Subjectivities of female and male physicians in attending victims of sexual violence in university hospitals in Medellín, Antioquia 2021-2022

Subjetividades de médicas y médicos en su encuentro con víctimas de violencia sexual en hospitales universitarios de Medellín, Antioquia, 2021-2022

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Abstract

Objective: To understand how physician's subjectivity is expressed while attending to victims of sexual violence at emergencies. **Methodology:** Qualitative research, a collective case design with an ethnographic approach, via the elaboration of a field journal, two institutional itineraries, 12 in-depth interviews to leaders and doctors and one workshop. **Results:** There were four moments identified on victim's itinerary at emergencies services, in each moment emerged subjectivity's expressions, that could be organized on forms of subjectivity and their mechanisms within. If the physicians embodied the modern medicine, a subfield of medicine, into their habitus, their practices tend toward the revictimization of their patients. In the other hand, if doctors do not embody such practices and assume a critical posture about it, they tend toward a comprehensive care. **Discussion:** The non-recognition of such practices leads to the impossibility of exercising health citizenship, its mechanisms are a result of socialization processes from sociohistorical constructs that are reinforced by hegemonic medical model and the medical field., generating tension between practical logics of physicians and the needs of the victims. However, a fracture of this model is observed as a possibility of transformation toward comprehensive care.

Keywords: Sexual Violence; Gender, Subjectivity; Right to Health; Medical Education.

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Resumen

Objetivo: Comprender la expresión de las subjetividades de médicas(os) en su encuentro con víctimas de violencia sexual en urgencias hospitalarias. **Metodología:** Investigación cualitativa, diseño de caso colectivo, con enfoque etnográfico, con la elaboración de un diario de campo, dos itinerarios institucionales, dos entrevistas a coordinadoras, diez entrevistas en profundidad a médicas(os) y un encuentro reflexivo. **Resultados:** Se identificaron cuatro momentos en el recorrido de la víctima, y en ellos emergieron expresiones subjetivas que se agruparon en formas de reconocimiento y mecanismos. Se incorporaron el campo médico en el subcampo medicina moderna en sus habitus, sus prácticas clínicas vulneraron a las víctimas de violencia sexual. Por el contrario, si se apartaron de las lógicas que impuso el campo médico, sus prácticas se tradujeron en un cuidado comprensivo. **Discusión:** El no reconocimiento conduce a la imposibilidad del ejercicio de la ciudadanía de la salud; sus mecanismos parten de procesos de socialización desde sus constructos sociohistóricos que se ven reforzados por el modelo médico hegemónico y el campo médico generando tensión entre las lógicas prácticas de médicas(os) y las necesidades de las víctimas. Sin embargo, se observa una fractura de dicho modelo como una posibilidad de transformación hacia un cuidado comprensivo.

Palabras clave: Violencia Sexual; Género; Subjetividades; Derecho a la Salud; Educación Médica.

Introduction

Sexual violence as a global phenomenon is the expression of a patriarchal and unequal society, with a system of power relations and domination in which girls, boys, and women are denied citizenship and are subordinated, reduced to objects of consumption, tradable goods, spoils of war, among others. (Goinheix Costa, 2012) The International Criminal Court (ICC) considers it a crime against humanity as it is a violation of human rights that causes moral damage to the individual and collective, to historical memory and to the social capital of communities. It is also recognized as a matter of public health concern (OMS, 2013) due to its magnitude, severity and tendency to underreporting. (Bott et al., 2012; Linhares; Torres, 2022; OMS, 2021).

For this reason, international organizations such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO) developed legal and procedural mechanisms to provide comprehensive care to victims of sexual violence in the health sector. These mechanisms were materialized in a set of standards to ensure such care with focused on rights, gender, with a differentiated approach. However, there is a gap between their availability and the reality of the health services where it is reported that victims are unable to exercise their human rights, sexual rights, and reproductive rights, due to delays in the provision of health services. This situation leads to revictimization (Jakubec; Carter-Snell; Ofrim; Skanderup, 2013) with visible consequences in mental health alterations, unwanted pregnancies, sexually transmitted infections, and non-adherence to treatment (Agudelo et al., 2007; Lehrer; Lehrer; Oyarzún, 2009; Gallo Restrepo; Molina Jaramillo, 2008).

In addition, there are aspects that go beyond the structural deficiencies of the current health system, creating barriers to access care based on recognition and an ethic of care. These aspects could be related to the influence of the medical field and habitus. The category of authoritarian medical habitus in a sociological view has been approached by Roberto Castro at the National Autonomous University of Mexico. His postulates offer an alternative for a critical and in-depth analysis of the mechanisms that occur in this encounter between health professional

and surviving victims of sexual violence. The author manages to expose in a sequential and coherent way how the relationships between subjects are organized, hierarchized, and idealized specifically in the context of medical practice. This context, which he calls authoritarian medical environments, has not been the focus of research or training processes for professionals who, on the contrary, have focused on an "education toward kindness" without delving deeper into the conditions of potential medical authoritarianism. (Castro; Erviti, 2015).

Castro defines the medical field as "a network or set of objective relations between positions" (our translation) that regulates health issues in commercial, political, professional, and scientific terms, aimed at achieving efficiency. The institutions of the field are the training schools, health care institutions, research centers, and the professional associations. These institutions house agents of different health disciplines. Within this medical field, the author identified two subfields, namely: modern medicine, which occupies a position of privilege; and traditional and alternative medicines, which hold a position of subordination (Castro Perez; Villanueva, 2019). This article reviews the subfield of modern medicine, specifically that of the clinic practice, which is the setting where emergency care is provided to victims of sexual violence.

The medical habitus is defined as a set of generative predispositions resulting from the incorporation of meanings and practices during the medical training process and the daily clinical practice. This is achieved by means of three mechanisms: systematic disciplining, hierarchy, and gender discipline. It represents the apparatus of medical education that, based on the findings of Castro et al., brings about transformations in physicians that later, jointly with other elements, lead to violations of the rights and mistreatment toward women within the hospital setting in the area of sexual and reproductive health.

All of the above could lead to a violation of the rights of the victims of sexual violence by making clear (Foucault, 1981) the biomedical position of power and control, as well as the use of devices to regulate sexuality based on gender. (Sosa-Sánchez; Erviti, 2017; Sosa-Sánchez; Menkes-Bancet, 2016). However, currently there is no visible study with a critical and comprehensive approach that specifically address the issue of sexual violence, which is the approach proposed in this study, with a theoretical bricolage between subject, subjectivity, gender, and public health.

In the author's perspective, the expressions of subjectivity should be reviewed based on the subject's notion, and how this subject is able to trigger transformations, in this case in the care of victims of sexual violence despite the burden represented by the medical apparatus. This article adopts an idea of subject from Hegel's assumption, based on intersubjective recognition (Honneth, 1997a), and that, in turn, is influenced by the gender category as a sociocultural construction. This construction recognizes people immersed in macro and micro sociological power relations, generating different types of interactions between women and men, which traditionally respond to a patriarchal and heteronormative logic. (Venegas, 2017). In this specific case, interactions in institutional environments dedicated to medical training and health care, in which practices mechanisms and devices have been identified as perpetuating inadequate dynamics in the health care of a survivor of sexual violence (Castro Pérez & Villanueva Lozano, 2019; Castro, 2014a; Castro & Erviti, 2015.

This approach recognizes an active subject that, in its symbolic dimension through discursivity and practice, has the potential to exercise reflexivity and resistance (subjectivation) creating health care spaces for survivors of sexual violence to grant and reestablish their rights. (Gorriti, 2015) All of the above within the framework of a Public Health with a socio-critical perspective that suggests the dialogue between subject and society as the right path, understanding that as subjects we have margins of autonomy and creative capacity (Benhabib; Bonss; McCole, 1995).

Materials and methods

A collective case design with ethnographic approach was proposed to obtain foreground and in depth descriptions of the context of what physicians think, feel, and the way they act when encountering victims of sexual violence in the

hospital environment, where the limits between the context and the phenomenon are not clearly evident and where the researcher is recognized as an instrument, as an interpreter of the events in their context without attempting to extrapolate this understanding to the entire population; thus assuming the recognition of the dialectical relation in contexts under tension, such as the hospital, where practices of non-recognition of otherness that could lead to revictimization can be reproduced.

Population

Physicians in charge of providing emergency care to victims of sexual violence.

Sampling

By convenience, constituted by physicians with experience in caring for victims of sexual violence in the hospital institution for more than one year and agreed to participate in the study

Research technique

a) Ethnographic interviews; b) Field diary as a systematic record of what was observed, felt, and experienced in the hospital environment and as an exercise of reflexivity; c) Reconstruction of the victims' journey in the hospital; and d) Reflective and social creativity meeting (Arnanz, Caballero, Hernández, Martín, & Villasante, 2019). The collection of information had several scenarios and participants. The experience of reconstructing the journey was carried out in two hospitals; interviews with management and care coordinators were carried out in two hospitals and one health center. The meeting with social workers was part of the process of reconstructing the journey in one of the hospitals. The interviews with physicians had participants mostly from one of the hospitals where the journey was reconstructed and others were professionals with more than 1-year experience in caring for victims of sexual violence who agreed to participate in the study. Interviews were pilot-tested and after transcription and anonymization they were sent to the interviewees for review and comments.

Processing and analysis

The techniques were audio recorded and transcribed with Transcribe software, textual analysis (coding and categorization) with Atlas.ti software, and information structuring in matrices with Microsoft Office Excel. (Cárdenas, 2003). By incorporating the constructed journey, the interviews, the field diary, and the reflective meeting, the text was written with a temporal sequence following the journey of the victims since their arrival at the emergency care. Four moments were identified, and at each moment visible forms of subjectivity expressed in the narratives were observed. Finally, those expressions that could account for the incorporation of the macro, meso- and micro-sociological levels into the meanings and practices of physicians were addressed.

Ethical aspects

Study classified with risk level higher than the minimum and endorsed by the Research Ethics Committee of the Facultad Nacional de Salud Pública de la Universidad de Antioquia, by means of communication 21030002-0053-2020 dated March 13, 2020. As a potential benefit, the generation of a space for reflexivity and re-signification about health care in victims of sexual violence was proposed. Informed consent was given, and a care procedure was established in case of acute emotional disturbance. There were no cases of emotional disturbance in the study. (OPS; CIOMS, 2016)

Results

From February to December 2021, two institutional journeys were built, two ethnographic interviews were conducted with coordinators of care for surviving victims, 10 interviews were conducted with physicians experienced in emergency care at different levels of complexity, and a pedagogical-didactic workshop was held. These techniques unveiled the route taken by the victims from the entrance at the emergency room to the exit from the institution. Four moments were identified: the admission to the institution, in which pre-screening, screening, billing, and waiting

in rooms are performed; medical consultation, completion of informed consents, examinations; admission to observation where psychological and social work assessments are performed; and, finally, the victim is discharged.

The description of the meanings and practices at each moment allowed us to pool four forms of expression of subjectivities in a spectrum that moves between basic expressions resulting from the socialization process with a structuralist view (Castro; Erviti, 2015), and expressions that account for a process of subjectivation with a reflective and critical view. (Butler; Athanasiou, 2017).

The forms of expressing subjectivities were: a) those that did not acknowledge the problem, naturalized it, made it invisible, and in their daily lives used practical logics and mechanisms of control toward the victims, their peers, and other disciplines; b) Subjectivities that recognized the problem in their narratives, but in their practices continued to naturalize and perpetuate the violation of rights; c) Subjectivities that recognized the problem and in their daily practices, with their own resources, tried to establish a comprehensive encounter; d) Only in two cases a subjectivity that recognized the problem, practiced and promoted transformations for themselves and their environment.

Most physicians were in the spectrum of the first two, where the conditions of comprehensive care for victims could not be transformed because "that is how the system works," leading to expressions related to difficulties of training, space, materials, and time. All situations external to the subject and from a perspective of the quality of services that focuses exclusively on procedures and efficiencies. This reinforces the analysis by Castro et al. that this model leads professionals to be functional to the medical field, reproducing its hegemony.

These subjectivities were expressed by mechanisms of language and practices, depending on the type of interaction established: physicians with victims; physicians with other professionals; and, finally, between physicians and physicians. Patterns such as partial recognition or non-recognition became visible in their interaction with victims of sexual violence as control mechanisms, such as blaming them for not consulting earlier, for putting themselves at risk or for neglecting their children, discrediting the victims as subjects, disqualifying their role expecting them to collaborate despite their pain, and disqualifying the victim's knowledge and experience by relativizing their story (not believing) or avoiding sharing the results of examinations. There was also the manifestation of naturalization of the abuses from an understanding that it was not sexual violence because it was the partner, or because they are sex workers, or older girls who were presumed to be adults; even the presence of obstetric violence, in this case by means of actual physical punishment, such as immobilizing the victim instead of increasing the dose of anesthesia during a voluntary interruption of pregnancy.

> *We still prefer reading internal medicine and other more specific medical topics on pathology care, but these things that are still important, we walk away. Out of sheer laziness to study, to read something different. (MD2Male)*

> *Then they say: ah, she looks like such a thing, more than that it was not that she was raped, but that she is getting even with that person. This is a very marked comment. (MD3Woman).*

Additionally, other control mechanisms emerged, such as evasion, avoiding providing care to victims of sexual violence because it is not a "medical issue" or because it is not a vital emergency and, finally, the mechanism of eviction, in which the narratives questioned the usefulness of care when "what for" implying that they **have already lost their worth as a person**.

> *Why go for medical care, for a case that happened 7 years ago for God's sake, and to the emergency room, no less! Well, why doesn't the psychologist handle it, a psychologist, social work, yes, and they could determine if she needs psychiatric therapy, etcetera. Or medical therapy. But I think that a lot of time is wasted on the medical side when cases like this happen. (MD1Male)*

The narratives showed that these mechanisms are based on socialization processes built on the socio-historical constructs of being a woman, of being a victim of a violation that affects sexuality,

of what a woman's or girl's body represents. These perceptions are the cornerstone for the development of the conditions that Castro mentions in the medical field as an encounter/dis-encounter between the practical logics of physicians and the needs of women and girls in health services. (Castro; Erviti, 2015).

Likewise, they were present **in the interaction between physicians and other disciplines**, recognizing complicity with nursing assistants, laboratory, among others, where the practical logics were mutually naturalized with codes and jokes. Conversely, an interaction described as conflictive in the work with other disciplines, as in the case of psychology and social work. Above all, with social work, where a clear delimitation of roles became visible: "the medical part" and "the social part."

It could be identified that the medical profession imposes and monopolizes legitimate schemes of health and disease over other paramedical disciplines, such as nursing and pre-hospital care, in this context. However, when other disciplines such as social work enter to dispute the field, tension is produced in response to an alleged threat to the status quo within hospitals, since it is social work that decides "safe discharge" (exit), which could threaten the medical field and habitus. And in this dispute, the victim is made invisible.

> *Look, I challenged a lot the social work care, first because the notes are never in the clinical history. Why, what is it for? I don't know. Well, in the many institutions where I go for my other jobs, the observations of social work are recorded on all medical records. Not in the hospital, in the hospital they are in the road map, i.e., next to what the admissions secretaries prescribe. And yes, so? I don't know. Today I am questioning why the note that one is looking for does not say anything, nothing special. What work are they going to do with that patient? And that's what I don't know either, when she gets out of there, what happened? What happened? How come they take so long; I have never had to discharge a patient. Up to that point, and then? (MD1Male)*

Likewise, a profound incorporation of the patriarchal system was identified, with a sense of subordinate womanhood, subject to "good morals," silent and ready, both for female physicians and for victims of sexual violence. A reflection of this was identified in the interactions between physicians. Expressions of subjectivity were evidenced in the mechanism **of gender role assignment** in which the female physician is assigned to provide care because it is a minor activity, of subordination, and not because the rights of the victims to choose the sex of the person who provides care to her were recognized.

> *The fact is that female doctors have us tagged so that we provide care to victims of sexual violence. (MD5Woman)*

> *So, here we prefer, not because of protocol but because of a certain gender solidarity, we prefer that it be women, female physicians who take care of them. (MD2Male)*

This concept is reinforced in medical training and in institutional health practices (medical field) via gender disciplining (Castro, 2014b). This disciplining materialized in the reports of female physicians related to the gender-based roles assignment and sexual harassment both in their university training and at work. This situation reproduces inequality, discrimination, violence, among other conditions that female physicians face every day.

Discussion

This exercised allowed approaching the understanding of how subjectivities of physicians are expressed in their encounter with victims of sexual violence through this theoretical elaboration based on the hypothesis that non-recognition, in the framework of power relations and inequality of class, profession, and gender, could lead to the impossibility of victims and survivors to exercise health citizenship. What in Castro's words would be what he calls the character of non-person, and in this case, individuals have been stripped of their dignity by a mechanism of ignorance of their possibilities, turning them into objects (reification) with a reduced capacity for self-transformation. In the context of the intersubjective encounter with physicians, this wound could be reopened in what is known as revictimization. (Butler, Athanasiou, 2017).

Castro argues (Castro, 2014a) that such an encounter between the structure of the medical field and the habitus of physicians leads to the social origin of authoritarianism whose result is the violation of victims' rights. These subjectivities, as authoritarian and disengaging medical habitus, could be observed in their interactions and in the use of mechanisms of control of professionals and institutional mechanisms for the reproduction of the medical field. Most of them previously identified by Castro, and others that emerged from the uniqueness of care toward victims of sexual violence.

In this Colombian context and under the same neoliberal perspective, the medical field in its modern medicine subfield, operates regulating the health issue since the medical training, with the systematic disciplining that could be identified in the narratives as sexual harassment during training and the gender-based assignment roles. Similarly, the hierarchical organization of their institutions was visible in the bureaucratic journeys, the complicit silence of professors in situations of violation of rights and tensions with other disciplines, and the exhausting conditions of hospital contexts that denoted hopelessness on the part of health professionals.

In view of the above, the question posed by Castro and Erviti is "To what extent is it possible for them—physicians—to establish citizen relations with health service users, i.e., relations based on equality, knowledge, and recognition of the several health and reproductive rights, on accountability, on non-hierarchical treatment?" (Castro; Erviti, 2015; our translation).

Transforming subjectivities is possible to the extent that this enabled visualizing different forms of expression of subjectivities, meaning that a process of change in meanings and action (subjectivation) has already occurred in adverse contexts mediated by the logics and mechanisms of the medical field. How to transform more and better? According to author's context: by promoting agency, organizing work networks, starting from a collective institutional reflection on medical training that allows transforming university and hospital environments (Foucault, 1977; Menéndez, 1988).

These forms of dispossession as a mechanism of disregarding the subject's possibilities could lead to a detachment of the sovereign subject, which also represents a possibility to detach ourselves from the sovereign medical profession, to question and confront it. To detach oneself from what he/she is and make an autopoietic as a response to the violence generated by the issues of non-recognition in a space where people have the ability to make ourselves with others, even if the recognition was partial. (Butler; Athanasiou, 2017)

There were also other cases of diverse manifestations of recognition identified in physicians, which from the author's perspective point to the possibility of transforming realities in the context of practice by means of two patterns of recognition (Honneth, 1997b) that arise in a linear and spiral manner. In this case of intersubjective encounter with surviving victims, it is essential to consider the pattern of the right, and from this the second pattern which is solidarity, understood as Lopera states as a co-production in the clinical environment, a first step to that culture of mutual recognition that results from the agreement between physicians and "patient" (Lopera Vásquez, 2019)recaídas, discapacidad y afectación en la calidad de vida. Además, se ha estudiado poco en Colombia sobre las barreras (sociales, arquitectónicas y del sistema de salud. In this sense, a comprehensive care of victims and survivors in a symmetrical valuation, where the incorporation of theoretical approaches (rights, differential, gender, and action without harm) grounds the procedures carried out with conscience-cognoscence-sentiment.

Final considerations

Analyzing the physician's subjectivities during their contact with victims of sexual violence contributes to the field of knowledge, especially in public health, because sexual violence is a global problem that is much neglected and has a major impact on the quality of life and health of girls and women. Furthermore, this approach from the point of view of the health care provider offers a perspective that questions and complements other previous theoretical approaches, such as the traditional health model, health care models, and the quality of services. This is based on the conviction that we, as subjects, have a creative capacity for resistance,

with the possibility of offering health care that has an implicit way of living-inhabiting the world in which ethics is based on justice.

Similarly, by approaching this problem from the perspective of the theory of recognition, I gained a comprehensive and hopeful perspective, as I was able to identify different patterns of subjectivity that ranged from the absence of recognition to the recognition of otherness. I think this showed that processes of subjectivation can occur despite adverse structural conditions, which translates into broad possibilities for improving the conditions of care for victims and survivors of sexual violence. This does not mean that the problem of comprehensive care has been resolved; guaranteeing dignified care that leads to the full exercise of citizenship for victims and survivors remains a challenge for public health. The theoretical framework proposed by Castro on authoritarian medical habitus and the contributions developed by Fernández in relation to institutional health practices allowed me to recognize in greater depth the way in which discourse and practices expressed these subjectivities in their contact with victims and survivors via mechanisms and interactions.

The next step I propose, based on my experience, is to invite educational institutions and health services to reflect internally to recognize these mechanisms and interactions (and other emerging ones) and incorporate the theoretical and philosophical approaches of recognition, the ethics of care and the authoritarian medical habitus, as tools to form a community around professional training and qualification that does justice within the health care field for surviving victims of sexual violence, based on empathy, in sensitive assistance that allows the recovery of trust for life (Boff, 2012).

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Authors' contribution

The theme's formulation, the construction of the theoretical framework, the study design, the collection, processing, analysis, and presentation of results were carried out by the main author as part of her doctoral thesis project in Public Health at the National Faculty of Health. Public of the University of Antioquia, Medellín, Colombia.

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