WOMEN'S GYNECOLOGIC HEALTH

THIRD EDITION

KERRI DURNELL SCHUILING FRANCES E. LIKIS

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07891-6

Production Credits
VP, Executive Publisher: David D. Cella
Executive Editor: Amanda Martin
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Composition: S4Carlisle Publishing Services
Cover Design: Kristin E. Parker
Director of Rights and Media: Joanna Lundeen
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Media Development Editor: Troy Liston
Printing and Binding: Edwards Brothers Malloy
Cover Printing: Edwards Brothers Malloy
Cover Image: Symbol: The symbol on the cover is adapted from *The Changer* by K Robins and is used with the permission of K Robins Designs. The editors are very grateful to K Robins for allowing us to adapt her design for our cover, and we encourage readers to visit www.krobinsdesigns.com where *The Changer* and other symbols are available as pendants. Background: © Evgenii Iaroshevskii/Shutterstock.

Library of Congress Cataloging-in-Publication Data
Names: Schuiling, Kerri Durnell, editor. | Likis, Frances E., editor.
Title: Women's gynecologic health / [edited by] Kerri Durnell Schuiling, Frances E. Likis.
Description: Third edition. | Burlington, Massachusetts : Jones & Bartlett Learning, [2017] | Includes bibliographical references and index.
Identifiers: LCCN 2016005174 | ISBN 9781284076028 (hardcover)
Subjects: | MESH: Genital Diseases, Female | Women's Health | Reproductive Physiological Processes
Classification: LCC RG101 | NLM WP 140 | DDC 618.1--dc23
LC record available at http://lccn.loc.gov/2016005174

6048

Printed in the United States of America
20 19 18 17 16 10 9 8 7 6 5 4 3 2 1

Dedication

To:

The indomitable Kitty Ernst, thank you for encouraging us to always look for ways to improve women's health care;

Our students and the women for whom we have provided care, thank you for being our best teachers;

The readers who have told us what you appreciate about our book, thank you for inspiring us as we worked on this edition; and

Our colleagues, friends, and family members who have been encouraging and patient throughout the labor of this edition. There are too many to mention each of you by name, but you know that we know who you are. We truly appreciate the support you provided.

—Kerri and Francie

To:

The memory of my dear friend Judy Pennington Adams, her granddaughter Tiffany and great-grandson Kyson, and their good friend Charlene Lewis, who were all taken from us far too soon;

Rachael Stade, MS, PA-C, for providing me with outstanding woman-centered health care;

Joani and Lisa, whose friendship supports me in ways too many to mention;

Donovan, for his unconditional love and friendship;

Judd, for his companionship and humor;

My parents, Marie and Don Hall, whose belief that I can do anything makes me believe that I can; and

My children and sons-in-law, Mary, Mike, Sean, Sarah, and Galen, who bring me life's greatest joys.

—Kerri

To:

My husband Zan, you are the one I love more with each passing day, and we make a formidable team;

My nieces Katherine and Elizabeth, my sister Mary, and my mother Katey, you are my favorite girls in the whole wide world;

My grandmother Frances, you are such an important part of who I am, and your determination and perseverance never cease to amaze me;

Ali, you are my trusted confidante and keep me hopeful about the future of midwifery;

Christy, you are a wonderful companion for adventures and an endless source of kindness;

The community of St. Augustine's Episcopal Chapel, especially our leaders Becca and Lissa, you embody love, mercy, and radical hospitality, and you help me find my way home.

—Francie

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PREFACE

Historically, women's health was framed within a biomedical model by clinicians. Textbooks typically used a biomedical framework to present women's health content. Although this approach can be useful on many levels, it also has limitations that can have significant negative effects on women's health, particularly gynecologic health. A biomedical model is disease oriented and focuses on curing illness—an approach that risks pathologizing normal aspects of female physiology. When a biomedical lens is used to assess women's health, there is a risk of essentializing women and reducing them to their biologic parts. As an example of this proclivity, *women's health* is frequently used to mean reproductive health, regardless of whether the woman plans to bear children. This reductionism transfers to practice when a woman's parts become the focus of diagnosis and treatment. The meaning of the diagnosis to the woman, as well as the impact that the diagnosis has on her, her significant others, and the work she does, is not addressed in this approach.

Feminist theories about women's growth and development provide a different perspective from earlier male-oriented models because they include women's lived experiences and the importance of relationships to women. Recognizing each woman as an expert knower supports women's agency. The focus with this approach is holistic, with health being assessed within the context of each woman's life.

It is important for our readers to know that we, as the editors of this book, are experienced women's health clinicians whose practice philosophy is grounded in caring for the whole woman within her lived experience. As teachers, we were repeatedly frustrated by our inability to locate a gynecologic textbook that we felt was suitable for our course. Many of the books that were available were written primarily from a biomedical perspective and, in our opinion, did not provide sufficient content about the normalcy of women's reproductive physiology. Books such as those authored by the Boston Women's Health Book Collective were extremely helpful with ideas about health and holism, but lacked the necessary content to educate student clinicians. Other books did not provide the health-oriented perspective that is vital to the philosophy of care espoused by nursing and midwifery, in which we both strongly believe. Additional books provided elements of both biomedical and health-oriented views and had very useful decision trees or categorization of concerns or problems. However, we felt that these books would not encourage students and practicing clinicians to think critically and to appreciate the importance of making decisions based on the most recent evidence.

For these myriad reasons, we embarked on producing a book that presents women's gynecologic health from a woman-centered and holistic viewpoint. Our goal was to create a book that emphasizes the importance of respecting the normalcy of female physiology, and provides clinical content appropriate for assessment, diagnosis, and treatment of pathology. We believe this book embodies these perspectives and underlines the importance of collaboration among clinicians.

Some aspects of this feminist approach will be obvious to our readers, whereas others may be more subtle. For example, we used illustrations of whole women, rather than pictures of only breasts or genitalia, when possible. We refer to a woman who has a specific condition rather than referring to the woman by her condition. For example, we speak of the woman who has HIV, as opposed to the HIV-positive

woman. We use the term *birth* as opposed to *delivery* because it situates the power to give birth within the woman versus transferring it to the clinician. We purposefully use *women's* rather than *gynecologic* as the first word of this book's title. Our intention in making these deliberate choices was to encourage readers to keep first in their mind that they are treating a whole woman, not her body parts, and not just a condition. We hope that this approach emphasizes the importance of treating women holistically within their lived experiences.

We were fortunate to have many excellent contributors to this book. Some are nationally known; others might be new to many readers. The common thread among all of our contributors is their expertise in their respective areas and their recognition of the importance of evidence-based practice. Our contributors are expert clinicians, educators, and scientists. Frequently co-authored chapters represent a clinician and researcher team, whose collaboration provides readers with a real-world view that is grounded in evidence.

This book encompasses both health promotion and management of gynecologic conditions that women experience. All of the content is evidence based. The first section introduces the feminist framework that permeates the book and provides readers with a context for evaluating evidence and determining best practice. The second section provides a foundation for assessment and promotion of women's gynecologic health. The third section addresses the evaluation and management of clinical conditions frequently encountered in gynecologic health care. The fourth section provides an introduction to prenatal and postpartum care.

We are gratified by how well the first two editions of this book were received by clinicians, students, and faculty, and it was an honor to receive the Book of the Year Award from the American College of Nurse-Midwives for both previous editions. In this third edition of *Women's Gynecologic Health,* we have updated, and in many cases extensively revised, all of the chapters from the second edition to ensure comprehensive content that reflects current standards of care. For example, the chapter on health care for individuals who are lesbian, bisexual, queer, or transgender has been extensively updated, as have the chapters on intimate partner violence and sexual assault. In response to requests from a significant number of educators and readers, we have added four new chapters that provide an introduction to pregnancy and postpartum care.

We believe this edition builds upon the precedents set in the previous editions and hope it contributes to women receiving evidence-based, holistic, gynecologic care within their lived experiences. As before, we welcome feedback from our readers that will help us in future editions.

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SECTION

1

Introduction to Women's Gynecologic Health

CHAPTER 1

Women's Health from a Feminist Perspective

Lisa Kane Low

Joanne Motino Bailey

The editors acknowledge Kerri Durnell Schuiling, who was a coauthor of the previous edition of the chapter.

WOMEN'S HEALTH CARE AND GYNECOLOGIC HEALTH

The state of women's health care today is a direct reflection of women's status and position in society. Many healthcare advances have been made in women's health, yet comprehensive, compassionate healthcare services that address the complexity and diversity of how women live their lives and experience health and disease are still lagging.

This text is based on a feminist framework in an effort to advance the quality of health care provided to women in today's society. The authors attempt to acknowledge the complexity of women's health by paying particular attention to women's status in society and their unequal access to opportunity and power, while focusing on women's gynecologic health and well-being. The purpose of this chapter is to provide an overview of women's health using a feminist perspective and gender considerations as a lens for exploring women's health in general and gynecologic health in particular. The glossary in **Box 1-1** offers definitions of key terms that are used throughout the chapter and are linked to feminist critical analysis of gender and health.

WHAT IS FEMINISM?

The author bell hooks (2000) offers a definition of feminism that is well suited for addressing the context in which women experience health and wellness: Feminism is a perspective that acknowledges the oppression of women within a patriarchal society, and struggles toward the elimination of sexist oppression and domination for all human beings. Acknowledging the oppression of women is increasingly difficult because affluence and increased opportunities within some sectors of employment and education are construed as equal access or equity in opportunity for all women. Hooks, however, defines oppression as "not having a choice." With this definition, many more individuals are able to recognize constraints in their personal experiences. Examples of such practices include unjust labor practices, lower wages for equal work, lack of maternity leave policies, limited access to a range of contraceptive options, and inability to access desired healthcare providers. These examples indicate the breadth of experiences within the context of a patriarchal society that denies women equal access to power, resources, and opportunities.

Characteristics of a feminist perspective include the use of critical analysis to question assumptions about societal expectations and the value of various roles on both sociopolitical and individual levels. The process of critical analysis is accomplished by rejecting conceptualizations of women as homogeneous. It acknowledges power imbalances, and uses the influence of gender as the foremost consideration in the analysis. Using a gender lens that is informed by feminism permits areas

BOX 1-1 Glossary of Key Terms

Cis-sex/gender: An individual whose gender identity coincides with that individual's birth-assigned sex/gender (e.g., a cis-man is often referred to as simply "man," a cis-woman is often referred to as simply "woman")

Classism: Discrimination or prejudice on the basis of social class

Discrimination: The prejudicial treatment of an individual based on that person's actual or perceived membership in a certain group or category (e.g., race, ethnicity, sexual orientation, national origin)

Feminism: A movement to end sexism, sexist exploitation, and oppression (hooks, 2000)

Gender: A socially constructed category addressing how people identify and act based on sex (e.g., men and women)

Homophobia: Prejudice against individuals with same-sex attraction

Intersectionality: The unique combination of multiple identities based on race, class, gender, and other characteristics, and the compounded experience of oppression based on these identities

Medicalization: Defining or treating a physiologic process or behavior as a medical condition or disease

Oppression: Exercise of authority or power in an unjust manner; according to bell hooks, "not having a choice"

Patriarchy: A social system of institutions that privileges men, resulting in male domination over access to power, roles, and positions within society

Power: The ability to do something, act in a particular way, or direct/influence others' behavior or a course of events

Race/ethnicity: Socially constructed categorization of individuals and communities based on a combination of physical attributes and cultural heritage

Racism: Individual and structural practices that create and reinforce oppressive systems of race relations

Sex: Biological classification as female or male based on chromosomes, genitalia, and reproductive organs

Sex/gender: Combined term of sex and gender acknowledging that the discreet meanings of these terms are not easily separated in research and practice

Sexism: Individual and institutional practices that privilege men over women

Social construction: The process by which societal expectations of behavior become interpreted as innate, biologically determined characteristics

Socioeconomic status (SES): An indicator that encompasses income, education, and occupation

Trans*: Represents multiple identities in transgender communities; read as "trans star" (Erickson-Schroth, 2014)

Transgender or trans: An individual whose gender identity does not coincide with that individual's assigned gender at birth

of disparity to be identified both between groups, based on gender, and within groups, based on the recognition of heterogeneity among women.

Feminist women's health explores the context of how women live their lives both collectively and individually within a patriarchal society. The various social, environmental, and economic aspects become integral to understanding the context in which women are able to achieve health and well-being. Furthermore, feminism requires

BOX 1-2 Components of a Feminist Perspective in Women's Health

- Works *with* women as opposed to *for* women
- Uses heterogeneity as an assumption, not homogeneity
- Minimizes or exposes power imbalances
- Rejects androcentric models as normative
- Challenges the medicalization and pathologizing of normal physiologic processes
- Seeks social and political change to address women's health issues

consideration of health, as influenced by the intersection of sexism, racism, class, nation, and gender, within a framework that acknowledges the role of oppression as it affects women and their health as individuals and as a group. **Box 1-2** summarizes the components of a feminist perspective when considering women's health issues or models of care, which can help to reframe one's view of women's health in a feminist perspective.

GENDER

What does gender have to do with women's health? Although women's health is focused on the female sex (as determined by chromosomes, genitalia, and sexual organs), its priorities are shaped by what are considered socially important attributes of being a woman (such as reproductive capacity and feminine appearance). Gender is defined as a person's self-representation as man or woman and the way in which social institutions respond to that person based on the individual's gender presentation. Gender is often congruent with sex (a person with female genitalia identifies as being a woman "cis-woman"), but can also be incongruent (a person with female chromosomes may identify as being a man "trans-man"). Sex and gender are ultimately "irreducibly entangled" from both the research and the practice perspectives, however, and are better referred to by the combined term "sex/gender"—a term that acknowledges the combined contribution of both the biologic and socially constructed aspects (Springer, Stellman, & Jordan-Young, 2012).

Sex/gender is a socially constructed attribute that is shaped by biology, environment, and experience and is expressed through appearance and behavior (Fausto-Sterling, 2012). Social construction is the process by which societal expectations of behavior become interpreted as innate characteristics that are biologically determined. Thus, behaviors associated with femininity become confused with innately determined behaviors rather than being recognized as socially constructed behaviors. As a result, health risks, treatments, and approaches to care are not necessarily biologically based aspects of women's health, but rather are determined by social expectations rooted in assumptions about sex/gender differences. In addition, diagnoses can be influenced by sex/gendered assumptions regarding behavior or what is socially constructed as feminine behavior. A significant body of literature has documented such influences on the manner of diagnosis and treatment in mental health (Neitzke, 2016) and obesity (Wray, 2008), as well as in the misdiagnosis of women's cardiovascular risks (Worrall-Carter, Ski, Scruth, Campbell, & Page, 2011).

Three primary aspects must be considered when examining the impact of sex/gender on women's health. The first is the priorities assigned to research, treatment, and outcomes in women's health as compared to men's health. The second is the context of sex/gender, including how it affects the process of providing healthcare services, which encompasses an acknowledgment of power differentials. The third aspect is the social construction of sex/gender, including how it affects women's health. Each aspect has implications for the manner in which women access, receive, and respond to health care. Collectively, these three aspects provide opportunities for us to better understand women's healthcare experiences and assist in the identification of underlying factors that influence the healthcare disparities experienced by women.

Sex/gender-based social role expectations can create undue burdens for women and may subsequently lead to increased health risks. For example, limited access to all contraceptive options may create reproductive health risks for some women.