ORIGINAL RESEARCH

The Hidden Violence of the Gynecology Clinic

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Introduction

This study arose from the need to develop a critical understanding of clinical gynecology. We employed sociological techniques to analyze medical discourse. One of our key findings was the central role played by violence in the clinic.

An extensive literature already exists on the relations between doctors and patients, on gender violence, and on the domination and subordination of women. In this paper, we carefully examined the socio-cultural devices employed in the patient/doctor relationship during interactions between male physicians and women receiving reproductive care.

The current study offers an anthropological-descriptive examination of the relations within a biomedical-oriented clinic in Social Security system of Aguascalientes, Mexico. By analyzing the relationships formed between members of the healthcare team and the women patients they care for, this paper offers a critical look at how medical care is conceptualized within the priority area of Reproductive Health. The focus of this study is find out when this asymmetry turns into gender-based violence and a human rights violation.

Our methodology was based on the centrality of the doctor/patient relationship. In order to observe what was going on we interviewed healthcare professionals and patients. Additional interviews were conducted with the reproductive health unit's managers. To complement the interviews, the investigators assumed the role of participant-observers. This occurred in two ways. In some cases, the observer was a physician who was familiar with the unit. This facilitated the observer's ability to understand the clinical context. In all other cases the observers were not clinicians and not associated with the unit being studied. This permitted less data contamination, decreased bias, and avoided any manipulation of the subjects. The independent observers were designed to assure that all information from the in-depth interviews was collected and recorded objectively. Our goal was to observe the phenomena under study with the necessary distance to obtain better quality data which could be used to develop hypotheses and build a theoretical model. Nonetheless, case studies were chosen to be illustrative.

Our findings offer doctors and other health professionals the opportunity to reflect on their behavior during interviews with patients. They also contribute to a richer, theoretical understanding of the role of gender violence within healthcare institutions that provide reproductive health services.

Background

Our research question could have been approached in a number of ways. From a medical point of view, epidemiological techniques could have allowed us to look at the effectiveness of various procedures. But we wanted to use a novel tech-

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Submitted:
Revised:
Accepted:
Conflict of interest: None reported
Peer-reviewed: Yes

nique that would allow clinicians to hear the voices of their patients. These voices are generally not heard outside of a few specific instances: satisfaction surveys done for quality improvement purposes, and the analysis of patient complaints and suggestions carried out by the Quality Assurance Department.

Setting

This study was conducted in Aguascalientes, Mexico. The setting was the No 2 Hospital of the Instituto Mexicano del Seguro Social (Mexican Social Security Institute, IMSS). It was carried out from 2011 to 2013. We looked for a research setting where male physicians interacted with patients - both male and female - who were seeking reproductive healthcare.

Participants

Initially, we identified users, providers and managers who volunteered to provide us with information that was anonymous and confidential. These individuals underwent an in-depth interview. These subjects also agreed to be observed. Initially the interviews were open. As the research progressed we began to conduct interviews that were more structured so as to determine the deep motivations and emotions of subjects on the research topics of interest.

Recruitment

We initially visited the medical clinics in order to find gynecologists and patients who were willing to be interviewed. A staff meeting was convened by the Chairman of the Gynecology Department to allow the researchers to explain what they planned to do. Access was given to the clinic's medical personnel. The chairman also provided the researchers with the on-call schedule. Six doctors were on-call in the mornings, five in the afternoons, three on the weekends, and four at night. He also provided us with a list of patients who were potential surgical candidates. He offered us a workspace adjacent to his office in order to conduct our interviews. This, however, turned out to be unnecessary since we were able to interview physicians in their own offices. In total four gynecologists agreed to be interviewed. The others either refused, kept delaying the interview, or avoided the research team.

Theoretical Approach

In order to study the social aspects of the doctor/patient relationship we were guided by Goffman's model of symbolic interactionism (1993). As the research progressed we collected model patient histories. We then used the information collected from the interviews and observation to guide discussions whose goal was to problematize and interpret our results.

We put great importance on the social actors working in the clinic. This led to our decision to use interviews as our primary data source. This opened up to us the various rituals and customs of different groups, as well as their specific language and its interpretation. This type of research required the ability to navagate a variety of novel situations and maintain a constant negotiation with the subjects. (Rodriguez 1999). In essence it allows both interviewer and interviewee to each other better.

The Problem

The daily activities of the Reproductive Health Unit at the No. 2 Aguascalientes Hospital offered an appropriate setting within which to study gender-based violence in the delivery of healthcare. There are three areas of conflict within the unit: doctor versus institution, doctor versus professional values, and doctor versus patient. To understand these conflicts we need to explore the various contexts within which these conflicts evolve. They include institutional policies and norms, bioethical guidelines which regulate physician behavior, and social conceptions concerning physicians and their social role.

The Institutional Structure

In Mexico's National Development Plan, reproductive health is considered a priority area within the public healthcare sector. The national plan reflects Mexico's international commitments to promote gender equality in reproductive health and to eradicate gender-based violence.

The Mexican state has made a formal commitment to develop public policies to address inequities

in access to care and to decide which strategies - political, medical or legal - will be used to diminish or eradicate gender violence in the healthcare system. These national public policies have been disseminated and then operationalized at a local level. The most important actors in this process are the physicians and gynecologists. They are the ones who care for women within the Mexican healthcare system and thus are ultimately responsible for implementing the governmental plan.

There are however two essential players in this game: the doctor and the patient. All relationships between two people are necessarily social relationships. Studying this social interaction can provide information regarding gender-based violence in healthcare.

Physicians differ from patients in a variety of ways. These include social position, gender, status, health status, dress, appearance, and knowledge. Each of these has symbolic meaning and each of these can confer power and authority to the physicians. The theory of symbolic interactionism offers a way of using social behavior and language - both written and spoken - to examine how values become attributed to symbols and their meaning. These various characteristics may lead social actors to look at each in different ways, perhaps even to alienate them, thus creating an asymmetric relationship.

The doctor-patient relationship is typically set up as an asymmetric interaction; this implies the use of power, making it - in principal - a violent relationship. Medical discourse sees this power differential as having a "functional" purpose. However, we need to examine what are the consequences of such inequality. This leads us to further consider the examining room as the area in which medical work is done. Within this area doctors are allowed to exercise their power, a power which has been legitimated by custom and practice. We can also ask when the use of this power becomes an unacceptable human rights violation for female patients.

It is of particular interest to see how these social practices play out in daily practice and how they are understood by our subjects. In this analysis the interpretation of symbols becomes important.

As mentioned previously, gendered-based violence and its associated symbols may be expressed in the asymmetrical relationship between doctor and patient. Medical discourse, for example, legitimizes the authority of the doctor to make the decisions. The doctor's superior knowledge justifies his power to decide on the basis of "medical appropriateness" (i.e. avoidance of mortality and morbidity).

These relationships play out in the context of health institutions within which they are accepted. As a consequence, we can speak of institutionalized gender violence. The power balance becomes fundamental to the structure of the clinic and is mirrored not only at the institutional level, but also in national health policies. These various levels will be examined using Goffman's theory of symbolic interactionism.

Within the hospital, the doctors' power establishes a pecking order in which the patient's role is to obey. The possibility that the physician may abuse his or her power - creating a situation of violence - is accepted. Such cases might occur when the physician forces a patient to accept a decision and negates the patient's ability to freely offer her informed consent concerning matters affecting her health.

The interaction between doctor and patient in a medical context allows us to identify, describe, and explain the various mechanisms in play as well and examine their social bases. For the purposes of this study we defined power as social tool which explains gendered violence in the doctor/patient relationship. To quote Foucault: (Foucault (2001: 16): "power is not a property, but a strategy that is exerted, no one possesses it, and it allows functionality ...it is like a set of mechanisms that give a solution." Based on this we can understand our observation that behavioral norms are just for the physicians, but apply more generally to the entire clinical staff of the hospital.

Discourses

Differing discourses reflect the position of the actors. Among the most important with respect to gendered violence are public policies regarding reproductive health, bioethical codes, and institutional norms regarding physician behavior. The laws creat-

ing the IMSS specify its vision and mission. The institution is charged with supervising physician conduct and protecting the welfare of its patients; negligence in managing these charges could result in institutional violence. This type of violence occurs when the necessary procedures to ensure the welfare of patients within the health care in reproductive health program are not implemented.

Goffman and Medical World

In order to analyze organized medicine, Goffman (1993) used the metaphor of a theater to explain the behavior of persons in specific settings. He sees the individuals as actors and their behaviors as a form of "acting" in a theater play. There is the stage and there is the area behind the stage. Some of the acting is on the stage; some of it is behind the stage. The area behind the stage dominates what happens as it includes behavior that is hidden.

Throughout their social life, men are continuously performing in such a way as to convey a convincing image before various audiences: family, friends, school, office, etc. It is not important what you are, what matters is what you seem to be.

As performers, individuals must attend to the many rules by which they are judged. However, when they are acting, individuals do not consider the morality of their performance. Their concern is the amoral question of how to appear a certain way. Most of our behavior is motivated by moral principles, but we have no moral concern for our role as actors. Our behavior, when acting, is an attempt to sell a vision of being moral. (Gary, 2006)

Goffman feels that from the moment we get up in the morning we recreate ourselves. We put on a mask that changes and adapts to the circumstances around us. In the course of the day we can wear the mask of father, mother, teacher, doctor, patient, secretary, hospital administrator, etc. This mask also changes when we are behind the stage, studying our lines before going out in front of the public again. In most plays there is a protagonist whose story forms the plot and an antagonist who opposes him. These might be a doctor and a patient. There are also minor actors who play a secondary role; they are analogous to the other members of the healthcare team (Gary, 2006).

In his book *Asylums*, Goffman discussed the concept of a "total institution." Examples of such institutions include prisons, asylums, barracks, and hospitals.

Goffman's work focused on mental hospitals. These institutions have two groups which interact: the interned and the custodians. For the interned there are two basic steps in their integration into any institution. First, they learn the institutional rules and structures. Second, they figure out how to make the institution work to their benefit. (Gary, 2006)

We can use Goffman's ideas to understand the disciplinary functions of institutions. We can even apply them to contemporary IMSS hospitals. Those who arrive for the first time at the hospital need to learn and obey the established rules. This approach sets out the various roles played by social actors. There is the healthcare professional, represented by the male doctor who perform as a traditional male authority figures. Medicine has traditionally been a male profession, and the gender difference is emphasized by the fact that the patients are all women.

Gender distinctions are further reinforced by the traditionally subordinate role played by nurses, whose work complements that of the male physician. This might also be considered evidence of gendered violence. To do so would require a clear understanding of how gender is constructed, how it is tolerated, and how it expresses itself in violence.

We believe that the recognition that the social relationship between doctor and patient is characterized by violence opens the way to forming a different relationship that is not characterized by violence. But policy changes also need to be made. Policies need to prevent - and ultimately eliminate gendered violence between physicians and patients. This can be done by promotion of women's' rights in the medical setting. This needs to be promoted in all of reproductive health units with Mexico's social security system.

Ethics

Formal permission to conduct the study was obtained from the Hospital's management. The re-

search proposal was approved by the local IRB. The hospital provided support to the study and asked to review a copy of the completed research.

Results

The Reproductive Health Unit

Services at the Number 2 Aguascalientes hospital are accessed through an appointment with the on-call physician. When necessary, patients are referred to specialists. The specialist may schedule surgical procedures, offer different treatment modalities, or refer the patient back to the reproductive health unit. The reproductive health unit principally offers contraception, infertility treatments and management of pregnancy in all stages. The surgical contraceptive methods offered to patients include tubal ligation and vasectomy. Institutionalized gendered violence can occur when physicians either suggest these treatments or withhold them. This may occur in a variety of settings and for a variety of reasons that will be clarified below.

Patents are also actors in this setting, particularly when they work with the medical team (composed of doctors and nurses). This forms the context within which the social actors work can be identified in this way. We can also learn from examining the public policies and bioethical principles which govern professional medical behavior.

The first element that strikes the observer is the asymmetry of the doctor/patient relationship; this is reflected in gender differences: physician/male vs. patient/female, health status and positions of authority and power.

Prior research, such as the work of Leon y Medina (2004) in Andalucia, allows us to clearly identify the asymmetry in the doctor/patient relationship. There is a distance in this relationship dictated by rules of conduct that are established when medical students first meet with patients. When is the decision-making capacity of patients - their ability to freely make an informed choice - violated in, for example, the choice of a contraceptive method that reflects the wishes of the partners and their sexual practices?

Learning about the Unit

The researchers carefully explored the unit in order to identify how patients and doctors moved between the exam rooms and the operating theater. Family Medicine Unit No 10 is located in the area dedicated to no scalpel vasectomy (NSV); this is part of the administrative area of the General Hospital in Zone 2. This area contains modular units for providing counseling, the surgical suite, and social services which provide information, counseling, and follow-up to male patients who will be receiving an NSV.

As we explored the Unit, the staff became familiar with us and accepted us as part of the medical team. This allowed us to become participant observers in the Unit. Our "stage" now included physicians, patients, nurses, secretaries and the orderlies.

We found the Unit's Operating Manual in the office of the Chairman. It included a history of the hospital, its physical description, its mission and values, as well as documents providing institutional support for national policies on reproductive health which are contained in the Program of the Institute of Reproductive Health. There was also a document entitled "Brief Report."

Daily observation of the physicians gave us familiarity with their working habits, how they moved within the physical space of the clinic, and how they acted when patients were present and when they were not. All of them felt they had too little time to do their job, and felt they were overburdened. Yet it was possible to find times when they were not interacting with patients; during these times they went to areas where patients could not see them (i.e. they were behind the stage), but they were still accessible to the medical team. This meant that the doctors were inaccessible to the patient and her family, but the rest of the medical team knew where to find them. This behavior was reminiscent of Goffman's (1994) metaphor of individuals using different social masks depending upon the role they were playing.

The Unit followed clearly documented rules. Patients were expected to arrive on time for their appointments, and then await orders: wait, sit, move, enter, and leave each space. Secretaries control ac-

cess to the exam room. The security guards control access to the hospital and they decide who can enter and when. Nurses indicate that the exam room is ready, and tell women when to undress and where to find the bathroom and the dressing room. Lastly, they reinforce the doctor's instructions.

The secretaries and nurses collaborate with the doctor. When the doctor reprimands a patient, the secretaries and nurses will repeat the reproach to the patient, lending it greater credence. Orderlies often take a superior attitude towards patients. They show little empathy and are - on occasions - rude. This attitude is particularly evident when the orderlies meet. They make jokes in front of the patients. These conversations often involve sexual inferences and foul language. This behavior essentially reduces the women who are forced to hear them into objects.

Inappropriate conditions in the Unit

The Unit is not a comfortable place for patients. The waiting room is separated from the areas where patients are interviewed and examined by a door. Those in the waiting room can hear the conversations on the other side of the door between the doctors and patients.

In a similar fashion, physical examinations are done in the rooms where interviews are performed. Women are examined in the presence of the nurse and anyone who accompanied her to the hospital. These are genital examinations which involve some of the most emotionally sensitive parts of the body. The patient is made to lie down with her legs in stirrups, thus exposing her genitals. Directly in front her - in direct line-of-sight to her genitals - stands another door leading to another exam room. Doctors, administrators, and nurses are constantly coming in and out of this door. To the patient's right and left there are additional doors. The one on the right leads to the waiting area and the one on the left leads to a hallway which is used by the doctors, nurses, orderlies, janitors, secretaries, and various other individuals. These include vendors of a variety of items such as food, cosmetics, clothing, and shoes. Everyone circulates quite naturally within the exam rooms. It is easy to spot the vendors since they don't have uniforms. Although they are not part of the hospital personnel, they manage to enter and leave without any difficulty despite the fact that they come during working hours and the patients are naked. When asked, patients say they are bothered by this, but do not see it as an aggressive practice.

Power Asymmetries

The asymmetric power relation begins with the medical interview. The patient is naked; the doctor is dressed. The woman is horizontal, the doctor is standing. And standing in such a way that he can see her genitals. There is only the briefest of greetings with the doctor asking: "How are you?" The interview ends with the writing of a prescription, instructions on when to return, and instructions to be followed. If there are any patient concerns, the interview is a bit longer.

Patient Complaints

We interviewed 10 patients in the waiting room all of whom complained about the long delay between appointments. First they needed to see a general practitioner who then referred them to a specialist. They complained about the long wait for the specialist appointment and then the short time with the doctor. We corroborated these concerns with the secretaries, the ones who are responsible for the daily agenda. The long time between appointments was the greatest source of dissatisfaction amongst the patients.

Institutional Pressure on the physicians

Institutional policies are demanding. Doctors need to see 14 or 16 patients when they are on service. The patients are divided into two categories: new patients (15 minutes per visit) and follow-ups (10 minutes per visit). Patients complain about the short time they are given with the doctor, and doctors complain that productivity requirements don't give them more time.

Doctors confirm that their patient load is excessive. There is not enough time to "do things properly" and this is not a good working environment. They feel exposed to committing errors which could lead to lawsuits. Furthermore, they feel unsupported by the hospital, the judicial system, and their current

union. They report that in the past few years "There are many cases where there have been accidents involving colleagues. But when they come before the court, neither the hospital nor the union are there to protect them." They also complain that: "we work without legal protection and under a lot of pressure. No one watches out for us."

Patients have an idealized conception of what a doctor should do and what should happen when they seek medical attention. This creates a social ideal of the roles of doctor and patient. Patients see doctors as being actors for good. However, "Seguro Popular" doctors are seen as being inferior to "paying for a private doctor." (Physician interview). This reflects a class bias against public services which are provided free and considered a hand-out.

Finally, none of the patients felt that they had experienced violence, even when they had been treated poorly by the doctor. In fact, they seemed quite tolerant of poor treatment noting: "well that's just the way he is." (Interview, Patient) Indeed one physician upbraided a postpartum patient for complaining of pain, noting that: "even if you were in a private hospital, you'd get the same treatment." This clearly indicates how physicians understand the rules that specify behavior in different clinical contexts.

Conclusions

The results presented in this paper are part of a larger study and focus on a research approach towards violence against women in a gynecology clinic that is grounded in anthropology and sociology. Our conclusions are based on being participant observers and on interviews, some semi-structured and some in-depth.

Research on this topic is difficult. Women recognize that things are not right, but do not recognize this as violence. Indeed, they normalize bad behavior. This indicates the degree to which our Social Security institutions have deteriorated. Since care is free, the women don't speak out.

Providing reproductive care is a group endeavor involving cooperation by various individuals following a common path. In this case the group is composed of a physician (the actor) and those who support him. As the group develops different roles emerge. The docto is the director who forges a consensus in the group, maintains good moral and attributes roles. Group activities are guided by rules which generate a dynamic conformity.

Goffman's work on asylums (1994) revealed that the culture of social institutions (such as hospitals) reflects that fact that institutional life occurs in the one physical setting and under one authority. All activities are necessarily group activities. All functions are programmed. All the diverse functions are integrated into a rational plan to further institutional objectives. (Indeed, it is the daily routine which legitimizes the actions).

Goffman describes how institutions create strategies to control the interned: mortification of the ego, separation, degradation, removal of signs of personal identity, overcrowding, loss of self-determination, and the use of rewards. Once you are identified as someone ill you have already suffered the first small abasement. You are separated from your family and have no way to contact them. You enter an environment which is not your own. You are called degrading names: the difficult patient, the bad patient. You are subject to the whims of the Institution. You have to take off your clothes. You are placed in a subordinate horizontal position. Your health is now contaminated with a diagnosis and you are added to a group: the diabetics, the crazy women, the hysericals, the hypertensives, those people living with AIDS.

Patients lose their autonomy the moment they meekly say: "Whatever you feel is right." And they are also rewarded when they are told that if they eat, bathe, and follow directions, the doctor will send them home. Of course, the interned are not without means to defend themselves. These include: group solidarity, resistance, maintaining their sense of identity, rebellion, or adaptation and colonization.

Our observations have suggested another rationale for the docility that is required of patients. It is a form of adaptation when they are faced with the power of the doctors and the health team. On the other hand, the clinic's personnel had their strategies to control the interned. These included maintaining a solid front both towards the outside world as well

as the internal hospital environment. Being part of the union also offered them an acceptable form of resistance.

In Conclusion: A Case Story

The normalization of violence and the consequent adaptation on the part of women are some of the key findings of our study. These field notes describe the Odyssey of one woman seeking care at the hospital:

> *"people pass by her and say nothing. The time passes. ... She sleeps in spurts and is awakened by the nurses' music. She watches them eat and feels very hungry. The orderlies take her... They are talking loudly.... They don't greet her and they use foul language. A doctor upbraided a patient by her side because she was crying out in pain. He told her to stop, that was normal to have pain with childbirth. Women have always been strong enough to give birth. Why is she so delicate? I overheard him say later to a student: "Why is she so choosy? She'd get the same care even if she were paying a private doctor. She's just too demanding." After he left and the patient was alone, she began to cry silently. Another woman tried to console her. She said - as if it was a complaint - "Why do they become doctors if they don't like to do their job properly. And yes, she did have the right to be treated well even if she wasn't paying for a private doctor. She worked and had a right to health insurance.*

In cases like these the legal system seems impotent. Patients are subject to the whims of chance.

> *That day there were many emergencies and they cancelled her case and sent her home. "She mentioned that she was furious at the hospital and did not want to go back again. But a month later, there she was back at this clinic making an appointment for the following week. She ended up by noting: "I'll see if she's there, she is the good one."*

References

1. Álvarez B., A. "Mortalidad Materna". *Gaceta Médica Mex*, 100: 555-563, 1970.
2. Ban Ki-Moon. *Objetivos de Desarrollo del Milenio. Informe 2008*. Objetivo 5. Mejorar la salud materna (24-27). ONU.
3. *Basics in Qualitative Research*. Grounded Theory Procedures and Techniques, Sage, London.
4. Beck, U. (1998). *La sociedad del riesgo: hacia una nueva modernidad*. Barcelona: Paidós.
5. Benjumea, C. "Teoría y Método. La Teoría Fundamentada como herramienta de análisis". *Cultura de los cuidados*, año X, n. 20, 2006.
6. Carabaña, J. "Valoración crítica del interaccionismo simbólico". *Revista Española de Investigaciones Sociológicas*. 1977, 1, 159-203. Reproducido en J. Jiménez Blanco y C. Moya. (1978). *Teoría Sociológica Contemporánea*. Madrid: Tecnos, pp. 277-320.
7. Carrera T. A. (1994). "La explicación científica en las Ciencias Sociales, del Empirismo Lógico al Realismo Científico". Tesis doctoral en Filosofía, Universidad Complutense de Madrid.
8. Castro, R. (2000). "La experiencia subjetiva de la sexualidad, la reproducción y la anticoncepción" (341-388). En *La vida en la adversidad: el significado de la salud y la reproducción en la pobreza*. México: Editorial CRIM, UNAM.
9. Charmaz, K. "Discovering chronic illness: using grounded theory". *Social Science and Medicine*. V. 30, 1990.
10. Cruess, R. L., Cruess, S. R., y Johnston S. E. (2000). Professionalism: an ideal to be sustained. *Lancet*, 356: 156-9.
11. Cuñat, R. "Aplicación de la Teoría Fundamentada (Grounded Theory) al Estudio del Proceso de Creación de Empresas". XX Congreso anual de AEDEM. Vol. 2, 2007 [Documento en línea] Disponible en http://dialnet.unirioja.es/servlet/articulo?codigo=2499458
12. Declaración conjunta 0MS/FNUAP. (1999). UNICEF, Banco Mundial.
13. Díaz Echeverría, D. F. "Mortalidad Materna. Una tarea inconclusa". *FUNDAR*, no. 3. Centro de Análisis e Investigación A.C., 2006.
14. Encuestas demográficas nacionales. CONAPO 1976-2009.
15. Foucault, M. (2001). *Un diálogo sobre el poder y otras conversaciones*. Primera edición. Madrid: Alianza Editorial.
16. Freidson, E. (2001). *Professionalism. The third logica*. Chicago: The University of Chicago Press.
17. Galeano, M. (2004). *Estrategias de investigación social cualitativa. El giro de la mirada*. Medellín: La Carreta Editores E.U.
18. Galtung, J. (1981). "Contribución específica de la irenología al estudio de la violencia: tipologías". En Domenach y otros. *La violencia y sus causas*. París: UNESCO.
19. Gary Alan Fine and Philip Manning. (2000). "Ervin Goffman" (457-485). En *The Blackwell Companion to Major Contemporary Social Theorists*. Oxford: Blackwell Publishing.

20. Giddens, A. (1990). *The consequences of modernity*. Stanford, CA: Stanford University Press.
21. Glaser, B. y Strauss, A. (1967). *The discovery of grounded theory: strategies for qualitative research*. New York: Aldine de Gruyter.
22. Goffman, E. (1993). *La presentación de la persona en la vida cotidiana*. Buenos Aires, Argentina: Amorrortu editores.
23. Goffman, E. (1994). *Internados, ensayos sobre la situación social de los enfermos mentales*. Buenos Aires, Argentina: Amorrortu editores.
24. Gordillo, A. y Terrades, I. (1973). *Agresión. Naturaleza y Cultura*. Barcelona: Ed. A. Redondo.
25. Hardin, R. (2002). *Trust and trustworthiness*. New York: The Rusell Sage Foundation.
26. Holt, N. L. (2003). Representation, legitimation, and autoethnography: an autoethnographic writing story. *International Journal of Qualitative Methods*, 2(1). Article 2. Retrieved January 18, 2006. Consultado en: http://www.ualberta.ca/~iiqm/backissues/2_1 final html.holt.html.
27. Irvine, D. H. (2004). "Time for hard decisions on patient-centred professionalism". Medical Journal of Australia, 181: 271-4.
28. Jones D., Manzelli H. y Pecheny M. "Grounded Theory: Una aplicación de la Teoría Fundamentada a la salud". *Cinta de Moebio*, n. 19, 2004.
29. Jovell, A. J. (1999a). "El futuro de los servicios sanitarios: gestión del conocimiento, de los recursos humanos y de los valores éticos". En Jovell A. J., Aymerich M. *Evidencia científica y toma de decisiones en sanidad*. Barcelona: Monografía de la Academia de Ciències Mèdiques de Catalunya i Balears.
30. Jovell, A. J. (1999b). "Medicina basada en la afectividad". *Med Clin* (Bar), 113: 173-5.
31. Jovell, A. J. (2004a). *Gestión del conocimiento afectivo, Siete Días Médicos*. 600: 102-8.
32. Jovell, A. J. (2004b). *El documento de voluntades anticipadas*. En www.diariomedico.com.
33. Karchmer, K. S. (2006). "Mortalidad Materna y Perinatal. Estrategias para disminuirla" (4-7). En *Obstetricia y Medicina Perinatal*. Tomo I. México: COMEGO.A.
34. Kornblit, A. (2004). *Metodologías cualitativas en ciencias sociales*. Argentina: Biblogs.
35. Kotter, J. y Cohen, D. S. (2002). *The heart of change*. Boston, MA: Harvard Business School Publishing.
36. Langer A. y Hernández B. (1998). *Revista de Salud Pública de México*.
37. León Rubio, J. M. *et al*. (2004). *Psicología de la salud y calidad de vida*. Barcelona: Mc Graw Hill.
38. Levi-Strauss, J. C. (1962). *La pensée sauvage*. París: Plon.
39. *Llibre Blanc de les Professions Sanitàries a Catalunya*. (2003). Barcelona: Generalitat de Catalunya. En www.gencat.net/
40. Martínez M. M. (2004). "Elección de la muestra que se va a estudiar" (83-87). En *Ciencia y Arte en la Investigacion Cualitativa*. México: Trillas.
41. Neiman, G., Quaranta, G. (2006). "Los estudios de caso en la investigación sociológica". *Estrategias de investigación cualitativa*. Buenos Aires: Editorial Gedisa.
42. OMS-FNUAP-UNICEF-Banco Mundial. (1999). *Reducción de la Mortalidad Materna*. Ginebra: OMS.
43. OMS-UNFPA. (2003). *Mortalidad Materna*. Actualización. 2002. En especial, *Atención obstétrica de emergencia*. New York.
44. OPS. 26a. Conferencia Sanitaria Panamericana. 54ª. Sesión del Comité Regional. Estrategia Regional para la Reducción de la Mortalidad y Morbilidad Maternas. Washington. 2002.
45. Padua, J. *et al*. (1979). Técnicas de investigación aplicadas a las Ciencias Sociales. Chile: Fondo de Cultura Económica, 1994.
46. Uribe-Elías, R. *International Journal of Gynecology and Obstetrics*, 82, 425-433, (2003).
47. Rodríguez G. G. *et al*. (1999). "Entrevista" (185-195). En *Metodología de la investigación cualitativa*. Málaga: Ediciones Aljibe.
48. Rodríguez, J. L. (2007). *Frame Analysis: Los Marcos de la Experiencia*. Madrid: Alianza Editorial.
49. *Salud Pública de México*. marzo-abril, vol. 32, no. 002, 170-180, 1990.
50. Sandín, M. (2003). *Investigación cualitativa en educación. Fundamentos y tradiciones*. España: McGraw Hill.
51. SEMFYC. (2005). *Mapa de Competencias para evaluación de competencias en práctica clínica (Portfolio semFYC)*. Barcelona: SEMFYC Publicaciones.
52. Sexton, J. B., Thomas, E. J., y Helmreich, R. L. "Error, stress, and teamwork in medicine and aviation: cross sectional surveys". *BMJ*, 320: 745-9, 2000.
53. Taylor, S. J. & Bogdan, R. (1987). "La observación Participante. Preparación del trabajo de campo" (31-49). En *Introducción a los métodos cualitativos de investigación*. Barcelona: Paidos.
54. Tojar H., J. C. (2006). "Procesos de Investigación" (177-225). *Investigación cualitativa. Comprender y Actuar*. Madrid: La Muralla.
55. UNFPA-ONU. (2007). Thoraya Ahmed Obaid. Directora Ejecutiva. *Estado de la Población Mundial 2007. Liberar el potencial del crecimiento urbano*. New York. Estados Unidos de América. 1-3, 93, 97-99.
56. Uribe E., R. (2002). *La Invención de la Mujer. Nacimiento de una Escuela Médica*. México: Fondo de Cultura Económica, Benemérita Universidad Autónoma de Puebla.
57. Weber, M. (1944). *Economía y sociedad. Esbozos de sociología comprensiva*. México: Fondo de Cultura Económica.
58. WHO, UNICEF, UNFPA. (2007). *The World Bank, Maternal Mortality in 2005*. WHO.
59. Williams, R. (1999). "Symbolic interactionism: the fusion of theory and research?". En Bryman y Burguess. *Qualitative research*. London: Sage Publications.
60. Yin, R. (2003). *Applications of Case Study Research*. California: Sage Publications.