Doctors Doing Gender at Eye Clinics—Gender Constructions in Relation to Waiting Times for Cataract Extractions in Sweden

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ABSTRACT

Why do eye clinics differ in their waiting times for women's and men's access to cataract extraction (CE)/"grå starroperation"? Taking a doing-gender perspective as the starting point, this study explores how gender constructions embedded in Swedish eye clinics contribute to longer waiting times for women than for men. Focus group interviews were conducted with doctors at two Swedish eye clinics: one with a larger and another with a smaller than average gender difference in waiting times for CE. Several differences were found between the clinics regarding how gender was constructed: Women and men were constructed as different with respect to ascribed traits such as assertiveness and care-seeking behaviour. Their need for visual acuity in working life was perceived as different by the doctors, and the study indicates differences between the clinics regarding their interest and awareness concerning issues related to inequity, reflected in the dissimilar prevalence of jokes with racist and misogynist connotations at the two clinics.

Introduction: gender differences in waiting for cataract surgery

Research into gender medicine has pointed out that differences that are not proven to be medically motivated exist in several areas concerning women's and men's access to medical care, both in Sweden and internationally, and that stereotypical notions about gender can affect the quality of medical care (Andersson, 2012; Hovelius & Johansson, 2004; Risberg, Johansson, & Hamberg, 2009). One of the areas in Swedish healthcare that has attracted attention due to potential inequality is cataract extraction (CE). During CE, the damaged eye lens is removed and replaced with a new, artificial lens. CE is a relatively simple and safe operation, requiring neither general anaesthesia nor in-patient care.

With more than 100,000 surgeries performed each year, CE is Sweden's most common operation. Women in general have longer waiting times for CE, are older, and have poorer...
vision than men when gaining access to surgery (Smirthwaite, Lundström, Albrecht, & Swahnberg, 2014; Smirthwaite, Lundström, Wijma, Lykke, & Swahnberg, 2016). The National Board of Health and Welfare (NBHW) has identified this difference between the access to care for women and men as constituting an interesting example of where both gender and age discrimination can occur (National Board of Health & Welfare, 2004).

Even though women in general have longer waiting times than men for CE, there are variations between different eye clinics. This research project started with the question of why some eye clinics have smaller gender differences in waiting times than others. Our hypothesis was that local gender constructions at the clinics could be relevant to differences in the gender gap in access to CE. The hypothesis was underpinned by research on gender constructions among doctors in a Swedish context which shows that doctors tend to interpret women's and men's health status differently, even in cases when the symptoms are the same, and that doctors may interpret women's symptoms as less severe and caused by psychosocial factors to a greater extent (Andersson, 2012; Risberg, Johansson, & Hamberg, 2009). The well underpinned hypothesis that, due to gender-stereotypical notions among doctors, women and men are at risk of being treated differently, and having different access to care, even in cases where the same treatment or access are medically motivated, constitutes part of a larger theoretical complex called medical gender bias (Risberg et al., 2009).

Aim and research question

The aim of this research was to explore and compare gender constructions between eye clinics with larger and smaller differences in women's and men's access to CE, in order to identify attitudes and gender constructions of relevance to understanding why men have shorter waiting times than women, and why there is a difference in the gender gap in waiting times between clinics.

The specific research question is: How is gender constructed among doctors in the context of Swedish eye clinics, and what role does local awareness of possible gender inequity play in these constructions?

Theoretical framework: doing gender and medical gender bias

The core concept for the study is the construction of gender, which takes its starting point in a doing-gender perspective. Doing gender was introduced by West and Zimmerman (1987), who distinguish between sex, sex category, and gender. They define sex as a “determination made through the application of socially agreed upon biological criteria for classifying persons as females or males” (p. 127). Concerning the sex category, they state: “Placement in a sex category is achieved through application of the sex criteria, but in everyday life, categorization is established and sustained by the socially required identificatory displays that proclaim one's membership in one or the other category” (p. 127). Gender is described as “the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one's sex category” (p. 127). Within the concept of “doing gender”, gender is perceived as something that people do in their everyday social interactions; it is an activity rather than roles or fixed and static categories or sets of traits within individuals (Fenstermaker & West, 2002; West & Zimmerman, 1987). Gender is “done” when people act in relation to norms and notions of gender. Hence, situations in healthcare
could also be seen as scenarios where gender is done. Since the concept of “doing gender” was launched (West & Zimmerman, 1987) it has developed to become more explicitly open to including other categorizations, such as race, in the “doing” (West & Zimmerman, 2009). We assume that corresponding phenomena can be discussed as “doing race”, or “doing class” (Staunæs, 2003).

The method used for data gathering in this project was interviewing eye specialists in focus groups, and thus we analyse speech and discourses rather than the actual doing in the interaction between doctors and patients. For example, we analyse which needs and behaviours the doctors ascribe to female and male patients; in other words, how they construct gender in the patients. We interpret these constructions as one of the means by which medical personnel are doing gender. Another theoretical concept of relevance to this study is medical gender bias (MGB). MGB is described as a complex and multi-dimensional phenomenon, involving doctors doing gender in ways that cause and sustain inequity in medical care. Due to space limitations, we do not elaborate upon MGB in this article, but we acknowledge it as an important theoretical concept for our hypothesis; gender constructions among doctors can result in differential access to CE among male and female patients (Risberg et al., 2009; Ruiz & Verbrugge, 1997).

Material and methods: focus-group interviews at selected eye clinics

Data gathering and material

The material for this study consists of focus-group interviews with doctors at two eye clinics. Written informed consent was obtained from the participants. The eye clinics were selected in cooperation with The Swedish National Cataract Register (NCR), which covers 98% of all CE performed in Sweden. The five clinics with the largest gender gap in access to CE, and the five clinics with the smallest such gap, were asked to participate. The gender gap in access was defined as the difference in mean waiting time for women and men, from the date of decision to operate to the date of surgery. Two of the clinics chose to contribute to the study with the number of staff and the amount of time that was needed to conduct focus-group interviews. At one of the clinics (hereafter called Clinic X), women had on average 10 days longer waiting time than men. This constitutes a relatively large gender difference since female CE patients in Sweden on average queue 3.73 days longer for surgery than male CE patients (Smirthwaite et al., 2016). At the other clinic (hereafter called Clinic Y), men on average had two days longer waiting time than women, which breaks the common pattern that women wait longer than men for CE.

The participating clinics had the following in common: approximately 15–20 eye specialists employed, situated in catchment areas displaying a mixture of rural and urban settlements with similar educational facilities and industries. As is common in Sweden, the eye clinics were run by the regional or county council health authorities, which are tax-funded.

A focus group (FG) is a special group when it comes to purpose, size, and composition. The purpose is to gather qualitative data through a focused discussion (Morgan, 1997). The focus-group interview (FGI) is conducted as a group interview. It is a carefully planned discussion concerning a well-defined topic, and it is a way to better understand how people feel and think about an issue (Krueger & Casey, 2009).
Compared to other types of interview, the FGI is characterized by a more free-flowing conversation. Through the dialogue, access is achieved to the interpersonal understandings and diverse dimensions related to the question under consideration. During the discussion, participants will communicate ideas and experiences to each other, which in turn stimulate the discussion so that further information will be generated (Morgan, 1997). We find FGIs to be a suitable method to study the construction of gender among eye doctors in specific eye clinics.

Participants for the FGIs were selected through purposeful sampling and consisted of eye specialists. These are the doctors who examine patients and determine whether they are to be put on a waiting list for surgery and, if so, whether the patient is to be prioritized. The doctors were invited to the interview with a letter explaining the study. The aim was to include all the doctors, but, for practical reasons, for example sick leave, this was not possible. One FGI was conducted at each clinic. Each interview lasted approximately 45 minutes and was digitally recorded.

Presentation of the focus groups

All the names of participants and references to geographical areas of the clinics are simulated.

The group at Clinic X (Group X) consisted of four women and seven men. In terms of speaking time and interrupting others, the group was dominated by three middle-aged white men—Sverker, Per, and Bertil—who were all senior doctors and had worked at the clinic for more than 10 years. Among the others who took an active part in the conversations were the following female doctors: Birgitta, a middle-aged white doctor, Emily, a young white doctor, and Aurora, a middle-aged racialized doctor, and the following young male doctors: Linus (white) and Sergej (racialized).

The group at Clinic Y (Group Y) consisted of seven women and five men. This group was dominated by women, both in numbers, speaking time, and the interruption of others. The dominant persons in the group were Alice, Annika, and Britt, all middle-aged white senior doctors with more than 10 years’ employment at the clinic. Among the other persons who took an active part in the discussions were Göran, the male, middle-aged head of the clinic, and Nils, a male, middle-aged senior doctor.

In both groups, about half of the participants could be categorized as racialized, while the other half passed as white native Swedes with Swedish as their mother tongue. A common factor for the majority of the racialized doctors in both groups was that they were younger and had worked at the clinics for a shorter time than the majority of the others. The racialized participants took a smaller active part in the discussions.

Field notes

Some parts of the data consisted of field notes concerning what information the contact person at the clinic had given the participants prior to the interview and how the group had prepared for the interview. Field notes were also taken about interactions; for example, which persons dominated the group by often spontaneously starting to speak, speaking for a long time, making jokes, interrupting others, and/or being a person to whom other members of the group often related.
Method of analysis

Each interview was transcribed into a full text body, and transcribed verbatim according to the principles recommended by McLellan, McQueen, and Neidig (2003). A constructivist approach, following Charmaz (2006, 2008), was chosen for the analysis of the interviews and field notes. According to Charmaz, the researcher and researched co-construct the data—“data are a product of the research process, not simply observed objects of it” (Charmaz, 2006, 2008, p. 402), an approach that we find to be coherent with West and Zimmerman’s interactionist theoretical approach (West & Zimmerman, 1987).

We have adhered to the following recommendations for initial coding: asking questions, analysing row by row, word by word, keeping close to the raw data, memo writing, comparing data, and using in vivo codes. When some strong analytical directions were identified, more focused analyses were made in accordance with these directions in order to explain larger parts of the data (Charmaz, 2006, pp. 47–73).

In the next section, we present our results, and we begin by presenting the different approaches the two clinics took to the interviews. Thereafter, we present the overarching categories in the clinics’ gender construction, and after that we present the more detailed results which constitute these overarching categories. While doing this, we also compare the clinics to each other regarding their gender constructions and attitudes towards equity.

Results: approaches and gender constructions at the clinics

The different approaches of the clinics to the interview

There were differences in how the clinics handled the interview, which might be relevant since these different approaches could be indicators of how the clinic’s management prioritizes gender-related issues. For example, do the management themselves take such an interest in gender that they participate in the discussion? And what is the status of the persons whom the management allocate as contact persons? Clinic Y appointed a senior doctor (Alice), with more than 20 years’ employment at the clinic, as the contact person. Alice had distributed the information letter on the study to the participants prior to the interview, and she took an active part during it, as did the male head of the clinic.

The contact person whom Clinic X appointed was an as-yet not fully trained doctor, who was about to be absent from the clinic for several months to continue her training in another city. She had forgotten about the interview and had not distributed the introductory letter to the staff. The interview thus came as a surprise to her co-workers, who had expected to be attending a regular workplace meeting. The head of Clinic X did not participate, but attended the meeting initially to inform his co-workers of some errands and then left before the interview started.

Overarching categories

We constructed three major categories with relevance to the aim of the study based on the ways in which the focus-group participants were conceptualizing gender as they talked. The categories were: doing gender in relation to the need for CE, ascribed traits and care-seeking behaviour, and attitudes towards inequity. These three major categories were in turn divided into subcategories, which are illustrated by quotations and references.
Doing gender in relation to the need for cataract extraction

This overarching category includes areas that doctors at the clinics pointed out as relevant to women’s and men’s need for CE.

Working life

Clinic X emphasized working life, in particular that of men, in discussions on gender-related needs to see well. Occupations such as engineers and drivers were labelled as male and emphasized as needing good visual acuity. Work labelled as female was not constructed as requiring good visual acuity, but rather the opposite:

… it depends on what occupation they have, how great the demands for visual acuity of their occupations are. It might be that men more often drive cars in their work … whilst a woman, if she’s a care worker, or whatever she is, might not need her visual acuity in the same way. (Bertil)

There was no construction of differences in women’s or men’s work concerning demands for visual acuity at Clinic Y.

Driving

Both clinics highlighted the ability to drive as a crucial area that needs good visual acuity. Similarly, both clinics constructed masculinity as more closely tied to cars and driving than femininity, but the link between masculinity and driving was emphasized more strongly at Clinic X than at Clinic Y. For example, Clinic X presented driving as something very closely linked to regional masculine identity: “Taking the driving licence from a man in this county is like taking the gun away from a man in Texas” (Sverker).

There was a tendency, especially among some dominant men in Group X, to construct driving as an exclusively male activity, and women as passive passengers. This was disputed by a female participant, who argued that quite a large number of older women had driving licences, and had actually driven cars.

Sverker: One is very dependent on the car in County X, you know.

Interviewer: Do you see any differences between women and men here? …

Per: Yes, it’s the driving.

…

Birgitta: But there’s more older women who have a driving licence today … I think it’s quite a lot who have a driving licence.

Per: Yes, but even if they’ve got one, it’s not always the case that they drive … if they are, if they’re a couple …

Birgitta: Yes, but I mean they have driven anyway. Not only that they’ve got a driving licence and the husband drives, but that they have been driving themselves.

Per: Yes, well.

Per conceded seemingly unwillingly to Birgitta in this discussion, but when it was summed up, Per again pointed out driving as a need exclusively concerning men.

It was mentioned at Clinic Y that elderly men more often had a driving licence than did elderly women, but there were no examples that corresponded with the tendency at Clinic
X to construct driving as an activity or need exclusively concerning men. It was common to both clinics, however, that heteronormativity was not once questioned during the interviews. The heteronormativity became especially prevalent in discussions on driving; for example, in the one quoted above, where couples were assumed to consist of a man and a woman.

A difference between the clinics was that men were explicitly constructed as safety risks at Clinic Y, but not at Clinic X. Men were said at Clinic Y to drive irrespective of whether they could see well enough or not, while women were said to cease driving when their vision became poor. Men were said not to care about their visual acuity when driving in the same way as women did.

Annika: Men might not care about this in the same way. They drive because they’ve driven without any complaints for 90 years!

Alice: Ha ha ha ha

... Nils: They’ll drive anyway.

Britt: Yes, exactly.

It was mentioned at Clinic Y that neighbours of men with poor visual acuity who still drove their cars were frightened. It was also said that the tendency among men to drive in spite of very poor vision could have consequences for prioritizing among CE patients. For example, Britt said:

I think men get access because they see badly, they kind of get access a bit quicker, if they need to drive, they will drive (…) and then they get access quicker than women. (Britt)

Stereotyping jokes were told about gender and driving at both clinics, but with different implications. The jokes at Clinic Y were at the expense of men, directed at a tendency among men to overestimate their own competence and to underestimate risks. Men were said to think that they saw “very well indeed” when they actually had very poor vision, and it was said that they excused their driving because they were “only going to the shop”. These types of jokes engaged most of the group and were often followed by general cheerfulness.

The jokes about car driving at Clinic X were directed at women as incompetent drivers. In a discussion that concerned the increase in the number of women drivers over the past 20 years, Sverker remarked: “But nowadays cars have become easier to drive.” This caused general laughter to spread in the group, laughter which increased in intensity when Sverker continued: “And there are also warning systems when reversing!”

Our interpretation of this joke is that the reason for more women driving cars today is that cars nowadays have become so easy to drive that even a woman can do so.

**Hunting**

Men’s need to see well was related to hunting at both clinics, especially hunting for elk, which was constructed as an exclusively male activity. Male patients at Clinic Y made it clear that they were not able to come to the hospital during the hunting season, so that the CE had to be performed either in sufficient time before the season or afterwards.

Men’s eagerness to participate in hunting for elk, even while having poor visual acuity, was constructed as a safety risk at Clinic Y. Annika stated that this did not affect men’s access to CE, but this was disputed by Alice:
Alice: But I don’t think this is true. I actually think, when there’s a man who you know hunts and if he doesn’t get operated on he will still hunt, and then there’s the risk that he wounds or kills somebody

/Here two female doctors hum approval./

Alice: So, mentally I think one will be affected by that. After all, it is a murder weapon they’re handling. So I think that one’s eager to see to it that they get operated on.

The participants at Clinic X also described hunting as important for men in the region, but without constructing men’s behaviour as a safety risk.

**Reasons for female patients to be able to see well**

On the question of whether there were gender differences in the need for CE, Per at Clinic X gave an answer that indicated driving and hunting for elk for men, but he did not mention women’s needs at all. Emily responded to this:

Emily: Then one might think that elderly women perhaps do more needlework ...? /Phrased like a question./

Per: Yes.

Emily: ... so then they ... they should also need to see well ...

The last words were uttered in a very small and almost silent voice. Emily did not receive any response to this from the group.

This statement about needlework was the only thing mentioned at Clinic X that concerned women’s need for good visual acuity, apart from the minor dispute about driving quoted above. As presented above, it was questioned at Clinic X whether women needed their visual acuity in working life to the same extent as men. No similar corresponding questioning occurred at Clinic Y, where, in contrast, women’s need for visual acuity was strongly emphasized and exemplified with many reasons and by several participants. The reasons given by those from Clinic Y for women to see well were: driving, reading, cooking, needlework, and crossword puzzles.

**Ascribed traits and care-seeking behaviour**

This overarching category includes the traits and care-seeking behaviour that doctors at the clinic ascribed to male and female patients.

**Assertiveness**

Staff at both clinics claimed, with no hesitation or expression of contradictory views, that patients would clearly benefit by being assertive. However, some different opinions were expressed at Clinic X concerning whether it was men or women who were most assertive or demanding:

Linus: It’s sort of easier for women not to think that their own needs are so important, to play down their problems.

...  

Sergej: Women are a bit more demanding.
On the other hand, Aurora and Emily experienced male patients as more assertive:

Aurora: My ... subjective experience is that the men are often more resolute, that's ... what I feel, and women, women often express their troubles in a slightly more diffuse way. Mostly.

Emily: ... I think I have to say that my experience is that most men might be, well, can be a little bit more assertive, a bit more concrete in their argument about why they want to be operated on ... I experience that women appear more easily to step back and think "okay, then we'll wait" ...

Men's assertiveness at Clinic Y was spoken of by the dominant participants and by the head of the clinic, and with a notably greater certainty than at Clinic X. For example, Britt states, “Men, when they are assertive, they are more assertive than women. More resolute.”

Göran describes men's care-seeking in contrast to that of women:

... they are at it, so to speak, then they are impatient for it, and then, they really want to be operated on now, "I want it now", while women, even if they seek it, so to speak, “yes, I can wait, it isn't that much of a hurry” and suchlike ... (Göran)

Gender and assertiveness were constructed in intersection with age at both clinics—younger patients, and especially men, were constructed as being more assertive than older patients.

**Men as late care seekers**

The participants at both clinics spoke of a tendency among men to be unwilling to seek care and to wait until a later stage of the illness. The late care-seeking men were said at Clinic Y to “be forced here by their relatives”, “when they can't see to drive”.

It was mentioned at Clinic X that older men in particular might be more afraid to seek care than women. Men's late seeking of CE was referred to as a part of the “male syndrome”:

Sverker: Men can have a small tendency to play down, more than women I think. It's part of this male syndrome.

Interviewer: To play down....?

Per: Their health condition.

Sverker: Yes, their health condition.

After this was said, several of the men in the group continued to construct a picture in which men played down their health condition and waited a long time before seeking care, for example, CE.

**Why are men more assertive?**

At Clinic X, men's late seeking of care was suggested as an explanation for assertiveness:

Might it be that it is, that women ... seek help earlier and more often and don't feel troubled to the same extent, while the man has been pondering for a while and feels that now, now this doesn't work any more, he feels that it doesn't work, for example, driving the car or something like that, and when he comes to the doctor, he's very hard to persuade ... because he's been pondering about this and now he really wants help ... So he has in some way taken this a step further in his own reasoning, whilst she went as soon as she felt troubled. (Per)
At Clinic Y, men’s late seeking of care was not used as an explanation for their assertiveness. Instead, Group Y mentioned the time aspect linked with the hunting season, but mainly spoke of an attitude whereby men perceive CE as a right. The following explanation of men’s assertiveness met with much approval in the group:

Alice: But I think that, above all, when it comes to an operation, that men also to a greater extent see an operation as a right. I have the right to …

/Humming approval from the group./

Alice: I have paid my taxes so indeed, now I shall …

/Humming approval from the group./

Göran: Yes, I also think so.

Older women, according to Alice, were brought up in a tradition that encouraged them to set themselves aside, while it is easier for men to claim their rights:

It’s a tradition that “oh, it’s not that bad, I shan’t complain, not little me; there are others who need this more.” I think it’s above all older women who are brought up to not … complain and whine, whilst I think that it’s easier for men to claim their rights and to say that they indeed have great troubles. (Alice)

The ways of doing gender employed by the dominant persons in Clinics X and Y were notably different, and these different ways of doing gender may have implications for the extent to which the higher level of assertiveness among men is seen as legitimate, a question to which we will return in the discussion section.

**Attitudes towards inequity**

This overarching category includes comparisons of how the focus groups identify situations where there is risk of inequity, how they explain situations which can entail inequity, and what kind of interest and awareness they show concerning topics related to inequity, among patients, among male and female doctors, and in the surrounding society.

**Inequity among patients**

The risk of unfairness among patients was explicitly mentioned at both clinics, but only by female doctors. A rule at Clinic X was that patients should not be operated upon unless they had reached a certain limit of poor visual acuity. Aurora at Clinic X said that it is “fairer” to establish a certain limit of visual acuity for when the patient gets surgery, instead of letting it be determined by the difficulties the patient describes:

When one is only guided by the difficulties, one can sometimes be manipulated by somebody who is a bit more assertive and maybe does not have so much difficulty, but speaks of the difficulties in such a way that the doctor is persuaded. That’s the way I think. (Aurora)

Aurora then stated that, according to her experience, men could be more resolute while women spoke of their difficulties in a more diffuse way. Apart from it being stated that assertive behaviour benefits the patient, Aurora was the only person at Clinic X who explicitly mentioned a risk of unfairness among patients (a risk that, following Aurora’s reasoning, would not be valid at the clinic, due to its guidelines setting a strict limit of visual acuity in giving access to CE). None of the participants at the clinic answered yes to a direct question
of whether there were any differences in women’s and men’s access to CE, but some in the
group said “no”, “it shouldn’t be”, or “I don’t think so”. Per’s answer to a question about
whether there were gender differences in access to CE on a national level was: “I don’t think
they divide the waiting lists by gender or anything like that, so those who are to be operated
on will most likely access surgery when they ought to.”

The direct question about differences between women’s and men’s access at Clinic Y led
to a discussion in which unfairness was emphasized regarding the use of a prioritizing tool
that the clinic had stopped using, and that contained a questionnaire in which one of the
questions was whether the cataract hindered driving. If the patient answered “yes” to this
question, then according to Alice this resulted in a higher priority, which in turn benefited
men:

/Women/ they thought like this: “okay, I’ve such poor vision that I can’t drive the car, so then
I skip driving.” So then there was not a problem, because they had already stopped doing that.
Men, they don’t skip it, but experience it as a problem, and signal that they have very great
difficulties—high score. Women: no difficulties, because I have already stopped driving. And
that seems to me severely unfair, so we don’t use it any more. Because I think it’s a glaring
piece of injustice. (Alice)

It was also stated during different parts of the interview with the doctors at Clinic Y that
they might be affected by the knowledge that men would continue driving and hunting,
even with very poor vision. It was said that the doctors were thus likely to make sure to
“get the operation done” and that men will “gain quicker access”. This was stated by the
dominant persons in the group. Our interpretation is that there was an explicitly acknowl-
edged awareness at Clinic Y that patients might be treated differently according to their
gender-related behaviour, and in ways that might shorten the male patients’ waiting time.
Another example of this is when Göran, considering that men were more assertive than
women, stated: “Thus I can imagine that it’s possible that it takes a bit of a longer time from
referral to surgery /for female patients/.”

**Explanations concerning a minority group**

There was one special group of female patients who both clinics noted sought help at a
very late stage—this was migrant women from countries south of the Mediterranean. We
assume that the group of women discussed in this case are positioned in an intersectionally
(Crenshaw, 1989; McCall, 2005) subordinated position, due to intersections between female
gender, racialization, advanced age, and a social grouping characterized by low income and
low educational level (Smirthwaite et al., 2016).

There were notable differences in terms of how the clinics constructed explanations for
the late care-seeking among this group of women. The only explanation mentioned at Clinic
X was that the women were hindered by their husbands:

In the southern parts of Simulatecity /referring to suburbs with many racialized inhabitants/,
they hardly allow the women away from the stove, so they can’t get access, it can be that the
women see very, very poorly before they are allowed access, before the husband lets them
leave the stove. (Sverker)

This comment generated much laughter in the group, and nobody objected to what was
said or offered alternative explanations.
Alice at Clinic Y said that the behaviour of seeking help at a late stage among immigrant women from countries south of the Mediterranean Sea “had to do with culture”. Alice stated earlier in the interview that older women were brought up in a tradition in which they were taught not to “complain and whine”. Culture and tradition can be closely related terms, but it is unclear whether she meant that the tradition in which older women were taught not to “complain and whine” also included the cultures in which these immigrant women were brought up.

When Alice said it “had to do with culture”, she immediately received the following response, which points to difficulties that immigrant women encounter:

But there’s also another parameter which is interesting, and it’s that they actually can’t make their own way in this society at all. They always have a relative who leads the way to medical care. (Annika)

Other explanations offered by the doctors at Clinic Y were that this category of women was afraid of seeking care, and that they had other health problems that were prioritized before the cataract. It was repeatedly mentioned during the interview that women read a lot and that this was a reason for the high level of demand by women for visual acuity. On the other hand, this group of immigrant women was constructed as an exception to this: It was said that illiteracy was common and that they thus did not have the same visual demands as Swedish women of the same age. Nothing was mentioned about the immigrant women being hindered by their husbands.

We suggest that staff at Clinic Y articulated a broader perspective on the late care-seeking of this group than staff at Clinic X. The surrounding society was constructed at Clinic Y as a hindrance that it was difficult for the women to navigate around, which may indicate an awareness of the existence of societal barriers for a group of immigrant women when seeking care.

**Different terms for male and female doctors**

Female doctors at both clinics spoke of experiences when patients had a different attitude towards them than to male doctors. This experience was described in terms of being met with less respect, and of having to work harder to gain the same level of confidence as male doctors received. Aurora at Clinic X said that the patients met female doctors with less respect than male: “They show less respect; clearly, one can feel that when one wants to show a patient to another colleague or something like that, then one notices that the patient behaves in a slightly different way.”

Emily had also noted a difference, but she emphasized that the patients were not negative, and she ascribed the patients’ behaviour to a great extent to the fact that she was young.

I think one … as a young female doctor, I think one notices quite often when one has older patients, that they are not negative in any way, but that they are a bit surprised, like … “oh, are you already, are you a doctor? … you could be my grandchild …” (Emily)

Two of the young, male, racialized doctors also talked about patients behaving differently depending on which doctor they met, but female gender was not clearly stated here as something negative.
It was stated at Clinic Y in a resolute way by the female doctors that the conditions for them differed in a negative way compared with conditions for male doctors. Alice answered a question about whether female and male staff treat patients in the same way:

*Of course* one doesn't. You obviously ... can't treat a patient in the same way as a man does, and that obviously will not be accepted. A man can be quite surly and grumpy, and still one thinks he is a good doctor ... But you can't as a woman. In every, every situation, you *have to* prove that you're trustworthy. You have nothing for free. You always have to *work* with every patient, you have nothing for free. So it's obvious that there's a difference. (Alice)

Alice received much approval from other female doctors as she said this. Statements about different conditions for male and female doctors also met with concerned questions from some of the male doctors. For example, Göran, the male boss, seemed deeply concerned. The following lines demonstrate how female doctors stated that it was a matter of course that they had to behave in a certain way, and that this was a long process to learn.

Göran: I'm astonished; I have to say ... that Alice says that one has to behave in a certain way.

Alice: Yes *of course* one has to.

Annika: One has to. It's a long struggle, I'd like to say.

Alice: Yes. It's a long training.

Annika: Yes.

Alice: One will learn.

We found the following differences between the groups regarding discussions about different conditions for male and female doctors: It was clearly stated as a matter of fact at Clinic Y, with no hesitation, that female doctors had to behave in a certain way. Several female doctors agreed to this. There was more hesitation at Clinic X concerning female doctors having disadvantages, with the exception of Aurora, who clearly stated that female doctors were met with less respect.

A comparison was made of the position of the persons who were most prominent at each clinic when speaking about female doctors having disadvantages in comparison to male doctors. We found that at Clinic Y it was a person who was firmly established there (Alice) and who met with much approval and interest from the group when speaking about this. The person at Clinic X was Aurora, who compared to Alice was less established in her group. Aurora had immigrated to Sweden and began her work at the clinic about a year prior to the interview. She did not get the type of approval that Alice received in her group, and neither was she asked any follow-up questions by the group.

**Inequity in society**

The view expressed at Clinic Y that men are met with more respect than women was expanded to be valid for society in general. During the conversation about female doctors being met with less respect, the following was said at Clinic Y:

Britt: This is probably something general, it's not only cataract, it's the relations in working life.

Alice: It's not only in working life, I mean, that's the way it is.

/Humming approval and the word “yes” from female participants./
There was no tendency at Clinic X to expand the view that women are met with less respect to something that was more generally true in working life or society.

Several times during the interview the participants from Clinic Y manifested something that we label as awareness of risk of inequity, an awareness that is relevant to healthcare as well as an overarching gendered pattern in society. For example, Clinic Y paid attention to men having higher wage levels than women, and showed an interest in whether this could affect access to CE:

If one looks at the private /clinics/ and it’s paid for by the patients themselves, which will cost them money—is there a difference there? That men have more, higher wages, and buy more surgery than women, is there a difference there, have you seen that? (Alice)

This type of question or references to financial differences between men and women never occurred at Clinic X.

Discussion—limitations and different gender constructions

Limitations

This study has focused on how eye specialists construct gender in discussions at their clinics. In addition to how these specialists construct gender in their talk, we assume that the following factors are relevant to the gender gap in waiting times for CE: doing gender in the interaction between patients and healthcare staff; doing gender among other groups of staff, such as nurses; and intersectional gender constructions outside the eye clinics. We assume that all of these factors together could be relevant to the gendered differences in waiting times for CE. However, this study is limited in that it only focuses on constructions of gender among eye specialists, and narrowed down to how constructions manifest in the eye specialists’ discussions. To cover such aspects as interactions between doctors and patients, other methods would have been required.

Differences in attitudes and awareness of inequity

There are many circumstances that indicate a greater interest in gender-related inequity at Clinic Y than at Clinic X. The differences in how the clinics prepared for the interview and the differences in the managers’ participation could indicate that the leadership at each clinic varied in their interest in and prioritization of gender-related issues.

Furthermore, Clinic Y but not Clinic X manifested an interest in gender equity and in the risk of gender inequity expanded to society in general, concerning such issues as differences between women’s and men’s wages and women being met with less respect than men. These circumstances relating to the surrounding society were never mentioned at Clinic X.

It was explicitly acknowledged and exemplified at Clinic Y that patients might be treated differently according to their gender-related behaviour, while Clinic X gave no such examples and denied that men and women were treated differently.

We find it relevant to take into account the positions of those who expressed views reflecting awareness of gender inequity. At Clinic Y, inequity was primarily brought up by Alice, and at Clinic X primarily by Aurora. Alice’s statements related to inequity, in contrast to those of Aurora, were generally met with great approval, follow-up questions, and comments from the group. We find it reasonable to suppose that views concerning inequity are
probably more influential when expressed by firmly established dominant persons, which was the case at Clinic Y.

We also suggest that the difference between the ways of making jokes at the clinics reflects a difference in awareness and interest about inequity. Jokes with racist and misogynist connotations were told at Clinic X without any protests. Instead, both the statement about immigrant women who were not allowed by their husbands to leave the stove, and the joke implying that women cannot drive cars, caused general laughter in the group. Misogynist or racist jokes did not occur at all at Clinic Y; instead, the jokes there were mainly targeting a tendency among men to overestimate their own driving skills and underestimate the risks and thus were in line with stereotyped notions of men as more careless and prone to risk taking in traffic situations than women.

Using these examples, we have indicated differences in attitudes and awareness concerning inequity and gender between the clinics. We suggest that these differences are relevant to understanding how the clinics constructed gender, and also to the difference between the clinics’ gender gap in waiting time.

Differences in articulating women’s needs

There was also a difference in how the clinics manifested awareness of women’s need for good visual acuity. Several participants at Clinic Y were engaged in presenting a variety of reasons for women to see well, while at Clinic X reasons for women to see well were rarely mentioned. Since women’s needs were not articulated at Clinic X, one cannot exclude the possibility that women’s needs were not identified or (unconsciously) given low priority. This could contribute to longer waiting times for women at Clinic X. If it is a common phenomenon that elderly women's needs are unidentified, unarticulated, or given low priority, this might be related to longer waiting times for women in general for CE in Sweden.

Working life

Some occupations were constructed at Clinic X as being male (drivers, engineers), and the need in these occupations for good visual acuity was emphasized. The working life of women was at the same time explicitly questioned in terms of the need for good visual acuity. One cannot exclude the possibility that the construction of traditional male occupations as more demanding in terms of visual acuity contributes to shorter waiting times for men. This might be valid both at Clinic X and at other clinics if such constructions are evident there. However, statistical analyses also show longer waiting times for women in age groups much older than the common retirement age in Sweden (Smirthwaite, Lundstrom, Wijma, et al., 2016). We hypothesize that there is a relationship between shorter waiting times for men both before and after working life in terms of a deeper pattern in which what men do is valued as being more important than what women do (SOU, 1997).

Driving, hunting, and safety risks

Men were constructed at both clinics as being more closely linked with driving and hunting than women, which is in line with common gender stereotypes. The safety aspect is relevant here and might affect a clinic’s inclination to operate quickly. Differences between
Clinics X and Y were that staff at Clinic Y clearly expressed the notion that men could be operated upon quicker or at an earlier stage than women due to a tendency among men to drive and hunt even with poor visual acuity. We cannot declare that research would confirm that men drive and hunt with poor visual acuity. It was, however, the experiences that were expressed by staff at Clinic Y, and we interpret this in terms of those from Clinic Y expressing awareness of the staff’s perception of the possibility of gender-related behaviour patterns affecting waiting time. If it is a common phenomenon that staff at eye clinics perceive men as unwilling to stop driving even when visual acuity is poor, we suggest that the perceived safety aspect in relation to driving could contribute to shorter waiting times in general for men for CE. Another contributing factor could be that clinics take the risk of patients losing their driving licence into account when prioritizing for CE, and it is more common among elderly men than elderly women to have a driving licence. Furthermore, since cars and driving are closely linked to the construction of masculinity (Balkmar, 2012), we cannot exclude the possibility that staff at eye clinics—consciously or unconsciously—value the ability to drive as more important for men than for women, and that this also affects waiting time.

We also suggest that hunting is a contributory factor to shorter waiting times in general for men, both because the hunting season entails a time aspect that clinics might consider when prioritizing, and also due to the safety risks that attend the handling of a “murder weapon” when visual acuity is poor.

**Assertiveness**

Male patients were constructed as more assertive than female ones at both clinics, and staff at both clinics said that they were convinced that assertiveness could shorten a patient’s waiting time. We suggest that a contributory reason for shorter queuing times for CE for men in general could be related to a combination of a greater degree of actual and/or anticipated assertiveness among men.

Even if both clinics constructed male patients as more assertive than female ones, there were differences in how the clinics explained men’s assertiveness. It was related to a visually demanding working life by staff at Clinic X. A persuasive reason for seeing well is that one needs to be able to perform one’s work, and thus we find that the working-life explanation has a legitimizing effect. At Clinic X, men were also constructed as *playing down* their health condition, whilst women were said to “seek care as soon as she felt troubled”. We link this to a more general discourse in which women are constructed as seeking care for small matters, while men who seek help have real and serious problems that need to be treated quickly (Andersson, 2012; Hovelius & Johansson, 2004; Smirthwaite, 2007; Smirthwaite, Tengelin, & Borrman, 2014).

Elderly women, in particular, were said by staff at Clinic Y to be brought up not to “complain and whine”. At the same time, men were said to be assertive and to claim that “they indeed had *big* problems”. Clinic Y emphasized a mentality in which men were more “*at it*” and saw it as *their right* to be operated upon. We suggest that this kind of explanation de-legitimizes men’s assertiveness rather than legitimizing it. We hypothesize that it is more likely for staff to give in to assertive behaviour if they find it legitimate than if they view it as just a means of gaining advantage over others. Since we find the explanations for men’s assertiveness as suggested by Clinic Y to be critical and de-legitimizing in comparison to those expressed at Clinic X, we find it reasonable to believe that the different attitudes
towards men’s assertiveness could contribute to the smaller gender difference in waiting time at Clinic Y.

Furthermore, we find it reasonable to assume that the clinics’ differing attitudes towards the legitimacy of men’s assertiveness, together with the gender constructions discussed in this article, are intertwined with the differences in the clinics’ awareness of and interest in gender inequity, and that this intertwined phenomenon is related to the gender differences in the clinics’ waiting times.

We also find it reasonable to assume that the doctors’ ways of doing gender affect the climate and gender norms at the workplace, and that the clinics’ gender differences in waiting time could be seen as an example of how gender constructions among co-workers in an organization may not only affect the co-workers themselves, but also “third parties”, for example, the patients.

**Conclusions**

At the clinic with the larger gender difference, jokes with misogynist and racist connotations were told without attracting protest. Traditional male occupations were constructed as more demanding of visual acuity, while the need for good visual acuity in women’s working life was questioned. Identifying women’s need to see well rarely occurred. Assertive behaviour among male patients was explained in legitimizing ways. There were indications that gender equity was not a highly prioritized question. Furthermore, there was a factor identified which might contribute to shortening men’s waiting time at the clinic with the smaller gender gap: behaviour among men with poor vision was constructed as a safety risk in relation to driving and hunting. We find it reasonable to assume that there is a relation between the difference in the clinics’ gender gaps in waiting time and how doctors at the clinics are constructing gender, which we have accounted for in this article. If the phenomena described above occur nationally, then they could contribute to longer waiting times for CE for women in Sweden.

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