personal accounts from the two Czech women in my study are not enough to answer such a big question of course, but they can qualify as indications to an answer.

In my search for participants, I was very explicit about my interest in accounts from women with experiences of pain/and or discomfort during gynecological examinations - in other words, I wasn't looking for women with "good" experiences, which naturally limited my target group. Some of the women who participated in the study made comments at the beginning of the interviews about their experiences probably not being "as bad" as what they imagined other women might have gone through, which indicates how specific I have been in my approach to the topic, emphasizing that it were definitely the "bad" experiences I was on the look for. I was also quite open about my own personal experiences with gynecology when conducting interviews with the women, as it explains such a large part of my motivation to do my master's study about this topic, which most likely has shaped my target group as well as I would naturally attract women with similar experiences and thoughts about the topic as myself. For instance, some of the women who participated in my study were also quite critical towards the gynecological practice already before meeting with me. Thus, my insights on the topic would most likely have been more varied if I had been more open in my requirements for the profiles of the women participating in my study and if I had been less open about my own reflections and experiences within the field. However, I chose to be

this specific in my approach both because I knew it would be impossible for me to separate my own personal history with gynecological examinations from the project, but also due to time and resource limitations as I had to conduct all of the interviews myself within a time frame of only a few months. This also means, that this study doesn't say anything about how many women experience the kind of pain and discomfort discussed in this thesis in relation to gynecological examinations in healthcare. Thus, the study is not representative of gynecological practices in general but has a very cut focus on the negative sides in gynecological practice.

Most of the semi-structured interviews took place at my flat in the central part of Prague, one took place at a café and two interviews were held online. I let it be up to each of the participants where they wanted the interview to take place by at least offering my flat or coming to their homes. As the topic we would be talking about is of very private and sensitive character I wanted to make sure that the interviews could be held at a location which would offer a degree of privacy needed for the women to feel comfortable and safe when talking to me about it, which is why I gave them the option of choosing the location. Three of the women who participated in my study as interlocutors are friends or acquaintances of mine who volunteered to participate in my study.

A colleague of mine, who is also an expat and who was a participant in my study, recommended me to make a post in the Facebook group called Prague Women's Exchange in order to find more participants for my study. This Facebook group is for all sorts of advertisements aiming primarily at expat women living in Prague and has about seven thousand members. As soon as I made a post in the Facebook group where I advertised my thesis project and my search for participants, several expat women reached out to me in the following days saying that they were interested in participating. One exception is a woman who was referred to me by a friend of hers who had seen my post in this Facebook group. The Czech women who participated in my study both read about my thesis project from a post I made in another Facebook group called Everyday Patriarchy Bullshit which is a group I got recommended from a Czech woman that I know. This group has nearly eleven thousand members and is meant as a discussion forum within the frame of intersectional feminism and both men and women can join the community.

The women participating in the study

The women from my study are between 23 and 65 years of age. All of them have a Western/and or European nationality, all of them are ethnically white and all of them identify as woman/female. They have all been living in Prague between 1 and 8 years, except from the two Czech women who live in other medium sized Czech cities, and none of them have ever lived in Prague. Most of the expat women from my study moved to Prague because of studies, either through the Erasmus exchange-program or for taking a full university degree at a Czech University, or because of work opportunities. Most of the expat women from my study consider Prague as a temporary place to live, but three of them said that they imagine living in Prague on a long-term basis.

All of the women from my study have a university degree. Master's degree is the highest level of education for most of them, except one who has a bachelor's degree as her longest degree of education and one who is currently doing a PhD. The social- and professional lives of the expat women from my study are characterized by maintaining their status as expats in Prague as all but two work for international companies with a local branch in Prague and as most of their friends are internationals like themselves. All of them have lived in at least one big city before moving to Prague, and most of these cities are located in Europe. For four out of seven of the women, the bigger city(ies) they lived in before moving to Prague are cities within their home countries.

My own embodied experience with gynecology

As my interest in this field of study origins in my own embodied experiences of pain and discomfort in relation to gynecological examinations, I have found inspiration in autoethnography and will use accounts from my own life to stress the issues I find in the gynecological practice. Furthermore, literature on autoethnographic methods have provided me with an angle to reflect upon how my own experiences with gynecological examinations have shaped my conduct of ethnography in this study. Carolyn Ellis (2004) describes how ethnographers conducting what she defines as *reflexive ethnography* use their own *self* – that is, their senses, bodies, and feelings – to learn about the other by using their own experiences in other worlds to reflect critically on their own. Additionally, it gives the reader of the

ethnography a sense of the researcher's point of view (Ellis 2004:48). Following Ellis, I have used my own personal accounts of negative experiences with gynecological examinations to reflect upon my critical attitude towards the gynecological practice, which should be obvious to anyone reading this thesis. It would be impossible for me not to bring this critical point of view into my research which is also why at the interviews with the women from my study I have introduced to them my motivations of conducting ethnography within this topic. I found it vital to do this since my opinions and attitude towards the topic would undeniably determine what stories the women would tell me during the interviews (ibid:49).

Ethics

In my study I follow the American Anthropological Association's principles of responsible and ethical practice (The American Anthropological Association, 2024). Informed consent from all the participants in the study have been obtained through verbal contracts. When looking for participants through Facebook groups I stated in my posts that the women participating would be anonymous, which is something I repeated to each woman right before the interviews. This means that all the women who participated in my study appear under a pseudonym when mentioned in this thesis. I also ended each interview by telling the women that they could at any time reach out to me if there was suddenly something that they had mentioned during the interview which they no longer wanted to be included in the data for my thesis. As the topics we would be discussing during the interviews could potentially make the participant feel vulnerable as they would share personal stories of intimacy and sometimes stories of emotional distress I ended each interview by asking the women how they were feeling after telling their stories to me to make sure that they were feeling okay when taking leave. Most of the women said that they felt fine or good, and few of them even expressed a satisfaction in sharing their stories as they hope for things to change in the future within gynecology and the approach to female reproductive and sexual health which they hope their sharing of their stories might be contributing to. One participant was quite shy and vulnerable when telling me her story and wanted a hug after the interview, which I gave her after asking.

Informed consent from the two gynecological doctors (and from Prof. Novák) were obtained also trough verbal contracts. At my meetings with Prof. Novák I would ask him if it was

okay that I took notes, which he always agreed to, even with the comment: “I would be surprised if you didn’t.” on our first meeting. During my sessions of participant observation I asked each of the doctors as well if it was okay that I took notes to the things they were telling me about their work, which they also agreed to. I also asked permission from both of the doctors to take pictures of their offices/the clinics which they granted me verbally as well during my participant observation. Both of the gynecological doctors and my gatekeepers appear under pseudonyms in this study as my observations involve their professional lives. Considering especially my critical point of view of the gynecological practice I want to ensure that their professional integrities are maintained, which is why they appear anonymous in this thesis. For this reason I have also kept the names of the hospitals/clinics at which I did participant observation secret, which means that the names Staroměstská Nemocnice and Nemocnice Centrální are fictional names and that the hospitals exist under other real names.

During my sessions of participant observation I made small attempts to make sure that the patients with appointments at the clinics would feel comfortable with my presence in the room. For instance, I always looked at each patient and smiled at them when they entered the examination room and greeted them with a “Dobrý den” (*eng: “Hello”)* whether they looked at me or not to announce my presence, and I always said “Nashledanou” (*eng: “Goodbye”)* to them when they left the room after their consultation. Out of respect, I usually looked into my notebook or looked in another direction when the women would walk around in the examination room undressed and when they climbed into the gynecological chair, as I considered these situations to potentially exposing the women to an extended feeling of vulnerability.

On a few occasions during my sessions with participant observation, I observed situations where my own sense of ethics made me want to interfere with the interaction between doctor and patient. For instance, during my first session of participant observation at Staroměstská Nomocnice, at some point Dr. Kopecký was doing a mammography examining on a patient. The woman was lying on her back at the examination bed naked from the chest down with her legs tugged up to her belly and slightly spread while Dr. Kopecký was sitting next to her on a chair in front of the sonogram screen which was placed next to the head of the bed and examining her with the mammography device with his one hand. Right behind his back stood

the guest doctor, Dr. Stevens, and observed the screen with Kopecký. Suddenly Dr. Stevens took out his phone from his pocket and started filming at the screen. He later told me that he was filming the sonogram as to remember some of the things he and doctor Kopecký were discussing while looking at the screen as he was there primarily to learn from this new technique that this modern sonogram offers. However, I noticed that the woman suddenly got a fearful look on her face and lifted her head when she saw Dr. Stevens taking up his phone to film as it was angled in a direction where it might look like she was also in the snapshot of the camera. I felt like interrupting Dr. Stevens and telling him that it seemed like the filming with his phone made the woman feel uncomfortable and unsafe, but as I hesitated, the woman asked Dr. Kopecký in Czech if Dr. Stevens was filming her, and he then assured her that it was only the screen he was filming. She then got a more relaxed expression on her face and turned her head back towards the ceiling as the examination continued.

After this experience I was a bit conflicted with myself. On the one hand, I felt I had just observed something which first of all might break the ethical code of informed consent for the patient, and second of all that it might not only make this woman uncomfortable but might potentially also make other patients uncomfortable as I realized that Dr. Stevens would film the sonogram examination of different patients, only not every patient noticed it. I felt like suggesting to him, that he (or perhaps better yet Dr. Kopecký) obtain a verbal informed consent from the patient about filming the sonogram while she would lie there undressed to make sure that this would not cause discomfort to any patients for the rest of the day. Then, on the other hand, it was my first day of participant observation in this clinic and as I was hoping to be allowed to come back for at least one more session of participant observation I wanted to give a good impression of myself. Criticizing the practice of the doctors in the clinic might jeopardize their trust in me and their willingness to welcome me back into the clinic and take time to answer my questions in between the consultations on an otherwise busy working day. In the end, I decided not to say anything as I decided to stick to my role as the observer. Instead, I would pay more attention to if other similar situations with some lack of informed consent from the patients would come up, and if so, then try to understand why that would be and if perhaps the lack of informed consent might be a bigger issue than just this one situation.

Sonogram and examination chair, Staroměstská Nomocnice, taken by author, d. 03.11.2023

1. Gynecological examinations: when, why, how?

Uncovering the one part of the female body that is usually the most hidden away, gynecological examinations are dealing with an area within female health which is associated with a broad range of emotions, taboos, policies and opinions. In this chapter I will introduce the principles of care in gynecology within the context of the Czech healthcare system. I will then trace this back to dominant thinking within Western medicine about the gynecological examination in its practical form by the hand of the physician and dominant thoughts about the physiology of the female reproductive body.

The principles of (gynecological) care in the Czech Republic

The Czech healthcare system is primarily funded by wage-based contributions collected from employers as payroll taxes making up a social health insurance system (SHI) which offers universal health coverage and high levels of accessibility in health services to its citizens. The Czech SHI has a broad coverage including inpatient and outpatient care, some dental procedures, rehabilitation and prescription- and (if prescribed by a doctor) over-the-counter pharmaceuticals (Bertoli et al. 2021:140–45). Together with general practitioners (GP) pediatricians, dentists, and gynecologists are considered part of the primary care providers within the Czech health care system and patients are free to choose their practitioner among these healthcare providers. Generally, the primary care providers are expected to serve as first source of care. The healthcare provided by the SHI can be accessed at individual practices, at hospitals, and at polyclinics (Bertoli et al. 2021:140–45; Holcik and Koupilova 2000:3). In the Czech Republic it is advised that women from the age of 15 should visit a gynecologist once a year for a preventive examination. This is described in the guidelines of preventive care by the General University Hospital in Prague which can be found on the hospital's website. The preventive gynecological care is aiming primarily at cervical and ovarian cancers (General University Hospital in Prague, 2019)

Since 1992 a legal act in the Czech Republic has allowed privatizations in healthcare and competitiveness between private health facilities which means that emergence of independent health establishments has increased throughout the last two decades. Emergency care is still handled primarily by the public healthcare in the Czech Republic,

but when it comes to "planned healthcare" – that is, care provided for health issues that are not acute and where the patient has more time to decide the care options – the health organizations aim at understanding the market demands by patients to increase healthcare services and their own competitiveness. The patients are free to choose healthcare providers who provide services that correspond to their personal health needs and to seek consultation services at other healthcare providers if they are not satisfied with their first choice of healthcare provider. Patients' decision-making of healthcare providers tend to be influenced by recommendations from their own general practitioner or friends and relatives and by their personal health insurance (Staňková et al. 2017:95,97,98,100).

Gynecological practices in Western medicine

In medical literature, it is widely agreed upon that gynecological examinations and pelvic examinations are particularly intimate and that the woman being examined is in a vulnerable position due to the exposed aspect of the way the examination is performed and the association with sexuality and pleasure in these body parts (Galasiński and Ziółkowska 2007:477; Gleisner and Siwe 2020:349). When a woman (or a person with female reproductive organs) is having a gynecological examination, she undresses the lower part of her body from her waist down and is then usually asked by the doctor to find her way into the gynecological chair in a position of lying on her back and with her legs in a left and a right stir-up opening up the legs and exposing her genitals to the doctor (Bialy, Kondagari, and Wray 2024: 2024.07.10).

The exposed position of the genitalia makes it accessible to the physician who will make the examination typically by the following steps: a visual inspection of the external genitalia by the doctor who will take note to the vulvar anatomy and look for visual abnormalities. Then, a speculum is inserted into the vagina to open it so that the cervix and the inner vagina becomes visible to the doctor who will look for the characteristics of the cervix such as position, size, color and the presence of lesions etc. (ibid: 2024.07.10). The way the gynecological examination is performed is characterized by what Michel Foucault (1976) has named the *medical gaze* where the doctor is reduced to an observing eye considering the body of the patient merely as visible intervals in nature in which certain signs differentiate one disease from another and dividing malign from benign which is recognizable to the doctor's medical knowledge (Foucault 1976:4,6,8,9).

Several studies have delt with how doctors in gynecology can accommodate the woman going through a gynecological and pelvic examination in light of the sensitive character to the examination. Jenny Gleisner and Karin Siwe (2020) for instance, who studied how Swedish medical students are taught how to deal with intimate examinations in both men and women, found that students learn about the small steps they should take in order to create good contact and trust with the patient prior to- and during the gynecological/pelvic examination as well. Here it is emphasized that these future doctors should pay attention for instance to the women's earlier bodily experiences with intimacy which might affect how they would react to the gynecological examination, how they should look away when the patient gets undressed and that they should acknowledge the patient's feelings in the situation (Gleisner and Siwe 2020:352).

In the following chapter I will analyze the accounts from the women who participated in my study about pain or discomfort that they have experienced in relation to gyno-vaginal examinations and try to understand the reasons why women feel pain during this examination despite medical literature emphasizing the importance of sensitiveness in relation to this examination.

2. No body is the same: When gynecological examinations are painful

When experiencing pain and discomfort in relation to gynecological examinations, one of the things several of the women from my study had in common was a difference in how they experienced the examinations in their bodies and how the practitioners performing the examinations understood their bodies from their professional biomedical perspective. To understand the differences in how the women felt in their bodies and how the doctors understood their bodies as described in the personal accounts from my participants, I will borrow Nancy Scheper-Hughes and Margaret Lock's (1987) concept of *the three bodies.* This conception of the body differs between the individual body or *body-self* (the phenomenological lived self and lived experience), the *social body* (the body as a representational natural symbol in our understandings of nature, society and culture), and the *body politic* (the regulations, control and disciplining of individual and collective bodies, or populations) (Scheper-Hughes and Lock 1987:7,8).

One of my interlocutors, Karolína, told me about her experiences with pains in her vaginal and pelvic muscles which she felt both during sexual intercourse and during gyno-vaginal examinations. When she first went to her GP, who is a man, with the issue, Karolína told him that she was unable to have sexual intercourse with her boyfriend because of the vaginal and pelvic pains she experienced. The doctor then made a vaginal examination on her and in the end, he declared that he could not see that there was anything wrong. He then started to lecture her about the importance of having sex with one's spouse and tried to convince her that she simply must keep trying to have sex until she is able to. Karolína left her doctor's appointment feeling both misunderstood and miserable. Not only did the doctor not have a possible solution to her problem but she felt he had invalidated her suffering from pain by suggesting that it wasn't *really* there.

Scheper-Hughes and Lock (1987) explain how Western clinical medicine is shaped by a philosophical separation of mind and body which effectively means that disease in Western medicine tends to be defined as either physical *or* mental in its origin (Scheper-Hughes and Lock 1987:9,10). When Karolína's doctor was unable to recognize her suffering and experiences of pain in this instance, it seems to be because he is relying exclusively on his biomedical understanding of the body where a causal explanation for suffering is essential for diagnosis within Western clinical medicine in which he is trained. It is a radical

materialist way of thinking which is characteristic for clinical medicine where the separation of mind and body makes him ignore the social and psychological information from his patient (ibid:8,9). In fact, her doctor's attitude towards her problem reveals the two-folded aspect of Karolína's issue with vaginal and pelvic pains, which apart from the pain itself involves difficulties in her intimate life with her partner. In her study of American women who suffer from vulvar pain, Christine Labuski (2015) describes similar two-sided issues with pain experienced by the women in her study. She explains how several of the straight-identified women in her study are unable to have a sex life with their partners as this kind of sexual partnership is framed by normative definitions of sex in heterosexual relationships which tend to be what she defines as *phallocentric* where penile penetration of female genitalia dominates the sex lives of these couples as this is considered "real sex" in heteronormative discourse. Thus, the issue of vulvar pain threaten these women's gender identity as they are unable to engage in an action that makes people into heterogendered men and women and the struggle becomes as much a matter of unsuccessful gendered work as an issue of pain in itself (Labuski 2015:4–8). In Karolína's case, her doctor's focus on her duties as a sexual partner to her boyfriend gives the impression that her suffering with pain is secondary to her obligations as a woman being in a heterosexual relationship.

Despite Karolína's GP's inability to locate and recognize her suffering with pain, the pain was real to her body-self and continued to be so. Following Edmund Husserl's (1989) thought on phenomenology of the body, Saulius Geniusas (2020) has elaborated on the phenomenological conception of pain in the body. He defines pain as an *embodied feeling* that affects the *embodied consciousness*, which means that pain is both physical and psychological in its embodied experience. Geniusas argues that any pain of which one is conscious cannot raise any doubt of its existence because pain absorbs our attention and frames our awareness of our body. He understands the body as a field of *sensings* and as a perceptual organ with which we experience or sense the world and objects around us, which he also refers to as the *lived-body*. As our own body is our only constant that is always with us, our experience of embodied pain can never be the same as pain experienced by another body (Geniusas 2020:120,121,127,128). This point in the work of Geniusas grasps one of the challenges the women from my study face when seeking medical professional help in relation to their experiences of vaginal and pelvic pain. The pain they experience is most often not visible to the examining eye of the medical practitioner, but is nevertheless very

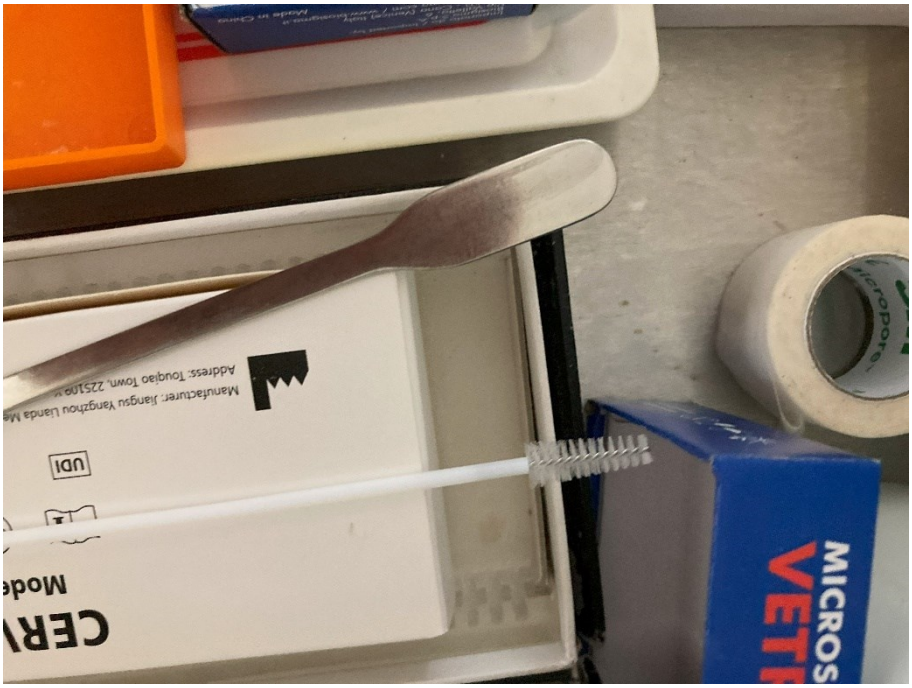
real in their own lived-body and sometimes strongly disabling to their intimate lives.

In the case with Karolína, her embodied experience of pain was later acknowledged by another male gynecologist who recognized that she was suffering. At her first appointment with this gynecologist, she started to cry out of pain from the gyno-vaginal examination which led the doctor to terminate the examination. Instead, he discussed with Karolína in which other ways they could examine her that wouldn't cause her so much pain. Neither this gynecologist was able to locate the cause to her experiences of pain at this consultation, but she told me that it gave her a great sense of relief that he didn't force her trough an unbearably painful examination and that he could recognize her suffering: "He said to me 'I can't see anything there, but I can see that you are in pain'. I had waited three years to hear this and I was so happy". It is remarkable how even though this gynecologist did not have the answer to her problem yet at this point, but simply the fact that he recognized her suffering made such a difference in her impression of this doctor compared to her first experience with gyno-vaginal examinations at her own GP.

Another of my interlocutors, Violette, described a similar experience during a gyno-vaginal examination in her home country, France. At age 22 or 23 she booked an appointment with a gynecologist because she suspected that she might have endometriosis due to pains in her vaginal and pelvic area. Violette described how at the examination the doctor "(…) just put her finger inside of me [vagina] and said: 'See, you don't feel pain' ". When Violette told the doctor that she was in fact feeling pain in that very moment the doctor merely brushed her off by saying: "You are too much in control" – which to Violette was an indication that she should be able to simply relax her pelvic and vaginal muscles and that her problem would go away in doing so. In the end, this gynecologist tried to convince Violette that she didn't have endometriosis and she felt like the doctor didn't want to believe her accounts of experiencing pain.

Comments from doctors during gyno-vaginal examinations saying that one should simply relax their (vaginal/pelvic) muscles when experiencing pain is, like for some of the women from my study, something I have experienced myself on several occasions. Scheper-Hughes and Lock (1987) describe how body alienation has developed within advanced industrialized societies where commodity fetishism has created symbolic equations of humans and

machines. This symbolic equation has fostered a tendency of body-as-machine metaphors for somatic and psychological states of the body, revealed in common sayings about bodily states such as being “worn out” or that our “batteries are low”. Following John O’Neill (1985) they further their discussion of the body-as-machine into biotechnology which allows surgery and genetic engineering to transform the body into “spare parts” and prosthetic humans, which save or extend lives of humans, but might in turn compromise our humanity in the process (Scheper-Hughes and Lock 1987:22,23). When being told by a physician to relax your muscles while being in extreme pain in your private and most vulnerable parts, it gives an impression of a similar understanding of the body as the one described by Scheper-Hughes and Lock. One where the body is treated as a machine that we should be able to master and simply “press the right button” that makes our muscles relax in that moment. The humanity, which Scheper-Hughes and Lock suggest might be compromised, can in these situations be experienced as a lack of recognition that our bodies are in fact not machines that we are in full control over.



Spatula and brush used for pap smear, Nomocnice Centrální, taken by author, d. 25.10.2023

Getting back to Violette’s experiences of gyno-vaginal examinations, she told me that her experiences with gynecological issues and examinations both in France and in Prague had given her a general feeling that she often had to insist on her own bodily needs and

experiences as if she often had to struggle to convince doctors that she was telling the truth and that what she felt in her body was not just something she made up. This made her change her attitude towards the encounter with doctors in relation to gynecological appointments and she explained to me that: “Now [at the beginning of a consultation] I always present to doctors: ‘This is my body and this is what I need’ “ to make sure that she would get what she needs from the doctor and that she wouldn’t be dismissed in her suffering and her needs in healthcare. As such, Violette’s way of coping with medical practitioners who might disagree with her in their evaluation of her health is to somehow take the position of an *expert patient* who is informed and aware of her own health. According to N.J. Fox et al. (2005) the great amount of accessible web-based health information such as discussion forums and health guidelines along with the production of lifestyle drugs has contributed to the transformation of patients into reflexive health consumers. Effectively, this has created a type of patient who is able to take a stance in the management of their own health and who ensures treatments that are appropriate to their individual health needs by doing research on their health (Fox, Ward, and O’Rourke 2005:1299,1300).

The examples of Violette’s encounters with gynecologists and doctors further display her expectations as a patient in a European healthcare context where growing interests in patient autonomy and promotions of patient-centered care have shaped the practice of medicine in European countries within the latest decades and where the concept of *shared decision-making* has been introduced within healthcare. Following Cathy Charles et al. (1997) and Laura Spinnewijn et al. (2020). shared decision-making in healthcare happens when both doctor and patient play an active role in sharing information and treatment preferences in a two-way exchange to reach consensus of the decisions on the patient’s health and treatment (Charles, Gafni, and Whelan 1997:685; Spinnewijn et al. 2020:1). For shared decision-making to happen the physician must establish an atmosphere where the patient feels that her views and preferences are valued as it is the practitioner who by and large sets the norms for interaction in the medical encounter (Charles et al. 1997:687).

In their ethnographic study on shared decision-making on a gynecological oncology ward at a hospital in the Netherlands, Spinnewijn et al. found that shared decision-making have shown positive outcomes when applied within healthcare, such as higher patient satisfaction and better adherence to treatment among patients. However, they also found that doctors can

be reluctant to implement shared decision-making in their practice which they suggest might be because of a high reliance on evidence-based medicine, where evidence is obtained through clinical trials, which the Dutch medical training is based on. Their own observations showed that although doctors might have a positive attitude towards the inclusion of patients' individual wishes and needs in the decision-making process, doctors often seemed to think they knew what was best for their patients and that they, based on clinical patient characteristics, often filled in patient-wishes in treatment planning before consulting the patient. In medical training young doctors are taught to deal with uncertainty in health decisions by seeking apparent security in medical data and algorithms as medical evidence while only little attention is given to training in how to deal with individual differences and patient needs and in communication skills to elicit patient wishes (Spinnewijn et al. 2020:2,4,5,6). I believe that these observations might reflect some of the reasons why Violette and other women from my study face challenges when seeking professional advice from medical practitioners who are willing to take their personal needs and preferences into account in relation to their condition, which I will elaborate on in chapter three.

Feeling invalidated by gynecological doctors in their emotional and embodied experiences with pain or other genital issues is something several of the women in my study could recognize. Nancy, for instance, told me that she felt very alarmed and quite uncomfortable during her first gynecological examination at a gynecologist in Prague because she didn't quite know what to expect since the doctor hadn't informed her properly beforehand. When the gynecologist felt her vagina wall with her fingers, Nancy told the gynecologist that it felt very uncomfortable and the doctor replied with a comment telling her that: "You're very vulnerable". This comment from the doctor indicates that Nancy is behaving in a way that is out of the ordinary in her position as a patient. At the same time the comment is not responding directly to Nancy's communication of her experience with discomfort and is to Nancy experienced as dismissive.

She recalls another experience with a gynecological check-up back home in the UK where she also felt dismissed when trying to express her bodily needs. She told me that based on this she had learned that: "You have to make certain statements about what you need from the doctor. You need to prove that you need medical assistance". Her former bad experiences with gynecological examinations both in Prague and back home in the UK have left her with a general concern that intimate boundaries might not be respected during

gynecological examinations. Effectively, this later meant that when she had an unwanted pregnancy for the second time, she had an abortion at home in the UK which she arranged on her own through advice and guidance from a worldwide women's community that she found on the website: womenonweb.org. As she explained: "I would always prefer Google than going to a clinic". Nancy's reliance on an online community in the management of her health is similar to the observations by Fox et al. (2005) in their study on patients struggling with weight issues. They describe how finding support and advice in communities online from people with similar health difficulties is popular among patients who feel that their doctors are unable to provide them with sufficient information on their conditions, and that this behavior stems from the same tendencies as those fostering the expert patient as it also reflects a sometimes critical view of the medical profession (1301,1304,1305). Similarly, having already had several experiences with doctors who did not seem ready to take her personal needs of care and treatment preferences into account in their decisions and evaluations of her health, Nancy found a community which showed her more support and assisted her in the management of her own health.

Invalidating and unemotional reactions from doctor's when experiencing pain or discomfort during gynecological examinations had given several of the women who participated in my study the impression that what they felt in their bodies was not normal and that maybe there was just something "wrong" with them or that they were oversensitive out of the ordinary. Following Labuski (2015) I believe that this bodily self-understanding is shaped not only by the lack of recognition of their experiences of pain by medical practitioners but as much by the ongoing gendered praxis connected to the ability to engage in penetrative sexual activities shaped by heteronormative discourse on "real sex" which is sustained also in the gynecological encounter where penetratively based heterosexuality is normalized and which thus renders these women's genitals "incompliant" (Labuski 2015:13,14,16,24).

In the next chapter I will analyze data from my participant observation at two clinics in Prague and other ethnographic research about how the female body is approached within gynecological and reproductive medical practice in Prague to understand what happens in the encounter between patient and doctor when women feel pain during gyno-vaginal examinations.

3. Medical expertise before emotional care

When following the daily work of the two gynecological doctors at Staroměstská Nemocnice and at Nemocnice Centralní I was particularly interested to understand how the doctors make efforts to prepare the women for the gynecological examinations and how they assist the women and guide them through the examination. I wanted to know when in the interaction between patient and doctor that poor communication causing possible discomfort to the patient might occur and how the doctors would deal with patients experiencing discomfort and/or pain.

At her clinic in Nemocnice Centralní, Dr. Svobodová would always put on classical music on low volume in the examination room before receiving the first patients in the morning. She does this because in her experience it can have a calming effect on the patients, she explained to me. Before the examination she always talked to the patients about their health condition and how they were doing at the time being while taking notes to the answers of the patients on her PC. During the examination she would usually keep a conversation going with the patient about the patient's health state or health issues etc., and she told me that she always repeats to the patients what will happen during the examination, even though most of them have been at her clinic for regular check-ups several times before. She could even be quite chatty with some of the patients, and when I asked her what she chatted with the patients about, she explained to me that some of them were colleagues and former students of hers whom she had known for years so the appointment would also be a time for them to catch up on life in general with each other.

During the vaginal examinations on some of the women with appointments I paid attention to the women's bodily reactions to how Dr. Svobodová would perform the examination. Several times I noticed that some of the women cringed their faces especially when Svobodová inserted the speculum, the ultrasound device or her fingers into their vaginas, or when she would move the ultrasound around inside their vaginas. In several of these instances I noticed that no word was spoken from Svobodová prior to the insertion of any of the devices or her fingers to the vagina of the woman being examined. On one occasion in a break between two scheduled appointments I told Dr. Svobodová that I noticed that the woman who had just been examined cringed her face when the speculum and the ultrasound

device was inserted in her vagina and when Svobodová examined her vagina with her fingers. I asked her, if she thought that it might be because the patient experienced pain by the insertion of the examination devices to which she answered that she didn't know, but explained to me that sometimes women would react to the insertion of the examination devices in their vaginas. On a similar occasion, I observed the examination of a patient who to me had seemed uncomfortable and a bit tense in the gynecological chair, and I asked Svobodová if it was her impression that the patient was relaxed during the examination. She answered that to her the patient had seemed relaxed so I explained to her how I had interpreted the bodily reactions from the patient to which she explained that sometimes she has patients who are not relaxed during the examination - "They fight with me" – as she put it, and explained to me that it is difficult to do the examination if the patient is not relaxed in her vaginal and pelvic muscles. She told me that in these situations the women would often apologize for their inability to relax their muscles. I then asked Svobodová if she would terminate an examination if the patient isn't relaxed, because I wondered if she would then take means as to help the patient relax her muscles before continuing the examination, so that the examination would be less painful. Svobodová answered that she would not terminate the examination on such an occasion.

Entrance to Dr. Svobodová's clinic and room separator, Nomocnice Centrální, taken by author, d. 25.10.2023

My general impression of Dr. Svobodová as a gynecologist was that she seemed confident in her profession by her relaxed energy when working at the clinic and performing the gynecological examinations. Her calm and indifferent attitude to some of my concerns regarding the bodily reactions of the women and my questions about women's experiences of pain seemed to witness about her many years of experience and routine in her field. She also seemed to have a clear idea about what kind of information was relevant to the patients about the gynecological check-ups and which information was only relevant to her as a doctor. Once I asked her, if she explains to the patients what she sees on the sonogram screen when doing ultrasound examinations on the patients to which she answered that she only informs the patient about what she sees if she sees that something is wrong. As she explained: "They don't understand what I see of course" and added that there's no reason to try to make the patient understand everything as they are not educated to understand all the technical details of the examination which she as a doctor is. Statements like this one gave me the impression, that Dr. Svobodová relied much on her biomedical understanding of the body and that she seemed to be confident in knowing what was best for the patient, rather than including patients' personal preferences in the decision-making about the gynecological examinations and their purpose. This was also clear to me, when she said that she always makes ultrasound examinations on the patients as part of the routine gynecological check-ups, even though it is not required, but because in her opinion it is always a good idea. Thus, the ultrasound examination didn't seem to be presented as something optional, although I never observed an examination in Dr. Svobodová's clinic where a woman refused the ultrasound.

Dr. Svobodová's attitude to her professional role as a gynecological doctor seems to originate in an understanding of the role of the doctor as an expert authority similar to those of obstetric doctors in Hrešanová's (2014) study on birth-care in the Czech Republic. Her research displays a clash in the ideas about the doctor-patient relationship which she identifies as a legacy from the socialist era on the one hand, mostly represented by the country's healthcare personnel, and with post-socialist neo-liberal ideas about consumerism on the other hand, represented by the birth giving mothers and the citizens in general. She describes the legacy from the socialist era as a time with a totalitarian society in which doctors represented a form of expert knowledge which gave them an authoritative position

against the common citizen who came in as patients and who had to simply follow the orders and instructions from the doctor without question (Hrešanová 2014:963,964). Examples from her study show that birth giving women in the Czech Republic within the last decade had negative experiences with obstetric doctors because of unfriendly and impersonal treatment and lack of emotional care from the doctors. The women in her study generally had the experience that the Czech doctors were more occupied by the technical part of birth giving and of applying medical technologies to the birthing body and leaving no attention to the emotional support and care for the mother. Hrešanová gives an example from one of her informants who describes how she felt she was treated like an ignorant patient who shouldn't challenge the authority of the doctors with her personal desires and opinions on her birth-giving (ibid:969,971,976).

In a similar study Durnová and Hejzlarová (2023) found in their study on the public debate on birth care in the Czech Republic that emotional care was often detached from obstetricians' own perceptions of their professional role and in dominant public discourses about medical expertise as well. The authors show how the role of obstetricians in the Czech Republic is framed by a commonly recognized perception of *expertise* as evidence-based knowledge marked by rationality and objectivity and that emotions are understood as opposed to expertise and related to unprofessionalism (Durnová and Hejzlarová 2023:550,551,553). Compared to my own observations at Dr. Svobodová's clinic she did not resemble the image of an unfriendly totalitarian doctor as observed in the studies by Hrešanová and Durnová and Hejzlarová, but the patients' bodily reactions and personal needs during the gynecological examinations were in my understanding not given much attention when she performed gyno-vaginal examinations on her patients.

Some of the women from my study described what they would classify as "hostile" or "insensitive" behavior from medical staff at their visits at gynecological clinics in Prague. Nancy for instance told me how the first gynecologist she went to in Prague scolded her because she was on her period at the time of her appointment as the examination could not be made for this reason. This had a very negative emotional impact on her, first of all because she had not been informed by the staff when booking the appointment that she couldn't be on her period upon the examination, and especially because she had just had an abortion and wanted to check if everything was okay after the procedure "I wasn't in the best mental state" as she explained. Andrea, who is a survivor of cervical cancer, told me about her experiences

with gynecological examinations in Prague in relation to the diagnosing of her illness and the treatment of her cancer. One of her gynecological examinations happened at the Military University Hospital in Prague after her own GP had raised concerns about cervical cancer because of myomas on her uterus which he had discovered during a regular gynecological check-up. Andrea had brought a Czech friend of hers as an interpreter between her and the doctors at the Military University Hospital in case the doctor or other members of the staff couldn't speak English as she doesn't speak any Czech herself. The doctor who was going to examine Andrea did speak English, said Andrea since she had heard the doctor speaking English to begin with when receiving her and her friend. However, as soon as the doctor realized that Andrea had brought a Czech speaking friend with her, the doctor switched to only speaking in Czech to the friend and not to Andrea herself, which made her quite uncomfortable - "It makes me uncomfortable when they don't look at me". Andrea further told me that she felt rushed by the staff at the hospital and as if she was bothering them with her presence, "In the Czech Republic they don't have a lot of friendly gestures" she told me, which made her convinced that the rather unfriendly attitude from the staff that she felt at her visit was due to cultural differences. As she explained: "I felt like her attitude was like: 'You're just a foreign woman, you don't know anything about medicine' ".

Andrea's experiences of unfriendly behaviors from the Czech medical staff are similar to those of the women in Hrešanová's study on birth care in the Czech Republic. Several of these women had experiences with health care providers who were rude to them while they stayed at the hospital in relation to giving birth, and like Andrea, they had the feeling that they were bothering the health providers (in particular the midwifes) if they were asking for something care-related. Several of the women also felt that the health care providers did not communicate enough to them about the birth procedure, that they didn't explain to the women what they were doing and why they were doing it when making interventions on the women's bodies in the birth process. This made the women feel that the medical staff were more focused on the technical parts of bodies giving birth than actually providing care for these birthing women. In fact, stating your personal needs to the health staff would likely be considered hysterical, is an experience that several of the women shared and made them concerned of the things they would ask from the health care providers in order to avoid unpleasant behavior (Hrešanová 2014:969–72).

Like Andrea, several of the women in my study had a feeling that health care staff were being rude to them or showed an attitude towards them which made them feel that they were being a burden mainly because of their lack of Czech language skills. However, it is interesting that the experiences of the attitudes and lack of care from healthcare providers that Andrea and other expat women in my study had experienced are so similar to those experiences of the Czech women in Hrešanová's research. This might suggest that the identity as an expat is less of a dividing factor than what might be the impression by the women from my study when it comes to health providers' attitudes to patients in Prague.

Andrea told me about another encounter with the same female doctor, who refused to look at her and speak English to her at her first visit at the military hospital in relation to her diagnosis of cervical cancer. Evidently, the doctor wanted Andrea's ovaries removed even though she still hadn't been diagnosed with cancer at the time and that her argument was that: "You don't need them anymore", which Andrea felt was an indication that she was anyway in the doctor's opinion too old to have children so they might as well just remove the uterus. However, Andrea felt that this was not a valid reason to remove an organ from her body and that this doctor just wasn't nice to her in general. As with the women in Hrešanová's (2014) study, Andrea was not given information on what options she had so that she could make an informed decision about what would be done to her body but simply had to take orders or information from medical staff about interventions on her body.

Eventually, when Andrea had finally been diagnosed with cervical cancer, she did have her uterus removed. She described an episode to me from when she was still hospitalized after the surgery where:

> *A female doctor came by with some medical students and went over to me and said "We want to take a look at your scar" while she just pulls up my shirt without asking me first if it was OK.*

This episode is an example of a violation of informed consent where each person has the right to have their dignity respected and that the unlawful touch of a stranger is deemed an assault, if following court papers in the US for instance (Sadler et al. 2016:47). Andrea also told me in her own words how she felt that "There was no dignity" at this particular hospital

and that eventually she decided to continue her treatment at a private hospital instead due to her experiences of disrespectful and unkind treatment by the medical staff at the military hospital.

In the following chapter I analyze the women from my study's experiences of pain and discomfort during gyno-vaginal examinations as a reflection of lack of basic care principles in gynecological healthcare and how this in fact can be defined as a violent act against the female body in reproductive and sexual healthcare.

4. When medical practice is violent to the female body

The doctor just said "Lie down, put your legs up" and then he just put the speculum inside of me and it was very painful – Violette, 31.

The quote from Violette above illustrates the lack of emotional care that several of the women from my study have experienced in relation to the discomfort and pain they have felt during gyno-vaginal examinations. Violette's account of this particular visit at a gynecologist at home in France indicates first of all the lack of psychological preparation from the doctor in terms of being informed about what was going to happen during the examination. Instead of preparing her for what was going to happen the doctor "just put the speculum inside" of her when she wasn't prepared and ready for it. According to Violette, he simply delivered a strict order: "Lie down, put your legs up" as the only way of guiding her into the examination. She told me that this experience felt very "impersonal" which added to her feelings of discomfort and then resulted in pain during the examination.

Following Pierre Bourdieu's (2001) theorizing of symbolic violence, Johanna Shapiro (2018) has defined violence in medicine and the different ways in which it is acted out with a differentiation of when violence in medicine is sometimes necessary and when it is unnecessary. Shapiro includes acts of "power" by an individual over another in her definition of violence, which allows for an understanding of violence where harm to the other is not necessarily the intent of the actor but is nevertheless one of the outcomes (Shapiro 2018:1). Within medicine she differs between three kinds of violence: violence to the body, structural violence, and violence in language. Following Shapiro's definitions of violence in medicine, the quote from Violette reflects two kinds of violence. It reflects an act of violence to the body which Shapiro defines as the transitory or chronic pain imposed by the doctor which is sometimes necessary and inevitable in the interventions on the body as part of the healing process. As she explains, sometimes healing means imposing new or more pain in order to simply reach the healed state of the patient. However, in Violette's case I would argue that in this particular moment, the pain which is being imposed to her by this gynecological doctor is one that is unnecessary, which I will elaborate on later in this chapter. The other form of violence that the quote form Violette reflects is violence in language, which in Shapiro's definition also includes demeaning interactions where the patient feels a lack of

dignity and respect in their interaction with the doctor (ibid:3,4).

Several of the women in my study reported feeling anxious prior to a gynecological appointment because of earlier experiences of severe pain or discomfort during a gynecological examination or because they were dealing with sexual issues related to experiences of pain and discomfort in the pelvic and vaginal area. Kristina, 27, for instance had a traumatic experience with a gynecological examination by her female family doctor when she was 13 years old when her mother wanted to know if she would be able to use a tampon because she had just had her menarche right before a family beach vacation. The doctor examined Kristina by putting her fingers inside her vagina which Kristina described as being so painful and invasive that she passed out during the examination. This experience meant that Kristina felt scared and nervous prior to her second gynecological check-ups more than 10 years later when in her mid-twenties because she feared the examination would be painful and that the doctor might do "something bad" to her. For this reason, Kristina emphasized how she felt that she had a good contact with the gynecological doctor at her second gynecological check-up and how this meant that she had a much better experience than she would have expected, because she felt that she could easily communicate her needs to the doctor.

In their study on trust in healthcare professionals by cervical cancer patients in the UK Patrick R. Brown et al. (2011) refer to the concept of "impression management" following Erving Goffman (1959) which describes the embodied presentation-of-self as a sort of multi-sensory communication by which the clinician evokes a patient's esteem of their character. This can be effectively applied by the physician in facets of physical presentations such as posture, eye contact and certain gestures with the body combined with verbal signs to establish (or, if used wrongly, undermine) trust from the patient. The authors emphasize how this form of "body work" by the physician is not only effectual in the present situation but that it lays the groundwork for the following legacy of expectations, assumptions, beliefs and hopes which can be summed up in the trust the patient has placed in the healthcare provider (Brown et al. 2011:281,282,284,285). The anxiousness that Kristina felt prior to gynecological examinations as described in the paragraph above reflects a clear issue of lack of trust in doctors evoked by a memory of her first encounter with a doctor making a gyno-vaginal examination of her as someone who cannot be trusted.

Not all the women from my study had experiences with painful gyno-vaginal examinations, but some of them had experienced discomfort at a gynecological appointment/check-up to a degree that made them trust medical providers within the gynecological field much less, and some of them would even avoid going to health check-ups related to their reproductive health because they did not want to possibly exposed themselves to a situation of such high discomfort again. Anna, whom I interviewed, gave me her account of a visit at a male gynecologist in Prague when she was dealing with irregular periods. At her appointment the doctor asked her about some information in relation to her health and when she told him her height and her weight he made the comment: "Oh, that's [her weight] quite a lot". Anna told me how this comment had upset her, especially since the doctor didn't relate it to anything having an impact on her irregular periods, so she felt that it was simply a judgmental observation from his side and unnecessary to comment on. She told me that she already didn't have the most positive impression of this doctor as he was not particularly kind or welcoming, so with this comment on her body weight in addition to that, she decided not to make any more appointments with him.

Brown et al. emphasize how trust is facilitated by expectations of shared norms which gives the patient an assurance that the trusted practitioner's behaviour is oriented by a normative obligation (Brown et al. 2011:287) which, described in her own words, was clearly not the case for Anna in at this instance: "I (…) didn't get along with him. And then with his comments, especially as a professional I was like, OK like definitely (…) He wasn't the doctor for me". Several other women from my study also gave accounts of when they were going for a gyno-vaginal examination how these particular practitioners failed to provide them with a sense of trust even by the first encounter. In this regard the women from my study had paid particular attention to if the doctor didn't look them in the eyes, if they felt rushed by the doctor or if the doctor did not give enough information prior to the gyno-vaginal examination about what was going to happen as factors that gave them a feeling of distrust in the particular doctor and made them reluctant to come back for another appointment.

Like Anna, several of the women I interviewed had experiences with gynecological doctors who would uninvitedly express their opinions on their bodies or their decisions with their health. Violette told me about a time where she had become involuntarily pregnant and that

she had booked an appointment with a gynecologist in Prague to discuss her options for an abortion. At the consultation she had the experience that the doctor wouldn't respect her choice. During the ultra-sound examination the doctor turned on the sound of the heartbeat from the fetus without asking Violette first, which made her very upset as she was already in what she described to me as a very stressful and emotional state. When Violette told the doctor that she did not wish to hear the heartbeat of the fetus the doctor said to her: "Maybe you will change your mind. I think you will be a good mom…". After the examination Violette was crying when sitting and talking to the doctor about her decision of an abortion with the doctor who then commented: "If you cry, it means you want the baby". Violette told me that these comments and what she experienced as the doctors attempt to talk her out of having an abortion made her feel that she had to justify her decision and added: "I felt not listened to. I didn't feel like a human. I felt like I'm just a uterus".

These examples of doctors making comments about women's bodies or pushing their opinions about their health and their reproductive choices are going against the informed consent part of patient rights. Sadler et al. (2016) refer in their study on excessive obstetric interventions to UNESCO's Universal Declaration of Bioethics and Human Rights (2005) which stresses the right to informed consent within healthcare, including the right to refuse medical interventions, and that autonomy and the right to make decisions upon your own health should be respected (Sadler et al. 2016:47,48). The women from my study mentioned other comments from doctors in relation to gyno-vaginal examinations which I, following Shapiro, would argue are direct acts of violence. For instance, when Violette was told during a gyno-vaginal examination that she was "too much in control" when complaining about pain and when Nancy was told that she was "very vulnerable" when expressing discomfort to her doctor during a gyno-vaginal examination, these comments are acts of what Shapiro would call disparaging comments and demeaning interactions, as these comments is an abuse of a powerful position resulting in psychological harm including deprivation of dignity and respect towards the women (Shapiro 2018:4).

In a quantitative study conducted at a hospital in Denmark about women's experiences of discomfort in relation to gynecological examinations Hilden et al. (2003) found that discomfort was strongly associated with negative emotional contact with the examiner. Good emotional contact with the examiner, on the other hand, was found to be established when the doctor shows empathy and takes time to listen to the patient's needs, expectations and

worries and by giving them information about the procedures (Hilden et al. 2003:1033). Empathy from the doctor and being given detailed information about the examination beforehand were also some of the factors that several of the women I spoke to emphasized when I asked them how a good experience of gynecological examination might be like. Julie, 24, for instance, had been very anxious before her first gynecological check-up at a clinic in Prague because she had experienced extreme pain during her first gynecological examination back home in Croatia. Her experiences of pain and discomfort at her first gynecological examination was related to both lack of preparation from the doctor's side in terms of giving her sufficient information about the examination but also a dismissive attitude from the doctor during the examination when she worded her experience of pain. However, at her gynecological examination in Prague she was examined by a female doctor who in Julie's own words was "very nice" because she guided her through the entire examination by describing to Julie what she was doing and what was going to happen next during the examination. The doctor also asked questions about her health and made small talk which added to Julie's feeling of comfort in the situation. Julie also described how the doctor would check-in with her during the examination with comments like "Are you OK?" and "Does this hurt?" which gave Julie the feeling that her boundaries were being respected and a general sense of care from the doctor.

Hilden et al. conclude their study by suggesting that doctors in gynecology prioritize more communication with their patients about personal issues and prior experiences of gynecological examinations to get a better understanding of the patients' personal needs to decrease the experience of discomfort (ibid:1035). Some of the women in their study had a history with sexual abuse and as sexual abuse and female sexuality are closely related to the pelvic area gynecological examinations might evoke memories of the abuse and cause distress and overall discomfort. For this reason, the knowledge about the patient's personal history and needs was found to be especially important prior to gynecological check-ups (ibid:1033).

Coming back to the quote by Violette in the beginning of the chapter, as several studies show steps which can be taken by the practitioner performing gynecological examinations on women in order to decrease feelings of discomfort and pain, I argue that when Violette's doctor puts his fingers inside of her vagina without a warning or emotional/psychological preparations of what is going to happen during the examination, it is an unnecessary act of

violence towards her body. In the following chapter I will discuss how women's experiences of pain and discomfort during gyno-vaginal examinations is rooted in structural violence against the female body within medicine.

5. Must women feel pain at the gynecologist?

The time I realized that there was nothing wrong with my body, but that there had been something wrong with the way my body was approached within gynecological medicine, was years after my first gynecological check-up when I had spoken to several other women who had had similar experiences with pain and high discomfort in relation to gyno-vaginal examinations, as me. The time when I was sure, that it was definitely the customs in how gyno-vaginal examinations are performed that are flawed was when I had to go for a pap smear screening for cervical cancer at my own GP in Copenhagen in 2022, who was a woman and who I (fortunately) trusted and felt very safe and comfortable with. At the appointment right before the examination was going to happen, I gave my doctor a few insights of my previous experiences with gynecological examinations in my vaginal/pelvic area and some instructions as to how I needed the examination to proceed. During the examination I felt that my doctor accommodated me in the way I had told her that I needed in order to feel relaxed and safe, and for the first time in my life, I did not feel any pain during a gyno-vaginal examination. It was an examination happening on the conditions of what I knew about my own body and my own needs and I genuinely felt that the examination was happening with a concern for my wellbeing and not just as a matter of public health protocol.

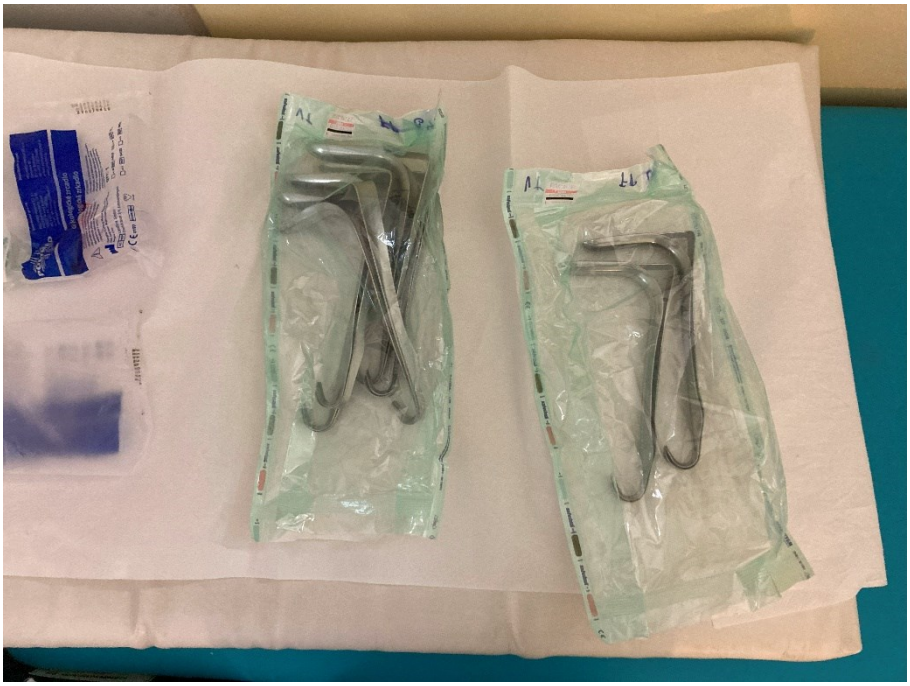
Three of the women from my study told me about a situation where they had experienced pain in relation to a gyno-vaginal examination and that when expressing this feeling of pain to the practitioner who was performing the examination, s/he then responded with an attitude or a statement saying that it is *normal* to feel pain during gyno-vaginal examinations. Julie told me about her first gyno-vaginal examination which she had in her home country, Croatia, where she felt such severe pain when the doctor inserted the speculum into her vagina, that she started crying. She told her doctor that it felt very painful and asked why she was feeling so much pain to which the doctor answered: “It is because you’re not relaxed enough” and continued: “It is normal to feel pain. But everything looks fine”. Julie told me that the doctor simply continued the examination without any sign of concern and that she felt not listened to by her doctor. She had already been anxious prior to the examination because it was the first time she was going to be naked in front of a doctor, which made her feel shy and vulnerable. Julie doesn’t recall that her doctor took any effort to explain to her

what was going to happen during the examination, and by the sight of the size of the speculum (which to Julie looked huge) she felt even more anxious and was afraid that it was going to hurt. After this experience with a gyno-vaginal examination she told me she was afraid of going back to a gynecologist, which she didn't do for several years.

In a design study about the historical development of the speculum Gina A. Taylor et al. (2017) found that the current design of a typical speculum used for pelvic and vaginal examinations has only had a few modifications since its design was updated in 1870. According to the authors the speculum is one of the primary reasons why women can feel anxiety and fear prior to a pelvic examination, but as it is needed in visual inspections of the inner vagina and the cervix it is an integrated tool in gynecological examinations. The fear and anxiety the thought of the speculum can cause to women in relation to the gynecological pelvic/vaginal examination is mainly because of the coldness of the metal, pressure or pain and roughness from the speculum. The authors also found that the size of the vagina can vary with up to 8 centimeters in length and with more than 4,5 centimeters in width and that factors such as age and ethnicity can influence the size and the shape of the vaginal canal. Yet, there are no industry standards for specula size and the authors found that manufacturers vary in their categorizations of specula sizes(Taylor, McDonagh, and Hansen 2017:2349,2351,2353,2356).

According to the authors, the main problem with the design of the speculum like with many other medical devices, is that they have been designed from a purely functional perspective with no consideration of the emotional and physical comfort of the patient. In this regard, the authors designed an improved version of the speculum with a high focus on the comfort of the patient (and ergonomically appealing to the practitioner) which they believe would decrease fear and anxiety for women in relation to the gynecological pelvic examination. In their design they have taken inspiration from materials used in sexual aids/sex toys such as soft, heat-resistant silicone which they used to coat the steel blades of the speculum with. This, they argue, will contribute to increased emotional and physical comfort as it will have a visual aesthetic closer to objects used for female enjoyment and it will look and feel less intimidating as the soft silicone on the blades will conform to the contours and individual shape of the vagina more easily (ibid:2357,2358,2359).

Julie is not the only one of my interlocutors who had experienced discomfort, fear and anxiety directly related to the speculum. Layla told me that once when she had a gynecological examination in her home country, Ukraine, when the gynecologist inserted a speculum into her vagina, she had the feeling that it was not the right size for her which made the examination quite uncomfortable. Andrea also told me how it had always felt painful to her when she would have to be examined with a speculum and when the speculum was opened inside her vagina, which she also suspects is related to the standard size of the device being too big for the shape and size of her vagina.



Standard sized specula in metal, Nomocnice Centrální, taken by author, d. 25.10.2023

The design of the gynecological chair was also something that six out of nine of my participants related to the discomfort they had experienced in relation to gyno-vaginal examinations. The words the women from my study would use to describe the discomfort that they had experienced in connection to the gynecological chair are: restricted movement, precarious position, feeling paralyzed, the stir-ups for the legs made of metal that feels cold, but also the visual design of it was something that created feelings of horror among several of the women. As Layla described it: “Honestly, I don’t find it [the gynecological chair] comfortable. When you look at it, I would describe it as a chair for torture”. Andrea also told me, that the fact that the chair cannot be adjusted to the body is something that adds to her

experiences of discomfort in relation to the gyno-vaginal examination, and Kristina told me that she was unable to relax while she was in the gynecological chair and that she was unable to "open up", referring to not being able to relax her vaginal and pelvic muscles which would make her accessible to the examination of her inner genitalia. According to Gleisner and Siwe (2020) the gynecological chair has been designed in a way that creates a good, ergonomically comfortable position for the doctor performing the gynecological examination and that the options for adapting the chair to the person being examined is limited. They also mention the exposed position of the body when seated in a gynecological chair as something adding to the sensitiveness of the gynecological examination (Gleisner and Siwe 2020:352,353).

Gynecological chair with metal stir-ups, Staroměstská Nomocnice, taken by author, d. 03.11.2023

A few of the women in my study did, however, mention situations where they had been examined in a different way by a practitioner when going for a gyno-vaginal examination, which had added to their feelings of comfort. Andrea told me about a gynecological check-up she had after her first operation with removal of her uterus as part of her treatment for the cervical cancer she had been diagnosed with. This check-up happened at the private hospital Canadian Medical in Prague which she had been referred to by her own GP after her negative

experiences at the military hospital in Prague. She told me that during the gyno-vaginal examination the doctor used a silicone coated speculum which felt much more comfortable than the classic speculum with bare metal blades as she couldn't even feel it when the doctor inserted it into her vagina. She also described the gynecological chair which was a more advanced model than the usual gynecological chair, which also added a great deal to her general comfort during the gyno-vaginal examination. This chair could rotate forwards and backwards automatically which means that Andrea had to sit in it like she would sit in a normal chair to begin with and then the doctor would rotate the chair backwards once it was time to make the examination. She told me that the stir-ups in this chair were flexible so that the doctor could gently push her legs to the sides into an open position once the chair was in the right position so that in this sense, she didn't have to put her legs in a spread position herself and that her legs were not fixed in this open position in the same way as in a normal gynecological chair.

Violette also told me about a time where she had a gyno-vaginal examination by a midwife back home in France. Before the examination the midwife asked Violette if she preferred to lie on her back or on her side during the examination, involving her in a shared decision-making, to which Violette said she would prefer lying on her side. She told me that overall this was a very pleasant experience as the midwife explained to her in detail what would happen during the examination and that she put a blanket over Violette's legs so that she wouldn't feel cold. The speculum which the midwife used was also warm and the midwife would check-in with Violette during the examination asking her if it felt ok, which also added to Violette's comfort. When I asked about her experience of being examined lying on her side she told me: "I felt more safe because you're not so exposed" and added that she finds the traditional gynecological chair to be horrible.

As has become evident from the personal accounts from my interlocutors and data from other studies on the topic of discomfort in relation to gyno-vaginal examinations, it is not necessary that women should feel pain or discomfort during gyno-vaginal examinations in most cases. Much evidence point to specific changes and adjustments which might improve women's comfort during gyno-vaginal examinations to a great extent such as softer, silicone coated blades on the speculum, a more flexible gynecological chair with flexible stir-ups, perhaps also covered with a softer material as for the metal not to feel cold, and more attention to the patients personal needs and emotional and physical reactions and history

with intimate examinations and more prioritization of explaining the details and steps in the gynecological examination to the patient prior to the examination. Clearly, there are clinics where this has already been incorporated into the routines of gyno-vaginal examinations. However, it seems that this is rather the exception than the norm. So why is that? Why is female comfort still not an integral part of the gynecological examination, and why must women suffer with pain in relation to their sexual and reproductive health?

In their study on gender bias in the development of medical implant devices used on both men and women with a focus on the US and Canada, Phillips et al. (2022) hypothesize that the failure to recognize women's disproportionate risk of harm from implanted devices can be traced back to an ubiquitous social myth which has permeated medicine which historically has viewed the female body as a smaller version of the male body with a few, unimportant parts missing or added. With the male body as the default body and the "othering" of the female body, this social myth has rendered women invisible in testing of medical devices and drug regulations, which exposes them to higher risks of harm in medicine, they argue. In addition to this, several women have given accounts of assumptions among medical staff that women make health related complains without justification which means that their bodily experiences are more likely to be dismissed compared to men's (Phillips, Gee, and Wells 2022:1,2,4,5). Following Phillips et al. I argue that women's experiences of pain and discomfort in relation to gyno-vaginal examinations are due to the same kinds of gender bias in medicine where the female body is rendered the second priority.

Following again Shapiro's (2018) definitions of violence within medicine, I argue that the pain women can experience in relation to gynecological vaginal/pelvic examinations because of poor emotional contact and an insensitive touch by the examiner and lack of information about the examination when they go to regular gynecological check-ups is an reaction to structural violence against the female body happening because of the same flawed ideas about the female body within modern Western medicine which has been observed within obstetric violence. Shapiro defines structural violence within medicine as certain social patterns which are so deeply embedded in ordinary social interactions that they are somehow taken-for-granted. She stresses how their existence is so *normalized* that they are almost invisible. The violent aspect is when these patterns or structures are preventing groups and individuals from reaching their full potential and causing impairments and

limitations in human life. It can be observed in situations where a doctor might for instance express patient-blaming attitudes if the patient is perceived as noncompliant with the health instructions from the doctor. Thus, when women from my study have been told that it is "normal to feel pain" during gyno-vaginal examinations, I argue that this is an expression of a structural violence against the female body within women's reproductive and sexual healthcare as it imposes harm to the women and violates women's autonomy to their own bodies and health.

At one of my meetings with Prof. Novák at his office in the beginning of March 2024 when I had finished the fieldwork activities for my thesis, I presented to him some of the patterns I had observed in the personal accounts from the women who had participated in my study. I told him that several of the women had experienced that when expressing pain during a gyno-vaginal examination the doctor examining them did either not do anything to comfort them or simply brushed them off by saying that it was normal to feel pain during this kind of examination. I asked Prof. Novák if he could imagine that this is something that happens often within gynecological healthcare to which he seemed very surprised and said: "I find it very hard to believe that this is common. I hope it is not common". What this comment from Prof. Novák reflects is the observation, described by Shapiro, that doctors of course do not take pleasure in causing pain to their patients. However, as mentioned earlier, sometimes pain must be inflicted in healthcare in order to avoid even greater pain or death, which she describes as a brutal dimension to medicine. And as it is the doctors who must inflict this pain they might engage with defensive coping strategies that makes them minimize or fail to acknowledge suffering and trivialize patients' negative experiences (Shapiro 2018:3).

In a similar vein, Taylor et al. (2017) argue that the medical profession is notoriously reluctant to embrace new techniques and new medical devices, and that despite new evidence of the discomfort the classic speculum often creates among women, they believe that the current dominant design of the speculum is good enough to a clientele who are considered not inclined to complain (Taylor et al. 2017:2359). However, as this violence, which I consider the speculum to be an artifact of, is structural, I argue that if women do not complain of the discomfort or pain that they suffer from during gyno-vaginal examinations it is because the normalization of women's experiences of pain in their genitalia is so permeated in Western medicine and beyond that it is taken for granted, even by the women themselves.

Conclusion

With this master's thesis study, I have aimed at bringing attention to an area within women's reproductive and sexual health which I find to be under-prioritized in research within social science, and more specifically within medical anthropology. It is rare to find ethnographic studies on "healthy" women's embodied experiences of pain and discomfort in relation to gynecological examinations. I believe this is partly because of the gender bias in medicine which often renders women invisible in the progression of medicine and medical technology and because of the internalized structural violence against the female body which all of us fall prey to, even the women being exposed to this form of violence in medicine when telling ourselves that it is probably "just me that is something wrong with". It has happened to me several times during my work with this master's thesis that I met women who, when I told them about my thesis topic, seemed amazed by the fact that it is possible to criticize the way the female reproductive and sexual body is approached in medicine when exclaiming: "Wow, I thought it was just *me* who is extra sensitive and that there is just something wrong with *my* body!". My collections of personal accounts from women with a broad variation of local backgrounds, mainly within Europe, attest to quite the opposite, as I have shown.

There is nothing *wrong* with our bodies when experiencing pain during gyno-vaginal examinations. Or, at least in many cases. Sure, there are women who suffer from conditions which are classifiable within biomedical vocabulary and which might be the cause to the pain they experience. This another thing we must take seriously grant attention within research in social science. However, it should not be normalized that women feel pain during gynecological examinations because pain should never be an acceptable aspect of our approach to the body in medicine, when it can be avoided. When feeling pain during gyno-vaginal examinations it is likely because the woman has not been offered the appropriate kind of care she needs in order to feel safe and relaxed during this vulnerable situation where her most private and sensitive parts are being examined and exposed. This, I argue based on my own collected data in this study, but also on the findings by other scholars in women's reproductive and sexual health.

With the personal accounts from several women and through participant observation, I have shown that there are certain reasons why women feel pain during gynecological

examinations. Lack of emotional and psychological care within gynecological praxis where technical skill and clinical evidence seems to be given more attention, is one of the main reasons why the women from my study have experienced pain or discomfort during gyno-vaginal examinations. A larger prioritization in medical training of skills in communicating with patients about their individual bodily needs might improve women's experiences of these examinations. Furthermore, communication skills within gynecology should also involve how the practitioner guides the patient into the examination in a way that makes the patient feel safe, informed and prepared. Instructing the patient in how to breathe and how to relax (and locate) their pelvic muscles, for instance, might have a great impact on the woman's experience of the gynecological examination, and would likely decrease feelings of discomfort and sensations of pain in the vaginal and pelvic area. Together with findings from other studies, my data also suggests that the clinical equipment used in gynecology is something that evokes great discomfort and causes pain to several women. There is lots of room for improvement in this area as well as to adjust gynecological medical equipment to the comfort and anatomy of the female body, such as the gynecological chair and the speculum, which both evoke feelings of fear and horror among women.

During my work with this master's thesis project I also found, that the female body, especially female genitalia, seems to be surrounded by sometimes strong opinions from medical staff, both in medical discussions, but also in consultations with the patients. My own data attest to this in several cases. We have the example with Violette faced with a doctor during an unwanted pregnancy who attempts to dominate her decision about her own body and reproductive health. Or Anna who is told by her doctor that her weight is "quite a lot" without even relating it to her medical issue. Not to mention Karolína, who's doctor tells her that it is her duty to have sex with her partner despite experiencing severe pain during vaginal intercourse. These examples do not stand alone. I could draw even more examples just from my own data collection, but also from other similar studies. The fact that medical staff might impose their own personal opinions and moral standards on the women seeking health within gynecology, or reproductive healthcare in general, questions, in my opinion, whether women actually have the rights to the autonomy of their own bodies in practice when they *should* have it according to official human rights policy.

This study is limited in several ways. The women who have participated in the study represent only a narrow part of the population as all of them are ethnically white women from Western and mostly European high-income countries and all have a university degree as well. This means that the study does not consider how ethnicity and socio-economic background impacts the medical encounter between patient and healthcare provider. Some of the women had sought medical advice on their health within the private sector of healthcare in Prague after having consulted healthcare practitioners within the public sector, which did not deliver the kind of care or treatment that they felt they needed. It is not all women who can afford seeking medical advice and care within the private sector as it demands payment out of pocket from the patient at their visit and is often expensive compared to healthcare within the public sector. Although most of the women from my study sought medical advice within the public sector in Prague before some of them turned to private practices instead, having the option of turning to the private sector is a privilege giving these women a certain degree of freedom in decision-making about healthcare providers as they do not have to accept the directions from a certain doctor, if they disagree with her/him. Thus, it is likely that the experience of going to a private gynecological clinic would be different than the experience of going to a clinic covered the public healthcare this is not something the study is able to make conclusions on, as I unfortunately never got the chance of doing participant observation at a private gynecological clinic in Prague.

Future research within this topic could contribute greatly to the findings in this study by including women with more diverse backgrounds in terms of ethnicity and sexuality. As the study takes place in Prague, the capital city of the Czech Republic, I have analyzed the local context in which the women from my study have had experiences of pain and discomfort in relation to gyno-vaginal examinations. However, as most of the women from my study are expats living in Prague, their history of experiences with pain and discomfort in relation to gyno-vaginal examinations does not always origin in the context of the local medical environment in Prague, but also in their home countries. Based on other studies which in fact showed that Czech women had similar negative experiences of vaginal examinations within birth care in Prague as the women from my study, and as several of the women had the same fears and worries and history of pain and poor contact with healthcare providers in gynecology regardless of their national background, I have argued that women's experiences of pain and discomfort in relation to gyno-vaginal examinations is a universal issue within

women's health in a mainly European context. Of course, this study cannot stand alone with such an argument. It would be beneficial if future studies within this topic were to take place in other European locations, or even at locations outside of Europe.

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List of Appendices