



AMCHSS

Achutha Menon Centre for Health Science Studies

The AMCHSS is the third wing of Sree Chitra Tirunal Institute for Medical Sciences and Technology (SCTIMST) Centre is devoted exclusively to public health and social sciences in relation to health development and health care. The Ministry of Health and Family Welfare, Govt. of India has recognized AMCHSS as a center of excellence for Public health training. The mission of the AMCHSS is to improve the health and well being of the community. Central to the fulfillment of this mission are Teaching, Research, Service. It commenced the Master of Public Health Course in January 1997 and starts a PhD programme from the year 2002.

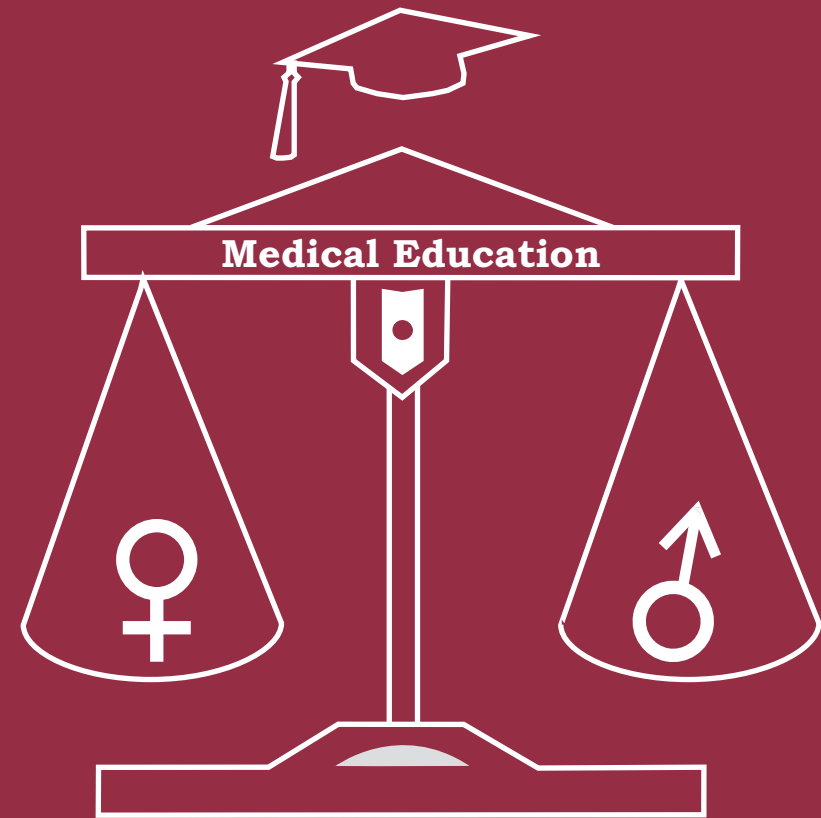


Centre for Enquiry into Health and Allied Themes

The CEHAT is the research center of Anusandhan Trust established in the year 1994, stands for research action, service and advocacy in health and allied themes. Socially relevant and rigorous academic health research and action at CEHAT is for the well being of the disadvantaged masses for strengthening people's health movements and for realizing right to health care. CEHAT's work is based on its ideological commitments and priorities and are focused on four broad areas, (1) Health Services and Financing, (2) Health Legislation, Ethics and Patients Rights, (3) Women's Health, (4) Investigation and Treatment of Psycho-Social Trauma.

Gender and Medical Education

Gender and Medical Education



AMCHSS
Achutha Menon Centre
for Health Sciences Studies



Centre for Enquiry into
Health and Allied Themes

Gender and medical education
**Report of national consultation
and
background material**

Edited by

**Amar Jesani
Neha Madhiwalla**



AMCHSS

Achutha Menon Centre
for Health Sciences Studies
Thiruvananthapuram



Cehat

Centre for Enquiry into
Health and Allied Themes
Mumbai

First published in June 2002

By Centre for Enquiry into Health and Allied Themes

For Achutha Menon Centre for Health Science Studies

Non-profit publication for educational purposes. The copyright over the authored material published in this book is that of respective author(s) and of the editor of the journal where such material was published. For reproduction of such material, their permission is essential.

Copies available at

CEHAT

Centre for Enquiry into
Health and Allied Themes
Sai Ashray, Aram Society Road
Vakola, Santacruz (East)
Mumbai - 400 055 (Maharashtra)
Tel : 91-22-6147727 / 6132027
E-mail : cehat@vsnl.com
Website : www.cehat.org

AMCHSS

Achutha Menon Centre for
Health Science Studies
Sree Chitra Tirunal Institute for Medical
Sciences and Technology
Thiuvananthapuram - 695 011 (Kerala)
Tel : 91-471-524140
E-mail : amchss@sctimst.ac.in
Website : <http://sctimst.ac.in>

Cover Concept & Design :
Ravindra Thipse

Printed at
Chintanakshar Graphics
Mumbai 400031

Contents

1

Introduction: Gender and medical education
K. Mohandas, Amar Jesani, Mala Ramanathan

5

Report of consultation on gender and medical education:
Understanding the needs for gender sensitisation, critiquing
content and method of medical education, and developing
Long-term strategies for intervention January 31, 2002 held
at SNTD Women's University, Mumbai

24

List of participants

Perspectives on Medical Education

29

Gender and power issues in medical education
Thelma Narayan

42

Sexism in medicine and women's rights
Padma Prakash; Annie George and Rupande Panalal

51

Integrating the gender perspective in medical and
health education and research
Yut-Lin Wong

Innovations in Medical Education and Best Practices in Women's Health Care

69

A women's health curriculum for an
internal medicine residency
Janice. L. Werbinsky and Sandra J. Hoffmann

73

The development of a primary care curriculum for
obstetrics / gynecology residents
*Kelly S. Parsey; Lori A. Bastian; Grace M. Couchman
Kenneth D. Slack; David L. Simel*

80

Women's health curriculum at stanford
Jodean Nicolette and Marc Nelson

85

Sexual coercion and PID in slum women of Mumbai:
Role of The health care provider
Renu Khanna; Korrie De Koning; Swati Pongurlekar
Usha Ubale; Manjiri S.

Women Health Care Workers

101

Ethnicity, gender identity, stress, and coping among female
African-American medical Students
Denese O. Shervington; Irma J. Bland and Amanda Myers

106

Harassment of women physicians
Melissa Schiffman and Erica Frank

122

Gender differences in medical school attrition rates, 1973-1992
Kevin M. Fitzpatrick and Marilyn P. Wrigh

Medical Education and Women In India : Some Statistics

133

Table - 1 : Status of Medical Colleges for admission
for 2001-2002

134

Table - 2 : Medical Colleges and Admission Capacity

136

Table - 3 : Post Graduate Degree / Diploma Awarded
by various Universities

136

Table - 4 : PHC's with Lady Doctors

Acknowledgement

The editors and organisers gratefully acknowledge the support of the following

All participants at the workshop:

Their contribution made this publication possible. Their contribution also made it possible to design a research and action strategy on this subject.

For selection of resource materials

Mr. Ravi Duggal, Co-Ordinator, CEHAT

Dr. Mala Ramanathan, Associate Professor, AMCHSS

For Articles

Articles included in this document were circulated during the programme and organisers are very thankful to the respective authors and publishers of the same.

For Rapporteurship

Ms. Rajeshwari Balaji

Ms. Qudsiya Contractor

For Venue

Authorities of S N D T Women's University, Mumbai

For logistics and secretarial support

Mr. Anirban Bose

Mr. Vikas Gamre

For financial support

We are very thankful to the MacArthur Foundation for its generous financial support in organizing the National Consultation.

INTRODUCTION

GENDER AND MEDICAL EDUCATION

We are happy to bring to you this document containing the report and background material of a national consultation organised by the Achutha Menon Centre for Health Science Studies (AMCHSS) of the Sree Chitra Tirunal Institute of Medical Science and Technology (SCTIMST), Thiruvananthapuram, Kerala, and the Center for Enquiry in to Health and Allied Themes (CEHAT), Mumbai, on January 31, 2002 at the SNTD Women's University in Mumbai. The brainstorming by some of the eminent medical and social scientists of the country provided strong support to our suspicion that the gender issues in medical education have been given less importance than they deserve. The participants also made some concrete suggestions on how we should go about trying to improve the existing situation. This publication is an effort to share the views of the participants with all concerned, seek their cooperation in the future efforts that we have planned on the subject and above all, solicit their views on various points raised in the meeting and the future programme of ours.

The vastness of the country is also reflected in the vastness of the task at hand. We have three systems of medicine, viz. the modern medicine or Allopathy, the Indian Systems of Medicine comprising of Ayurveda, Unani and Siddha; and Homeopathy. Each one has its own distinct system of medical education with separate Medical Council and rules related to registering the doctors trained in the Medical Council recognised colleges. If one counts all medical colleges of these three systems, we have over 500 medical colleges giving admission 30 to 40 thousands students every year. Not only it would be impossible to reach out to such large number of colleges spread out in different

parts of the country, but our own limitation of being a medical institute in the Modern System of Medicine would not make it possible for assessing and intervening in the medical education of the other two systems of medicine. Hence, the primary focus of the material in this publication is only on education in the Modern System of Medicine. The task in the Modern System itself is very tall one. There are now 183 established medical colleges, of which 119 (or 65%) are in the public sector and the rest 64 (or 35%) in the private sector. Of the 183 medical colleges, 154 (84%) are already recognised by the Medical Council. These medical colleges are currently admitting 20,093 students every year.

While medical education in India has expanded very fast due to the high demand of doctors and of course due to concomitant high return expected from the occupation of medical practice in the ever-expanding medical market, the research on the content and method of medical education has lagged behind. This does not mean that efforts have not been made to affect changes in medical education from time to time, but that these efforts have turned out to be inadequate to the tasks at hand. In the process, some of the crucial issues that must be addressed in the formative phase of medical professionals, in order to produce community oriented, sensitive and ethical doctors; have been given less attention and they are not fully integrated at all levels of the medical education system. Inculcating gender sensitivity and ethics are two, amongst many others, such issues that the medical educationists will need to work on in coming time.

Based on the suggestions made by the National Consultation, the AMCHSS/SCTIMST has decided to undertake a three-year programme on gender sensitisation of medical education and network its efforts with other institutions and individuals in the field. It will be a multi-disciplinary endeavour focusing on medical colleges, particularly the teachers of these colleges, in few states and in the process also develop some much needed teaching material on gender and medicine. For the sake of convenience, we have selected six states for our focus, namely,

Rajasthan, Gujarat, Maharashtra, Karnataka, Goa and Kerala. These states account for 83 (45%) medical colleges out of 183. However, some of our programmes may also get organised in other states depending upon the response received.

We have tentatively planned the following activities (more may get added in consultation with our collaborators from time to time) as a part of this programme:

- 1) Formulation of a training module for gender sensitisation and criteria for gender sensitive setting for medical education:** The National Consultation has emphasised both the gender sensitivity in the medical education as well as in the setting (the medical college, the hospital community-based field area) in which the medical education is imparted. A rigorous exercise by a multi-disciplinary group will be undertaken to develop such module and the criteria, and they will be fieldtested.
- 2) Organisation of gender sensitive training of the medical college teachers:** In the some of the states where we want to focus our efforts, we intend to create centres for bringing selected number of teachers of medical colleges for the actual training using the module developed.
- 3) Reviewing Indian medical text books and preparation of review papers on various subjects in medicine from gender perspective:** This activity will be started at the same time as gender sensitisation module preparation and training. We will be inviting experts in the field to undertake such review and prepare papers.
- 4) Organisation of a National Seminar and a National Conference:** In second or third years of the programme, we will be organising a national seminar to discuss the review papers. Such a seminar will provide an opportunity to have detailed discussion on and peer review of the papers and the authors will be expected to undertake revision of papers after the seminar. A National Conference of the Vice-Chancellors of the Universities, Deans of medical colleges, members of Medical Councils etc. will be organised to bring to their notice the findings of the programme and solicit their support in the ongoing work. It will also be an occasion to sensitise them to the need to formulate gender sensitive policies in medical education.

5) Publication and dissemination: In the long run, the movement for gender sensitisation will require critical mass of literature for the teachers, students and all others concerned on the subject. This programme is expected to contribute in developing such literature by publishing the gender sensitisation module, the review papers and other material.

The work of this type and magnitude would demand contribution from all concerned institutions and individuals. This is not something that can be achieved over-night and by few people. We will make concerted efforts to network with as many as possible, starting with all those who participated in the first national consultation and gave us very useful suggestions to formulate this programme. We are thankful to all of them for their contribution and we will continue seek their cooperation in this endeavour. We are also thankful to the MacArthur Foundation for its generous financial support in organising the National Consultation on January 31, 2002 and for also committing funds for the programme for next three years. Our thanks are also due to the CEHAT, Mumbai for collaborating with us in organising the consultation and in publishing this book.

Dr. K. Mohandas,
Director, SCTIMST

Dr. Amar Jesani,
Programme Coordinator, AMCHSS, SCTIMST

Dr. Mala Ramnathan,
Associate Professor, AMCHSS, SCTIMST

*Thiruvananthapuram
April 24, 2002.*

REPORT OF CONSULTATION ON GENDER AND MEDICAL EDUCATION

Understanding the Needs for Gender Sensitisation-Critiquing Content and Method of Medical Education & Developing Long-Term Strategies for Intervention

**January 31, 2002 held at
SNDT Women's University, Mumbai**

PROCEEDINGS

On January 31, 2002, a meeting was held at the SNDT University, Juhu to initiate the process of introducing gender concerns in medical education. The meeting was organised by the Achutha Menon Centre for Health Science Studies, Thiruvananthapuram and Centre for Enquiry in to Health and Allied Themes, Mumbai.

BACKGROUND

Following introduction of the participants and the organisers, there was a short presentation to put this meeting in its perspective. Introducing gender issues in medical education is a complex process. The objective of this meeting was to reflect on the strategies, which should be used, and the issues, which needed to be addressed. Therefore, it had been decided to invite individuals from different disciplines to have a fairly broad discussion on this subject. All of those invited do not necessarily adhere to a specific ideology, nor are they all actively involved in women's issues, but they have some insight into gender. The meeting was structured in a manner by which partic-

ipants could articulate their thoughts and ideas on the subjects without the constraints of a strict agenda.

In order to provide a guide to the discussions, some questions were posed to the group

- *Is there a need to understand gender in medical education?*
- *What is the nature of this need?*
- *How do we approach this need?*
- *Whom would we approach for the same?*

In this context, certain issues emerged.

Medical education provides entry into the medical profession; hence, it is important to influence medical education itself. However, apart from students, those who have passed out of medical colleges should not be left out. There is also a need to include all those involved in medical education and integrate gender issues into regular teaching. Initially, there had been some significant efforts by women's groups to do a critical review of textbooks and biases within medicine itself. There is a need to look at all existing textbooks, whether Indian or foreign. It was also felt that strategic institutions such as Sree Chitra Tirunal Institute for Medical Sciences and Technology are well placed to initiate the process of engendering medical education.

This raised the question of strategies, which should be adopted. Who are the key agencies to be involved in this process. What kind of interventions will be acceptable at this juncture to medical colleges and institutions?

This meeting would provide a framework for initiating such a process and create a platform from which networking with different institutions and groups would be possible.

Before starting discussion, two presentations had been planned to review the state of affairs in medical education and research as well as identify issues emerging from them. Dr. Thelma Narayan presented a critique of medical education in India in a historical perspective, whereas Dr. Mala Ramanathan made a presentation on the manner in which gender issues are reflected in medical and health research.

SUMMARY OF PRESENTATIONS

Evolution of medical education in India—Thelma

Narayan: Dr. Thelma Narayan commented that successive health policy documents and review committees asserted that medicine and health related disciplines are social sciences and not merely concerned with technology. There was also considerable emphasis on the social role of medicine and the need for it to have an ideological foundation. Medicine needs to respond to social needs and should not just be geared towards the elite. While a few attempts were made to introduce reforms and innovations within the system of medical education. It was hindered by the unchecked growth of practice. These innovations were integrated into the teaching of medicine by some institutions. However, the general standard of ethics or social consciousness within the profession was, in fact, eroded. Even the recommendations made had not been completely implemented.

This led the Srivastava Committee Report in 1975 to comment that implementation of the existing recommendations is the most important priority. However, even in this report, gender concerns are not mentioned. It was only independent organisations such as the Medico Friend Circle, Pune and the Community Health Cell, Bangalore who raised gender issues within medicine.

The uneven development of medical education was another reason for the general erosion of standards and values in education. The 1960s witnessed a spurt in medical colleges promoted by government, which amounted to subsidizing the growth of private health providers and the late 1980s saw growth based on privatisation of medical education and the introduction of capitation fee colleges. The latest trend is the tie-up arrangements of the medical colleges with international agencies / universities. New medical colleges have been given certificates very casually without compliance with existing norms and standards. This mushrooming of new institutions is worrying as there is no proportionate availability of faculty and equipment to cater to the new medical colleges. And infact many of these

private medical colleges are using public hospital infrastructure to comply with Medical Council of India norms.

The over-production of medical personnel viz. Doctors, was remarked upon by the Mudaliar Committee Report which stated that we have more doctors per population than we actually need. However, there has been unequal growth across states - Karnataka and Maharashtra State have a very high density of medical colleges (largely the result of the 1980s growth of private institutions) compared to Bihar and Uttar Pradesh, which have fewer seats and very few institutions, although there is actually a greater need for medical personnel in these states.

The nexus between politicians and the medical fraternity has brought about this situation. Infact many private medical colleges are run by Trusts mentored by politicians. Apart from the quality of medical education, which has faced a major setback especially in terms of a fall in ethical practice and gender sensitivity, medical institutions are ridden with caste/communal based biases, excessive political intervention, bad management, lack of teacher's training, support to wrong values, a larger focus on salaries and allowances and faulty practice policy.

Medical education does not produce professionals to fulfil the need of healthcare felt by the large majority of the population. It caters to the small elite which can afford private care. There are also several worrying practices within medical colleges—private practice by government doctors, political interference (most colleges have emerged out of powerful commercial lobbies—sugar, alcohol) and poor management. As a result those who pass out of medical colleges are not really equipped to provide appropriate medical care. They are cut off from the problems of the poor. Although there are few statistics available on wastage of resources, it is known that 30 percent of the medical graduates migrate to other countries.

The recommendations in order to revamp the existing situation would be to involve people at all stages of planning, transcend cultural gaps and reach out to the entire

population. This can be achieved by reviewing the training, changing the curriculum, exam reform, assessing the existing human resource, incorporating public health education and more importantly focusing on a community health orientation. Existing innovations such as community placements have failed to achieve the desired result due to the lack of a rural orientation programme for the students placed in such settings.

There has to be a paradigm shift in the medical profession from a cognitive to an affective approach, from a technological to a humanistic attitude and from an institution building to a resource development centre. Methods of medical education from hierarchical male methods to more interactive learning

The speaker also pointed out that there is considerable scope for innovation and change within the 1997 Medical Council of India recommendations on medical education.

One of the other concerns raised by the speaker was the harassment of women professionals by colleagues and teachers right from student to practice stages.

Gender and Social Perspectives in health research: Need for fresh thinking — Mala Ramanathan: Mala Ramanathan presented a review of gender issues in medical and health research. Apart from a general overview, she also referred to an in-depth review of studies in reproductive health. She began with laying down a framework for health research. We need gender and social perspectives in health research to identify and find better explanations for the inequalities in health status so as to bring down such inequalities. To achieve such a goal one would have to move from the traditional medical model of health to one based on socio-economic and environmental fundamentals, incorporating of the public health approach as opposed to the individual oriented life style approach. The potential of such an approach would bring into focus new areas of research such as gender violence and its impact on health and well-being. It will help to see men and women as actors and agents instead of being passive objects of

research. The approach will facilitate in developing better analytical frameworks for research by recognising power dynamics at the individual and community level, viewing biological processes in context of social and gender perspectives

Findings from gender informed research for e.g. the South African Health Policy and policy regarding breast cancer screening in Australia can help to redirect health policies.

An exercise reviewing the extent of gender and social equity concerns on reproductive health in India clearly indicated a total lack of gender perspective in any form. Out of 112 studies reviewed, only 6 addressed gender in any way. The studies were critically analysed based on content, methodology and ethics. The content issues analysis revealed that men are largely missing in studies on reproductive health. Perception of women's own experiences are almost never examined. Gender roles and dynamics are hardly ever examined.

In terms of content, it was found that a key aspect of reproductive health, ante natal care is never examined. What is its content and why it does not predict future problems is never reviewed. The sensitivity and specificity of tests used for gynaecological morbidity is never evaluated. In terms of analysis, it was found that while socio-economic status is used as a variable for analysis, what is the exact path by which it influences health status and outcomes is never explored.

Certain biases and assumptions are seen reflected in the priorities for research as well as in the choice of participants. Infertility - male infertility is examined only after ruling out female infertility. Although it is far more easier to eliminate male infertility. Very few studies include men at all. There are also certain ethical issues involved which arise specifically because of the hierarchical gender division of labour within the medical system. Many of the controls are nursing professionals in the institutions. What are the power dynamics involved? Why are these not

addressed? Such ethical issues, including ethical issues related to publication are not addressed.

Following these two presentations, there was an unstructured discussion on the issues involved and several viewpoints were put forward. While the range of issues raised was vast, they could be broadly categorised into the following issues related to medical education, issues related to medical practice and the role of the medical education/system and its interaction with other groups in society.

ISSUES RELATED TO MEDICAL EDUCATION

Western medicine, as a discipline, is highly male-centred. Its language, knowledge base and world-view, all reflect this bias. A view was expressed that process changes can not be separated from structural changes. Those who undergo training in this system are socialised in its value system and perpetuate the bias. While this basic problem cannot be easily resolved, the participants also raised several issues related to the organisation of medical education, its content and the possible strategies to introduce more gender awareness and sensitivity.

At the outset, concern was expressed about the lack of transparency in the whole process of revamping medical education. There are indications that privatisation of teaching institutions is on the anvil. It was also feared that association is also heading the Medical Council of India (MCI) is indicative of the degree to which the autonomy of the MCI has been compromised.

Preventive and Social Medicine (PSM) which is the discipline meant to give students a social perspective on health has been extremely neglected. Students also tend to dismiss it lightly, with the result that they remain unconnected with the actual reality of health care. With privatisation, it is feared that PSM, which has no marketable value, will be further diminished in importance.

It was noted that even in the basic medical education, women's health problems and concerns are not given any

importance. For e.g. most general practitioners do not know how to conduct deliveries at the end of their training. Many would have liked to receive more instruction on obstetrics and gynaecology during their graduation.

Students are also not taught about the existing laws such as PNDT, MTP Act on how they affect women, how do they impinge on the practice of medicine? etc. These issues have to be taught at the undergraduate level itself to tackle live issues in medical practice. For e.g. doctors and paramedics are often caught in an ethical dilemma and confused about reproductive rights (e.g. Whether or not to give contraceptives to women who are single and who have not consulted their families).

Another important issue highlighted was that there is no mechanism for integrating the experience of practicing doctors back into medical education. Thus, many of the issues which arise during practice, (including gender discrimination, or unethical practice) do not get reflected in the teaching.

It was felt that in order to introduce gender into medical education, there was a need to reinforce values and principles. Gender could provide a way of making medical education much more socially relevant. It was felt that various strategies could be adopted to engender medical education. Short study courses for both medical students and continuing medical education could be designed. It was felt that rather than have a separate department for gender, gender concerns should be integrated into the teaching of all medical disciplines. For e.g. what is the gender dimensions of any illness (T.B., Malaria, Cancer) should be a part of the curriculum.

There is also need for curriculum research. Alternative text-books have been designed for gynaecology by women's groups, but these need to be brought into mainstream teaching. Also other text-books need to be looked at from the gender perspective.

Unless gender is integrated into all aspects of the teaching it will not be imbibed. There need not be a sepa-

rate department for gender issues. We have to agree that gender sensitivity should be incorporated in all aspects of medical education. Value education aspects should deal with issues of ethics and values. There should be a core course and a foundation course, and the foundation course can deal with the gender related issues with a rights perspective. It is extremely important that we include all this in our evaluation so that the students treat the subjects very seriously. Research topics related to gender should be given to students. Values begin in schools and we need to develop a questioning mind earlier itself. Selecting students through interview would ensure that selection process is gender sensitised

We also need to identify people who are sensitive trainers also, who can write on the basis of their experiences the kind of changes needed in the medical curriculum. We also need to look at experiences of countries where such curriculum exist and try and imbibe them (e.g. South Africa).

ISSUES RELATED TO MEDICAL PRACTICE

It was pointed out that women's groups had provided a critique of medicine by studying the manner in which women are treated within the medical system. One participant commented that earlier some groups had gotten together and taken risks and brought gender issues into the agenda of mainstream organisations and institutions. However, at a later stage, several NGOs and funding agencies had jumped into the bandwagon and diluted the ideological and radical content of this critique.

On the other hand, women have always been in the focus of the medical profession. Women have always been enrolled as recipients, thanks to the demographers and population control policies. Due to corrupt practices rooted in the current health care system, i.e. sex selection, unnecessary surgeries, and many more areas where there are no positive images of women.

Drug industries are producing drugs for menopause and osteoporosis, for which there is no diagnosis. The fam-

ily planning lobby and also the private sector have skewed the way gender questions are introduced, focussing on women to only retain them as patients. There is no sensitivity shown to women's needs and lifestyles.

Even in medical research, women's needs are ignored. Women are not given information in genetic testing, screening. As a norm, women are not enrolled as subjects in clinical trials. There are suggestions coming from women's groups that women should have the right to enter clinical trials, with the exception of women in the reproductive age. Because it is the women who are going to use these drugs. In medical research, social dimensions and gender are not included/explored.

During counselling and informed consent procedures, women are often not consulted. Questions and information is directed at the husband where very often the woman is sidelined and her husband is consulted. Her own consent and opinion is not considered, particularly when she does not agree with the decision of the family. There is a gender divide in the access of health care use and health care costs and these inequities are increasing. Women access informal providers and informal care. The result of the women and health movement in the west has elevated the relationship between women and doctors as women have better understanding and they are able to ask intelligent questions to doctors and doctors are providing better response than in the past.

Even reproductive health issues are not given adequate importance. Many students after graduating feel that they would have benefited if more time were spent on teaching skills required in obstetrics and gynaecology. The status of women in the general health scenario is entirely neglected. for e.g. We have very little knowledge about the differential impact on women of diseases like T.B., Leprosy, HIV etc.

There is also a need to re-orient those who have already passed out of the medical colleges through continuing medical education. Actual training begins after graduation when doctors begin practising. There should be a mecha-

nism by which doctors can integrate their experience into medical education.

ROLE OF THE MEDICAL EDUCATION/SYSTEM AND ITS INTERACTION WITH OTHER GROUPS IN SOCIETY

Apart from introducing changes in the medical practice and education, there has to be a critical analysis of how the medical profession interacts with other groups in society. As stated earlier, women's groups were instrumental in critiquing the medical system and pointing out the sexism in all areas of health care.

Gender discrimination is rampant in the hierarchy of the medical profession. There is no respect for female functionaries, e.g. nurses and the paramedical staff. Even within paramedical staff (for e.g. multi-purpose workers) male workers are given more respect and autonomy than female staff. Women health workers, like all the other women workers face a lot of harassment and discrimination in the workplace. Even in terms of enrolment, one finds that though more women students are being admitted to the medical colleges, the gender division in postgraduate specialisations is clearly seen, where women opt for the subordinate specialities. We must examine the reason for this as well. Further, data published on enrolment often is not gender disaggregated.

The fact that health care access itself is poor, places the problem of gender discrimination outside the health care system. For e.g. 80 percent of the deliveries are still conducted at home by untrained providers. Therefore, health care system has to actually reach out to women within their own households to circumvent the discrimination against them by families.

There was considerable discussion on the process by which medical education and practice can be re-oriented. It was felt that there needs to be close inter-action with women's groups which have been the focal points of critical perspectives on medicine. One has to introduce a rights perspective in medical education. Some unanswered ques-

tions were posed about how to set in motion such a process. Who should be approached and how should decision makers be influenced. One suggestion given was that a few politicians who are concerned about such issues should be asked to raise questions to create a groundswell.

A question was also raised about the gender perspective in non-allopathic systems of medicine about which very little is known. These systems are also very poorly organised and there has been considerably less effort to reform them. Though, it does appear that they are as patriarchal and male centred as allopathy.

At the end of this unstructured discussion, the group drew up a framework within which the discussion in small groups could take place. Following the reporting of groups there was a plenary discussion based on the same framework. Presented below is the gist of the discussion as well as the specific strategies that emerged.

SUMMARY OF GROUP DISCUSSIONS

What should be the process of engendering medical education and practice and other stakeholders and groups? What are the elements of gender? One of the groups began their discussion by attempting to define what is 'gender'? They opined that gender refers to difference, and addressing gender concerns did not merely involve including women and reducing gender to maxims (e.g. making sure that there is x proportion of women in the treatment programme.) Gender sensitive healthcare involves 'unpacking patients'. It means looking at men and women patients and their specific needs, look at what class backgrounds and cultural backgrounds they belong to, examining presumptions and stereotypes that have been entrenched. Over and above, recognising the fact that patients come from households and they live in a social environment. Gender could be used as an indicator because it incorporates all kinds of inequities.

There should be a gender analysis of the different diseases. e.g. how does T.B affect women differently from men? What are the specific needs of women, which are different from those of men? One participant shared her

experience that while writing a book on women's health, they found that almost every illness could be deconstructed from women's perspective. The medical system is premised on the assumption that there is a family, which is able and willing to carry out the role of caring. Women really struggle to fit into this perspective because they never have this kind of support.

It was commented that the process of making medicine gender aware requires that we approach it from both ends, medicos and the public. The social construction of gender within medicine should be deconstructed. Women medicos themselves have internalised the ideology of patriarchy. One has to build links with the larger people's movements and active people's organisations to create this consciousness. Gender also cannot be viewed in isolation, cut off from other hierarchies. One has to therefore build a broader alliance of progressive groups to address all these issues.

Who should be doing this? There was disappointment about the fact that the medical council had not proactively addressed this issue. One suggestion was to enlist the support of those who were interested in medical education and have a sound gender perspective through gender workshops. These participants could be the starting point and they become the faculty or resource group to take the work forward. A suggestion was made to use the concept of mobile workshops already being used in medical education. Faculty for the mobile workshops will go from place to place.

It was pointed out that a group (*Sakhi*) in Trivandrum had developed a course on gender, health and development with the involvement of three or four groups and individuals. Such material could be adapted. One participant also pointed out that there are several informal networks of medicos, which could be the route through which medical professionals could be sensitised. However, it was also pointed out that unless such changes are introduced through the mainstream, they will not get integrated.

It was felt that the best teachers should teach these

modules because in medical education, the charisma and reputation of the teacher is very important. These persons should serve as role models to others.

What are the tools and mechanisms, which we can use in this process? Are there any innovations that we can suggest? There were a large number of suggestions related to the strategies, tools and mechanisms for introducing changes in medical education. One over-riding concern was that there should be consonance between teaching and practice. Thus, whatever changes are introduced in the curriculum, should also be reflected in the actual health service delivery.

CHANGES TO BE INTRODUCED IN THE CURRICULUM

It was felt that the first priority would be to develop a module for under-graduate medical students because they form the large majority of the medical students. There is already a network of medical colleges for introducing innovations in medical education. We can use that existing platform to introduce changes. Apart from undergraduate colleges a need was expressed to develop some material for the key decision makers, deans, nursing directors and hospital administrators. There is also a need to introduce this training in continuing medical education.

It was pointed out that there was already considerable literature existing as well as training modules which should be reviewed and adapted for use in medical colleges.

For the preparation of the modules, several sources of information and input were suggested. It was felt that there are several local level initiatives, which have not reached the medical colleges. These should be documented and used.

Module: The module should have a strong rights perspective and the module should have a perspective chapter, which explains what is meant by gender. We need to provide examples of gender dimensions of all diseases and illnesses so that this can be incorporated in the teach-

ing. There are very few speciality specific modules, which look at the gender dimensions in the different medical specialities. Such modules would have to be developed. It was suggested that a few individuals should be identified who could review these modules and make sure that the information is accurate.

Another suggestion in this regard was that the module should have a checklist. Every institution, which undertakes to use this module, must evaluate its own functioning according to this checklist to ensure that which is taught is also practised. A common observation made about medical practice is the fact that medical professionals are bad communicators. A suggestion was that oral and written communication skills must be taught at the undergraduate level as well. There is a need to introduce curriculum reform for various reasons. Certain subjects such as genetics and immunology, which are becoming very important need to be taught at the undergraduate level. Thus, the module on gender could be introduced as part of the larger process of revision of curriculum.

The process of implementing the module would involve finalising the module, training trainers and having a series of workshops to introduce the module in different institutions. Indian Council of Medical Research (ICMR) could be motivated to undertake this initiative.

One pragmatic suggestion was that there should be a review of what can be removed from the syllabus before recommendations can be made to make any additions.

Critical Review of Textbooks: A specific suggestion that was made related to developing a critique of the textbooks used in the various disciplines. Individuals would be identified to prepare perspective papers on different specialities. These could then be presented in a national seminar and published and disseminated widely so that the trainers have a critical mass of literature available for use.

CHANGES IN THE SETTINGS IN WHICH MEDICAL EDUCATION IS PROVIDED

In order to make the experience of gender sensitive health care provision palpable, it is necessary to make radical changes in the medical settings in which medical education is imparted. This includes the teaching hospitals attached to the medical colleges as well as community based outreach centres. It was suggested that there should be combined workshops for the nursing and medical staff to increase interaction between them. This will also facilitate discussion on the existing hierarchies within the profession. Another suggestion made was that we should start with the participants' own experiences. Nothing can be imposed by decree from above, otherwise people will become resistant to this kind of change.

An important factor in the maintenance of gender hierarchies in the medical system is the gender division of labour. While doctors are seen as curers, the physical work of caring is entirely to be carried out by the nursing staff. The different values attached to each role contribute in sustaining gender hierarchies. If nurses are allowed to graduate as doctors with some additional training, it will help to reduce the hierarchy and also open up more avenues for women.

It was also pointed out that women are often not able to complete their medical education due to domestic responsibilities. If a semester system is introduced, more women students would be able to graduate. A post of a gender equity officer should be created to look into such issues, independent of the management.

Women as patients also face subtle discrimination and their experiences are negated or delegitimised. Women's illnesses are explained away in psychological terms. Certain experiences of women, which are so common, like the experience of menopausal syndrome, are not recognised by the medical profession. On the other hand, actual mental distress, such as anxiety or depression are not identified or treated. Even though most of these problems emerge due to

the deep-rooted male-bias in the medical system, there are several ways in which gender sensitivity can be introduced.

One of the general problems with medical practice is the inability to see an individual as a whole. There is a tendency to compartmentalise patients. Each disease, ailment is viewed on its own. Departments are organised according to that and patients are treated in this fragmented manner.

Some small changes like introducing a book system, rather than case paper, where each practitioner is compelled to read and respond to the notes of others can encourage doctors to treat the whole person rather than the disease.

Similarly, reorganising departments can change the actual experience of learning medicine and practicing it. For e.g. if a pregnant woman has symptoms of T.B., encourage the ANC unit to treat her rather than shuttle her to the chest OPD. This will compel doctors to look beyond the pregnancy at the social and physical conditions in which she lives.

Certain changes in procedures can be introduced. For eg. OPD timings can be made more flexible so that actually respond to people's needs rather than force them to make adjustments. Women should be given space to express their own views about the medical system and these should influence the organisation of services. It would be useful to develop protocols that compel practitioners to follow certain norms and guidelines. For e.g. a protocol would lay down the procedure for obtaining informed consent after providing full information. Often, doctors complain that responding to requests for information can become quite exhausting and time consuming. But the experience of other countries has shown that once it becomes part of the routine, doctors adapt easily to the extra effort and time required.

A useful exercise would be to document best practices in this field and use them as models for replication. The experiences of Agarwal University, Jaipur as well as other such initiatives should be recorded and discussed.

Who should we be addressing? Finally, who constitutes the constituencies for introducing these changes. Influencing the teachers is very important because students imbibe values and attitudes from their seniors. Sometimes, the hierarchical structure works to our advantage because by convincing the top person (e.g. head of department) the entire unit can be made to change their behaviour.

As stated earlier, not only undergraduates but also those already practicing as well as post-graduate students need to be involved. Certain issues, e.g. ethics or gender discrimination, become alive for doctors only when they start practicing. There should be a mechanism by which the experiences of practicing doctors can be integrated back into medical education.

However, efforts should be made to enlist the support of some committed organisations, which can lead the way. E.g. JIPMER or SCTIMST Indian Medical Association & State Medical Associations. Professional organisations such as medical associations as well as voluntary organisations like the Medico Friend Circle need to be involved so that they can reach out to professionals in different fields and areas. Getting the endorsement of key organisations such as the Medical Council and the World Health Organisation can play an important role in mainstreaming changes. Eventually, reaching out to the public will be most important so that they can create pressure to demand for changes within the medical system. Therefore, it is equally important to align with people's organisations and women's organisations who were instrumental in providing a critique of medicine and offering alternatives.

It is extremely important to address the Medical Council, which is the body responsible for medical education. Sustained advocacy efforts with the Medical Council are required to ensure that the changes in curriculum are institutionalised. Universities, to which medical colleges are affiliated also need to be involved in this process. Government institutions, such as the public health departments and the medical bureaucracy also are involved in

the organisation of services and programmes. Enlisting their participation in this process is also vital.

A concrete suggestion that emerged from the discussion was networking between medical colleges and institutes. There was mention of a network of medical colleges across the country, which could be utilised to introduce gender sensitivity training in the curriculum. The Achutha Menon Centre for Health Science Studies is also associated with the community medicine departments of various medical colleges in India and South Asia, which could provide a platform for introducing gender sensitisation training on a large scale. Institutions such as JIPMER, which are premier institutes for training teachers in medical education has introduced several new methods and modules in medical education. It has also shown readiness to experiment with the introduction of gender sensitisation in medical education as well.

This group committed itself to initiating the process of networking on this issue. The idea of setting up a website was suggested and Sree Chitra Tirunal Institute for Medical Sciences and Technology took responsibility for the same.

□ □ □

LIST OF PARTICIPANTS

- (1) Dr. B. Ekbal, Vice Chancellor, Kerala University, Thiruvananthapuram. Tel: (Work): (0471) 306634. (Home): 444362. Email: ekbal@vsnl.com
- (2) Dr. Manoj Kar, WHO, India Office, Nirman Bhavan, New Delhi. Email: ManojKar@npsuindia.org
- (3) Dr. Lakshmi Lingam, Women's Study Unit and Coordinator, Centre for Health Studies, Tata Institute of Social Sciences, Sion-Trombay Road, Mumbai 400088. Tel: (Work): (022) 556 3290 Email: (1) lakshmil@tiss.edu (2) laxmil@hotmail.com
- (4) Dr. Dileep Mavlanekar, Indian Institute of Management, Vastrapur, Ahmedabad, Tel: (Work): (079) 630 7241, 630 3357 Ext. 4949. (Home): (079) 646 4168, 630 6896, Email: dileep@iimahd.ernet.in
- (5) Dr. Vasantha Muthuswamy, Indian Council of Medical Research, Ansari Nagar, New Delhi. Email: vmuthuswamy@hotmail.com
- (6) Dr. Poonam Muttreja, MacArthur Foundation. India Habitat Centre, Core C, Zone 5A, First Floor, Lodi Road, New Delhi 110003. Tel: (011) 464 4006. Email: macarth@giadl01.vsnl.net.in
- (7) Dr. K. A. Narayan, Professor of Community Medicine, Jawaharlal Institute of Post-Graduate Medical Education and Research (JIPMER), Pondicherry 605006. Tel: (Work) : (0413) 372380, 372389 Ext. 269, 502, (Home) : (0413) 273620. Email: (1) narayan_ka@vsnl.com
- (8) Dr. Thelma Narayan, Coordinator, Community Health Cell, 367 Srinivas Nilaya, Jakkasandra, I Main, I Block, Koramangala, Bangalore 560034. Tel: (Work) (080) 553 1528. (Home) (080) 553 3064. Email: sochara@vsnl.com
- (9) Ms. Aditi Iyer, Indian Institute of Management, Faculty Block D, Bannerghata Road, Bangalore 560034. Tel: (Work) (080) 658 2450
- (10) Dr. Veena Shatrughna, National Institute of Nutrition, Jamia Osmania. Hyderabad 500007. Tel: (Work): (040) 701 8909. (Home): (040) 701 8687. Email : veena52@yahoo.com
- (11) Ms. Padma Prakash, Deputy Editor, Economic and Political Weekly, Hitkari House, Shahid Bhagatsingh Road, Mumbai 400001. Email: epw@vsnl.com
- (12) Dr. Kirti Iyengar, ARTH, 39 Fatehpura, Udaipur 313004. Rajasthan. Email: arth@softhome.net

- (13) Dr. Veena Poonacha, Director, Research Centre for Women's Studies, SNDT Women's University, Juhu Campus, Santacruz West, Mumbai 400049
- (14) Mr. Ravi Duggal, Coordinator, CEHAT, Sai Ashray, Aram Society Road, Vakola, Santacruz (East), Mumbai 400055, Tel. : (Work) 614 7727, Email: cehat@vsnl.com
- (15) Ms. Neha Madhiwalla, Senior Researcher, CEHAT, Sai Ashray, Aram Society Road, Vakola, Santacruz (East), Mumbai 400055, Tel. (Work) 614 7727 Email: cehat@vsnl.com
- (16) Dr. K. Mohandas, Director, Sree Chitra Tirunal Institute of Medical Science and Technology, Thiruvananthapuram 695011, Kerala. Email: director@sctimst.ker.nic.in
- (17) Dr. K. R. Thankappan, Associate Professor, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute of Medical Science and Technology, Thiruvananthapuram 695011, Kerala, Email: thank@sctimst.ker.nic.in
- (18) Dr. Mala Ramnathan, Associate Professor, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute of Medical Science and Technology, Thiruvananthapuram 695011, Kerala, Email: mala@sctimst.ker.nic.in
- (19) Dr. Amar Jesani, Programme Coordinator, Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute of Medical Science and Technology, Thiruvananthapuram 695011, Kerala, Email: amar@sctimst.ker.nic.in

THOSE WHO COULD NOT ATTEND

- (1) Dr. Rani or Abhay Bang, SEARCH, Shodh Gram, PO/Dist. Gadchiroli 442605. Maharashtra. Email: search@satyam.net.in
- (2) Dr. Sulochana Abraham, CMC, Vellore, Tamil Nadu. Email: chad@cmcvellore.ac.in
- (3) Dr. Indira Murali, National Institute of Health and Family Welfare, New Mehraulli Road, New Delhi 1100. Tel.: (Work): (011) 616 0156. (Home): (011) 618 5432
- (4) Dr. Subhash Salunke, Director General, Directorate of Health Services, Maharashtra State. Government Dental College Building, 4th Floor, St. George's Hospital Compound, Mumbai 400001. Tel: (Work): (022) 262 1031 to 36, 262 Email: (1) sbtc001@vsnl.net (2) dir1201@vsnl.com

RAPORTEURS:

- (1) Ms. Rajeshwari Balaji, CEHAT, Mumbai.
- (2) Ms. Qudsiya Contractor, CEHAT, Mumbai

□ □ □

**PERSPECTIVES ON MEDICAL
EDUCATION**

GENDER AND POWER ISSUES IN MEDICAL EDUCATION

Dr Thelma Narayan

Currently gender is recognised as a term that reflects the complex social relations between men and women (Kannabian 1997, Bhasin 1997, WHO-SEARO, 1998) accepting biologically determined differences as being more unchangeable, the focus is on socially constructed roles that have developed historically within and across cultures. This process of socialization has led to the generally inferior positioning of women within families and in all other institutional groupings that exist in society. The underlying issue of power equations in the relationship, that manifests itself in terms of dominance, subordination equality, inequality, role in decision making, control over resources, division of labour and access to services, is one that needs to be constantly reflected upon to ensure that the interests of more powerless and vulnerable groups are not made subservient to those that are dominant.

Cross-cutting linkages with other power structures in society such as class and caste or ethnicity adds additional oppression to the position and condition of women in particular social groupings. The internationalization of these social relations, roles and attitudes is deeply ingrained through socialization process during childhood and adulthood. They are reinforced by culture traditions and religion, such that both women and men usually implicitly accept given roles. These social relationships with their inherent hierarchies and positions of privilege are characterized by conflict, often with the use of overt force and violence. A veneer harmony may mask much subterranean 'silent suffering' which is part of the glorified and sanctified role assigned to women. However, social; construction are products of the human mind and though they may be rein-

forced by strong beliefs and ideologies, they can be deconstructed.

THE POSITION OF WOMEN IN INDIA AS REFLECTED THROUGH HEALTH INDICATORS AND MEDICAL PRACTICE

Available health indicators (more accurately indicators of levels of death and disease) provide evidence of the position of women in India. While globally the gender ratio (number of women per 1000 men) favours women because of the certain biological strengths, the ratio in India from the turn of the century is adverse to women. More alarming is the fact that it has been consistently declining, despite fifty years of political freedom, decades of development efforts, and the spread of education. It has continued in spite of awareness created during the international Decade of Women and the efforts of women' groups throughout the country. All these liberative forces have not been able to dislodge sets of factors that seem to be very deeply embedded in our society. The continuing high rates of maternal mortality and high rates of anemia among women point to deprivation of basic physical needs.

George S and others have researched and documented the prevalence of female foeticide in Haryana and Tamil Nadu. It has also been reported from Maharashtra and Rajasthan and probably occurs all over the country. Medical technology in the form of diagnostics, particularly ultrasound and amniocentesis is used for sex determination, despite the national legislation passed in 1992 banning its practice. The finding of a girl foetus is usually followed by performance of a Medical Termination of Pregnancy (MTP), often by qualified obstetricians, a practice legalized by the MTP act. The selective abortion of girl foetuses is justified as an exercise of free choice by parents and the mother. The medical ethical issues underlying these practices by medical professionals do not seem to find a place in the professional discourse of members or women themselves. It is hypothesized that the practice of female foeticide is one of the reasons for the declining gen-

der ratio. Private ultrasound and MTP services have been mushrooming even in small towns and large villages, though in contradiction, at the same time shortages of simple iron and folic acid tablets for anemia (required particularly by pregnant women and costing just few paise) have been reported from all over the country in 1997 and 1998. This contradiction raises questions regarding the actual interests of both private and public sector health care services vis-a-vis women's health needs.

Malini Karkal (1996) based on years of research observes that asymmetric gender relations often cause discriminatory treatment of daughters within the parental family, and that this is further strengthened by marriage practices. It has been found that burns comprise one of the largest causes of death in young women aged 15-35 years, even more than pregnancy related causes. One study in Mumbai found that 60% of deaths due to burns occurred in the parental home and not in the in-law's house as commonly believed. Malini Karkal (1996) also hypothesizes that patriarchy operates on age hierarchy with ageing enhancing a women's position in the family. Hence, the support for patriarchy by older women.

High stress levels, due to playing multiple roles, causes women to have an increased vulnerability to mental illness with feelings of helplessness, worthlessness, apathy, depression and sometimes suicidal behaviour (CHETNA 1996), from Indian NGO's report on CEDAW, published by Coordination Unit for Beijing Conference, 1995). Girls and women are socialized to tolerate discomfort and pain, often leading to delays in seeking care, support and treatment, with resultant progression of underlying disease processes.

Access to care is lower for women, as has been found in some studies looking at utilization of inpatient and outpatient medical services. It is suggested that part of the cultural definition of being a women in India is her association with the inside namely within the confines of the home and the family (World Bank 1991). This restricts knowledge and access to services including to health care, but also to the outside world where political and economic

power is exercised (ibid). the poor health status of women in India and their limited access to care is part of the overall iniquitous social position of women. While medical and health care can potentially liberate women through reduction of pain, suffering and death, medical professionals have sometimes misused medical technology to perpetuate an anti-women bias as is particularly evident in the widespread practice of female foeticide and in the promotion of a family planning programme in pursuit of state demographic goals at the cost of women's health.

There is evidence of lack of power of women in India in other spheres as well. For instance, in general women do not own land, they have less access to markets, about 75% are illiterate, and 90% of rural and 70% of urban women workers are unskilled (World Bank 1991). These factors along with low purchasing power, lack of food security, poor access to safe water and sanitation, impact more adversely on the health of women, and vulnerable groups than do individual germs and bugs. One needs to assess how much and how seriously medical education addresses these underlying social/societal factors that impinge so greatly on health.

GENDER AND MEDICAL EDUCATION

Medical education, both graduate and post graduate, forms medical professionals, and along with research, informs medical practice. It also sets the guidelines and tone for education and training of allied health professionals. How does medical education confront and address gender issues? Is it sensitive and responsive to women's health concerns? Or is it another institutional arena in which gender issues get played out without being challenged?

Though medicine is commonly associated with objective scientific thought and methods in its practice there is little rationale in the structure of medical education. Historical factors relating to the growth, acceptance and dominance of certain disciplines, as well as the prestige attached to them at that time, resulted in greater or lesser

allocation of time for their study. Thus anatomy receives of larger time share while psychology and psychiatry are still struggling for their space. Sociology has not yet found a strong entry point and medical ethics is still on the fringes. The foundations of modern medical education occurred during the period of 'scientific optimism'. There was little space for the social sciences or for the experience of medical practitioners through their interaction with reality, to be able to raise questions concerning the social roots of disease and ill health or the relevance of medical prescriptions to the lives of people, particularly of women.

Thus, for instance, medical students spend the first one-third of their taught under-graduate course with cadavers, frogs and biochemical experiments that bear relatively little relevance to their practice as healers. These are probably early steps in the process of dehumanization, which later leads to a fragmented focus on organs and systems rather than on the whole human person who is suffering and in need of care besides cure. Medicine and medical education, though described as a social science took a scientific detail of their biological components. The growth and faith in molecular biology and genetic intervention is evidence of this. Modern medicine has thus not related adequately to social and cultural reality, to intra and interpersonal behavioural factors and much less to conflictual social relation. A major lacuna in this regard is the lack of recognition given to women's health and gender issues.

HISTORICAL DEVELOPMENTS

Historically, modern medicine and medical education come to India through the European colonial powers of the time (Portuguese and British). A process of gradual marginalization of the Indian System of Medicine (ISM's) and folk health practices followed. The ISM's though also urban based and to some extent elite, had a more holistic approach to the sick person as total and attempted to maximize and build up the healing powers within the persons body. An extensive pharmacopea and surgery had been

developed by the ISMs over centuries of empirical observation, classification and codification. However, it appears that the approach to women's health focused largely on her role in child-bearing and motherhood. More importantly, the ISMs had traditional cultural links with local indigenous healing practices including dietary and other preventive practices which were widespread throughout the countryside. Women were largely the bearers of these local knowledge system and practices. Western medicine, including gynaecology, "gradually marginalized midwives (*dai's* or traditional birth attendants), medicine women, women healers; they declared women's indigenous knowledge as non-knowledge" (Bhasin, 1997, p 23). The marginalization of ISMs occurred even in health planning and policy and this is continued even after gaining political independence. Even today, ISMs receive about 5% of the budgetary outlays for health at national level. At the state level, some states accord ISMs slightly greater priority though the major allocation still go to modern medicine. Western or allopathic medicine by asserting and establishing a hegemonic dominance in India, has negated local systems of knowledge and medical practice and denied them a legitimacy that is theirs by right.

POLICY GUIDELINES FOR MEDICAL EDUCATION

A review of the Medical Council of India recommendations of graduate medical education (MCI 1981) is revealing regarding its gender sensitivity:

- a) While mention is made that "the importance of social factors in relation to the problem of health and diseases should receive proper emphasis throughout the course", specific social factors such as gender are not mentioned. That social factors can be a cause of ill health and disease is also not considered.
- b) The importance of population control and family planning for health and development has been strongly emphasized, with a detailed curriculum for the teaching of Family Planning methods. A strong demographic agenda is evident, related to 'the needs of the country'

as understood, determined and defined by the state. That women's health needs and interests may differ from state interests is not considered. Women have been made targets (Prakash, 1983) and objects of methods that in themselves are an iatrogenic cause of ill health, due to the side-effects of most of the available contraceptive methods

- c) Obstetrics and Gynaecology in Phase III focuses largely on the obstetric, child bearing aspects. Thus " not less than 2/3rd of hours of clinical instruction shall be given to Obstetrics including Antenatal Care, Newborn care and Maternal Health". Notice the lack of emphasis on the whole woman and on the total dimensions of her health and well being at all ages.
- d) During internship, of OBG is to be focused on " Antenatal care, family planning, contraceptive technology, operative techniques, sterilization, newborn care, well baby clinic and paediatrics". Again a large lacuna persisted in the understanding and approach to women's health. Gender sensitivity was completely missing.

The gender bias in the content of the curriculum received comment from the Medico Friend Circle, an all India 'thought-current' of persons interested in health issues affecting the majority population, the poor. The MFC was and is interested in socially relevant medical education and in women's health issues. There was no other social grouping in India then that took up this issue. (Narayan, 1991). Dialectical discussions on the presence or absence of a 'sexist bias' in the teaching and practice of Obstetrics & Gynaecology also took place (MFC, 1983)

The next revision of the MCI Recommendations termed MCI Regulations (MCI 1997) made remarkable shifts in statements from disease to health and from hospital to community, with an emphasis on being relevant to service situations as obtaining in the country. It recognised the health rights of all citizens and called on doctors to fulfill their social obligations, to observe medical ethics; to appreciate socio-psychological, cultural, economic and

environmental factors affecting health and to develop human attitudes. This is indeed a positive change and in the right direction. However, again it is silent regarding the broader, total dimensions of women's health. Obstetrics and gynaecology continues to be biologically oriented and confined to the reproductive system. Five of eight teaching objectives relate to pregnancy, with only one "to identify common gynaecological diseases and describe their principles of management". Here again, the medicalisation of problems occurs.

While Pharmacology specifically mentioned the prescription of drugs during pregnancy and lactation, infancy and old age, Psychiatry had no special mention concerning women's mental health.

Additionally, the emphasis on "analytical, logical, scientific thought and independent judgment" (MCI 1997) while useful, is too brained or masculine and needs to make space for integrative and collective learning, and intuitive creative abilities.

These new regulations seem to offer an opportune moment for greater interaction between Universities, those responsible for medical education and women's health and gender sensitive activists and scholars, to evolve gender sensitive curricula and methods.

CONTENT OF MEDICAL EDUCATION

There is need for further work to review the syllabus from a gender perspective and to make positive suggestions as to the elements that need to be introduced, deleted or modified. While obstetrics and gynaecology, pharmacology and psychiatry could be the subjects to start with, the exercise needs to be done for all the disciplines. For instance, all doctors in all departments need to be sensitized to the issue of domestic violence which may underlie a presentation of a woman with injuries at the surgical or orthopaedic OPD or in the casualty. The underlying real cause may not be divulged unless the physician has the sensitivity and skill to get such a history. The support, care and profes-

sional intervention that is required in such a case is much more than just treating the wound surgically. Similarly a young girl or woman may present with burns-underlying the treatment of burns is the deep socio-psychological trauma that may prevent her from telling the truth or it may even force her to make a false dying declaration. In other instances, women who are raped need the professional advice of a forensic expert and of the local general practitioner. Paediatricians are faced with girl children who are brought late for treatment or in worse situations with children who are sexually abused. Common medical / surgical procedures are performed unnecessarily on women such as the practice of routine episiotomies for all primies, the increasing rate of caesarian sections and hysterectomies and the use of the lithotomy position for normal deliveries. Thus, every aspect of medical practice and therefore of medical education comes face to face with gender issues. Medical professionals and even more so all allied health professionals are in a unique position where they can go beyond the immediate to address some of the deeper causes of gender related health consequences. For this, there is a need for mainstream education to take in the learnings from the women's movement and from research studies.

METHODS OF MEDICAL EDUCATION

Methods need to move beyond didactic hierarchical, exam and theory oriented teaching to use interactive, participatory, problem based learning methods, that are centered on student growth but also equally importantly relate to social context and health needs of people.

A number of innovative experiments have been tried in India (Narayan et al 1993). Some of these are not widely known or lost to history. However, there is a stream within mainstream medical education that has always sought social relevance and has tried community based or community oriented approaches. These are the natural allies through whom gender sensitive approaches could be introduced into medical education. Globally there is the

Network of Community Oriented Educational Institutions for Health Sciences. It was initiated with the help of WHO and continues to have its active support. At their annual meeting in 1994, a suggestion was made from Pakistan and India to have a women's health cell. This could be further pursued. Their journal is appropriately titled Education for Health. There are a few Indian institutions and individuals who are members. Some Indian Universities have taken a lead in introducing progressive changes. Mumbai University is introducing women's studies as an integral component of several of their courses. The Rajiv Gandhi University of Health Sciences - Karnataka, Bangalore, is restructuring the curriculum based on the 1997 MCI Guidelines. It is one of the first Universities to introduce the teaching of medical ethics throughout the course. Thus, there are windows of opportunity that need to be used to promote an understanding of gender and power issues in medical education that will also translate into action into the educational programs offered.

VALUES IN MEDICAL EDUCATION

With current global and national trends towards globalisation, liberalisation and commercialisation which includes the commodification of women and of medical care it is important to emphasize and reiterate in medical education certain basic values in health. These include equity, social justice, ethics, gender sensitivity, sustainability and self-reliance. There could be many others such as respect for plural people's health traditions, and cultural sensitivity.

WOMEN IN MEDICAL EDUCATION AND MEDICAL CARE

A detailed review of medical education found increasing numbers and proportions of women medical students gaining admission and graduating from medical colleges across India (SOCHARA, 1995). From 21.5% in 1971-1972 admissions of women students were 39.8% in 1989-90. There are gender differences in admission to the prized post-graduate specialities of surgery and medicine. Gender discrimination

is reported to occur in promotions, with women considered to be unavailable to handle all the responsibilities due to the double burden of also managing their families and homes. This as in all other occupations raises the issue of joint responsibility for child care and home management. Women physicians in Delhi have been reported to have a better status than in the past, also occupying leadership, and decision making positions as heads of departments and institutions. However, they are still viewed as occupying specialisation that are less academic and inferior (Abidi; 1993). There are still marginal numbers of women in cardiology, neurology, medicine, surgery, disciplines that are seen as requiring greater abilities (ibid). Studies abroad show that women are concentrated in primary care including family medicine, paediatrics and psychiatry (Notzer & Brown, 1995). They report that repeated studies have found women doctors to have a more humanistic and personalised approach to patient care (ibid).

A brief literature review found sexual harassment experienced by women medical students during their under-graduate and post-graduate period and registrarship. This includes psychological abuse and discrimination because of sex. It has been reported from Canada (Myers, 1996, Philips, 1997) and elsewhere. This dimension is not researched in India and hence one cannot estimate its extent. However, its occurrence itself reflects the position of women in society.

CONCLUSION

There is tremendous need for further work on gender and power issues in medical education. Besides research and analysis, the coming together of different streams, with networking and sharing of experience between the groups is required. Most importantly, there is need for engagement with bodies concerned with medical education, such as the Medical Council of India, Health and other Universities and the Indian Medical Association.

References:

- . Bhasin K, 1997, Gender Training Endangered by Fragmental Thinking: A View from the South, SEARCH Bulletin, 12,4, p 20-24.
CHETNA, 1996, convention on the Elimination of all forms of Discrimination Against Women (CEDAW) - An Alternative Report by NGOs, Article 12 Health Care Services-summery.
- . Kanabiran V, 1997, Sharing the Fish Head : The philosophy and Practice of Gender Training in South Asia, SEARCH Bulletin, 12,4, 25-45.
- . Malini Karkal (Ed), 1995, Our Lives Our Health, Coordination Unit World Conference on women - Beijing, 1995, New Delhi.
- . MCI (Medical Council of India) 1981, Recommendations on Graduate Medical Education, MCI, New Delhi.
- . MCI, 1997, Regulations on Graduate Medical Education, MCI, NEW Delhi.
- . MFC (Medico Friend Circle) Bulletin, March 1983, Prejudice against women in health care- report of the discussion during the Ninth MFC Annual Meet at Anand, Gujarat in January 1993.
- . Myers MF, 1996, Abuse of Residents : its time to take action, editorial comment, Can Med. Assoc. J, 154(11), 1705-8.
- . Narayan R, 1991, Medical Education Alternatives - Anthology of Ideas in Medical Education Re-examined, Medico Friend Circle,1991
- . Narayan R, Narayan T, Tekur S.P., 1993, Strategies for social Relevance and community Orientation in Medical Education, Community Health Cell, SOCHARA, Bangalore.
- . Nigar Fatima Abidi, 1993, women Physicians - A Study in roles and Role Conflictm Manak Publicaitons, Delhi.
- . Noizer Nand Brown S, 1995, The Feminization of the medical pefession in Israel, Medical Education 1995, 29 (5), 377-81
- . Philips S, 1996, Sexual Harassment of Female Physicians by Patients. What is to be done? Can Fam Physicians, 42, 73-8 (only an abstract was available on medicine).
Prakash P, 1983, F.P. Programme, Women as "Targets", Background paper for Ninth MFC Annual Meet, MFC, Pune. (See also other background papers)
- . SOCHARA, 1995, Perspectives in Medical Education - A Report prepared for the 'Independent Commission on Health in India'
- . VHAI, 1994, Women & Health Report - Women's Health is a Human Right, VHAI, New Delhi.
- . WAH Secretariat, 1997, Approach Document - the women and health programme (WAH!), India & Nepal, CHETNA, Ahmedabad.
- . WHO-SEARO, 1993, National Meeting on Women, Health and Development, New Delhi.
- . WHO-SEARO, 1998, Regional Health Report 1998 - Focus on Women, WHO-SEARO, New Delhi.
- . World Bank, 1991, Gender and Poverty in India - A World Bank Country Study, The World Bank, Washington DC.

□ □ □

SEXISM IN MEDICINE AND WOMEN'S RIGHTS

Padma Prakash, Annie George and Rupande Panalal

The rights of women in the field of health should be viewed within the context of and as an extension to the rights of women in society. The authors elaborate this stance by dissecting women's poor health condition mired in their general, overall status in society. Any right to health as consumers must, therefore, contain within itself a right, to health which in turn implies many other rights

The rights of women as health consumers can be seen in the context of and as an extension to the rights of women in society. This may be elaborated in two ways. First, women's health status is rooted in their socio-economic condition and is circumscribed by the political power they wield in society. Although there are only few systematic studies which relate women's morbidity patterns to their lifestyles that it is so cannot be doubted. Thus, any right to health as consumers must contain within itself a right to health, which in turn implies many others, such as the right to work, to food, to housing, to safe water and sanitation, to social security, to clean air and environment, to education, to form associations, etc.

Second health care is provided in a setting, which is a microcosm of society and reflects, in an enhanced manner, the dominant prejudices and biases of society. This bias is so integral to the practice of medicine that even its recognition creates turmoil in the establishment and it is so hidden in the interstices of every day practice, that even to trace it is a complex exercise. There is today enough literature to show why and how the biases grew. The removal of biases then involves a radical overhaul, which will inevitably mean a transformation of society. Women's rights as health consumers can only be seen as an extension of their rights in society and in consonance with their rights as health care providers.

However, it is important to recognise that when women come to the health system, they are in, what may be termed, an 'ill state which has added to their vulnerability. In a sense women who come to the health system are survivors of socio-economic injuries. And this is why it is necessary to elaborate on the specific rights of women health consumers.

Doctors in our society are predominantly male and come largely from middle class backgrounds and respected professions. Their patients differ in that they are mostly from working class background and are non-professionals. Their women patients differ in gender, which adds another dimension to the social distance between them. This distance decreases when the patient is from the middle class and /or is a professional. The situation is no different for the women patient if the doctor is a woman. The women doctor graduating from a male dominated school has to in order to survive imbibe and integrate the dominant value system, whether it be about women or about the poor. This process is facilitated by the fact that they have, because of their location in society, already internalised, many of these values, including those of woman's place in society.

This distance between the doctor and the patient is evident in the manner the health care system, which is largely urban and capital intensive, operates. How are women patients treated by the medical establishment? Women patients come to medicare setups for treatment of illness or for obstetric help or as victims of violence. They also come to seek medical aid for their children. The medical system deals with women's illnesses in a special manner. While there are no Indian studies, a number of foreign authors have noted that some common and troublesome conditions in women and children were dismissed as psychogenic. They document evidence for this in the case of dysmenorrhoea, nausea during pregnancy, labour pains and infantile colic. Specific ways in which both doctors and patients accept stereo typed definition of social as well as psychological causes of the problems of women patients have also been documented. A study revealed that male physicians

take medical illness more seriously in men than in women.

Women patients are often seen as hysterical, irrational and incapable of making decisions. Following traditional linguistic convention, patients in most medical school lectures are referred to exclusively by the male pronoun 'he', there is, however a notable exception in discussion a hypothetical patient whose disease is of psychogenic origin the lecturer automatically used 'she'. Majority of women in our country are housewives. In most other countries women do as much as office work as men and in addition do duties of housewives. Thus Indian women have more spare time. Since a majority of them have no other activities or hobbies and they do no reading they spend most of their spare time concentrating on their vaginal discharge.

This bias against women is seen not in attitudes, but manifests in the physical facilities available to them. For instance, the number of beds allotted to women patients in various wards of hospitals is much lower than the number of beds available to male patients. In fact, the diet given to women patients is much lower in calories than that given to men patients because it is assumed that women need less food than men.

We need to stress the fact that women in our society approach the medical facility only if their illness interfered with their daily routine. It is well known that they do not recognize their illness as such until it hampers their work. Also they do not want to deplete their family's meager resources by spending it on their health care. So when they do approach medical facilities, it is imperative that they are treated with attention and sensitivity.

Veena Shatrugna's analysis 'of bed strengths' in teaching hospitals in Hyderabad reveals that burns are high among women patients between ages of 15 and 45, but more beds are allotted for men in the plastic surgery wards.

Another point of women's contact with medical facilities is at the time of pregnancy and childbirth. A woman's ability to give birth unaided is no longer an accepted activity and is taken over as medical or surgical emergency. In gen-

eral, there has been an increase in the rate of caesarians and hysterectomies over a period of time. Various sophisticated labour induction techniques are introduced and routine episiotomies are performed. The cost of childbirth is on rapid increase. In public hospitals women report rude behaviour on the part of the staff, thus increasing the trauma of the woman who is undergoing labour. There is no provision made for a significant other woman to stay with her to help reduce the alienation of the hospital setting.

Another point of contact is when the woman is approached for routine antenatal care, family planning, immunization and illnesses of family member., while on the one hand the hospital setting is extremely alienating, depersonalised, inattentive towards women, in the case of the family planning programme, on the other hand, women are made the prime targets. Women are seen as reproductive machines to be controlled if one has to solve the 'population problem'. Women in reproductive age groups fall under the category of 'eligible couples'. They are encouraged to adopt family planning methods like tubectomy, IUD insertions, injectables, etc. Very little information is given to them about the risks involved. Women often become targets for testing of new devices and contraceptives, most often without consent.

Sterilization as a procedure is often offered to women only as a condition for conducting abortion on an unwanted conception. Very little attention is paid to post-operative complaints or those by current contraceptive user. Most research concentrates on developing female contraceptive as opposed to male contraceptive. An interesting paradox here is that, on the one hand, there is lot of investment in controlling the female reproductive capabilities, while on the other, there is an emphasis laid on offering test-tube babies for those unable to bear a child. Women are also tapped for immunization campaigns, but while administering these almost no information is given about the side effects or possible complications. Although women routinely accompany children when they are admitted to paediatric wards, there is no provision for them to

stay. They are often treated rudely and end up performing the nurse's duty towards the patient they have accompanied.

Women also approach the medical establishment as victims of violence and when they do, very little sensitivity or sympathy is shown to them. This is even more damaging, because often women are not willing to talk about the circumstances which have caused the injury. In fact, in cases of rape women go to doctors on an associated complaint, often not revealing that a rape has occurred. Doctors, assessing the injury, inadvertently or otherwise deflect attention from the criminal act by seeking unnecessary information about the sexual history of the women.

Modi's text book of Medical Jurisprudence and Toxicology (21st edition, 1988) has cautioned the doctors to 'beware' of women. It states that many complaints of rape are false since the women must have consented. It says, it is very difficult to rape single-handedly a grown up and experienced woman without the stiffest possible resistance from her. It instructs doctors to note the previous character of the girl and warns doctors that they may be charged with rape because of the nature of medical examination involved, and suggests they conduct the examination in the presence of female staff.

Keith Simpson's Forensic Medicine says it is very common, in instances of rape, for the girl to lie. According to Krishnan's handbook of Forensic Medicine and Toxicology "as far as the women from the low class is concerned, it is impossible to rape her because she is stronger."

The case of Narasamma, a middle aged slum resident who was gang raped is instructive. She was rushed to a public hospital soon after the rape occurred. She had a lump on her head; her blouse was torn, revealing scratch marks on her breasts. The medical officer who was approached barely looked at her and gave paracetamol and sedative. The next day she approached the same medical officer, this time accompanied by a social worker who informed the doctor that the woman had been raped. The

doctor maintained that the onus of saying that she was raped is on her. In a society where the distance between a woman, especially a poor woman, and a doctor is so great and the woman is in a state of shock, it is hardly likely that the woman will tell the doctor of the event. It is for the doctor to elicit the information, even if not by direct questioning but by putting the patient at ease and recognizing that the medical establishment, which because of its bias against women, does injustice to them.

WOMEN'S RIGHTS

In the earlier pages we have discussed the status of women in Indian society and the reproduction in the medical system of the sexist bias which operates to the detriment of women when they interact with the medical system. In this section we discuss the rights of women as consumers of health care.

The health rights of all patients irrespective of gender, social class and geographic location in India are fundamentally similar. Apart from these general rights, women have certain additional health rights on three grounds: 1) they are more socially disadvantaged 2) they are usually the procurers and providers of health care for their family members, particularly children and the elderly and 3) they require the services of health professionals for health procedures related to child bearing and contraception. In this context of the special needs of the demand made by women, the health rights to women are discussed.

Women's perspectives on the causes of ill health, the relationship of traditional beliefs to health status, family decision-making dynamics and the usual patterns of resort to health care must be understood and incorporated in the design of all health programmes. This calls for a restructuring of the educational and training programmes of health professionals at all levels: doctors, nurses, ward assistants, community level workers. Any other rights demanded by women become meaningless and ineffective. Thus the rights of women as consumers of health care must be seen in the context of the rights of women as seek-

ers of training in providing equitable and unbiased health care.

All health care programmes must, as far as possible, be guided by women at the level of actual implementation. This is so as to ensure that programmes will take into account their multiple responsibilities and roles. In both community-based programmes and in hospitals women must be represented in all administrative bodies. That this representation must not be merely cosmetic is implicit. Quality of care is intrinsically correlated to the utilization and effectiveness of women's health services. Quality of care must take into account the process of service from the woman's perspective and must reflect/incorporate her cultural setting.

Elements, which determine the quality of care, include interpersonal relations between the woman and the provider. A woman's dignity and self-respect must never be abused, whether in the course of routine services or in a crisis situation. While privacy and confidentiality must be ensured during all interactions, a woman has a right to seek the attendance of another woman during these interactions.

Complete and accurate information must be given to women about the medicine being provided, the investigations necessary, the risks involved, as well as about the diagnosis. This should be given in supportive and friendly environments. Also, the attempt must be to make the woman understand her ailment and the medicine must not be delivered as a mandatory act. This means that the health care providers must be trained to be communicative in a manner, which the patient can understand. This is necessary especially in the cases of women, where attitudes, prejudices and biases against women in society at large are reflected in the medical system.

Informed consent, whether for medical treatment, surgical procedure or experimentation, must not mean a shelving of responsibility on the part of the doctor. A patient must be encouraged to make an independent deci-

sion on the understanding that the doctor abides by that decision and will take responsibility for it within the constraints defined.

Health care providers should conceptualise female morbidities broadly, so as to include and recognise the full range of activities undertaken by women, thus it is necessary to recognise that a woman has as much right to seek and receive help for disabling complaints, such as constant backache, as a man. These cannot be disregarded because a woman's work creates conditions for such a disability. It is as much the right of a woman to have the condition studied and treated, as a doctor's responsibility to link the medical condition with the social circumstances of women's lives and, therefore, attempt to empower women with the knowledge that their illnesses are often a consequence of their social location, and that the ultimate remedy comes with a change of the social situation.

This is also true of violence against women, which has taken many forms: rape, assault, wife battering, burning and incest. It must be demanded that the medical establishment recognise the social pathology of these medical conditions. Such women have the right to treatment, which enhances their coping and control of situations where they become the victims. This may be through specially trained personnel in departments, such as burns, psychiatry or orthopaedics, or through the involvement of women's groups working with women survivors of domestic violence.

Although a woman's childbearing role is the most emphasized, women as mothers or as reproductive beings have few rights. For instance, she has little control over how many children she can bear or if at all she will bear children. The medical system plays a direct role in obstructing her right to appropriate contraception in various ways. It is important that the entire range of contraceptives must be available to her with complete information on their long and short-term effects and reliability. Women must also have the right to safe abortion for whatever reasons.

A woman must also have the right to choose where and how she will deliver her child. If she chooses to deliver children at home she must have the right to trained help, or specialist care in an emergency. Similarly, she must have the right in principle to choose whether or not she will breast-feed her child, whether or not she will seek particular immunisation. But this right, it must be underlined can be exercised only in the context of society where unbiased information is available freely and there is no pressure on her to adopt a particular practice.

It is hardly necessary to point out that ifs and buts that constrain these rights are many. But a beginning has to be made in defining these rights in individual locations so as to concretise them.

(Source : The Indian Journal of Social Work, Vol. : LIV, No. 2, April 1993)

□ □ □

INTEGRATING THE GENDER PERSPECTIVE IN MEDICAL AND HEALTH EDUCATION AND RESEARCH

Yut-Lin Wong

CENTRAL QUESTIONS, CORE ISSUES

“I hid the pills (OCP) in a safe place. But, one day, my husband found them. He was furious. He threw them away, and he beat me.” [battered woman at a Refuge, Kuala Lumpur]

“It’s difficult for me to take the pill. My priest said it is not done for good Catholics. If I take it, I would be ashamed to say it during Confession.” [Kadazan woman in a urban slum, Sabah]

I really can’t say ‘No’ to my husband. What I can do, is to go and sleep with my kids.” [Muslim factory worker and mother of seven, Penang]

These experiences are not unique to Malaysian women. Instead, they speak to women’s general lack of control over their sexuality and reproductive health in both developing and developed countries. These expressed needs exist despite the availability of health services, modern medical technology and the overall improvements in maternal morbidity and mortality statistics, albeit with much variations between and within the First and Third World countries.

Indeed, women’s lack of control over their bodies, inequalities in health status between men and women, and women’s unequal treatment in health care, medical education and research are the major women and health concerns that require urgent, systematic and global intervention and change. This is so that we can put into action the commitments to women and health made in the 1994

Cairo Plan of Action and 1995 Beijing Platform for Action. The central question for us gathered here today at the meeting on women and health is, whether women's health concerns and needs can best be addressed by following the usual biomedical practices, education, research and policies?

Women's experiences and realities, part of which being voiced by the Malaysian women above, clearly testify otherwise. In fact, in most medical, health and prevention issues related to women's health, the central issue is **male-female power relations**, and not merely the lack of health services, medical technology or/and information [E. Fee & N. Krieger, 1994 1.

These realities thus urgently call for a gender analysis of health, which refers to a systematic study of how and why do diseases affect women and men differently. It also takes into account how factors of social class, race, education and other socio-cultural factors interact with gender to produce discriminating impact on men and women's health. Gender analysis is crucial to distinguish between **biological causes** and **social explanations** for the health differentials between men and women, and to understand that these gaps are outcomes of the unequal social relations between men and women, and not merely due to consequences of biology. Gender analysis will also accurately inform on diagnosis, treatment and prevention. At the same time, it will transform the biomedical and gender bias currently imbedded in medical education and research, so as to better serve the health needs of women.

GENDER INEQUALITIES IN HEALTH, SEXISM IN MEDICINE

A hierarchy of diseases is said to exist, whereby "women's diseases" are viewed as less important because of the diffuse symptoms in various parts of the body seemingly without a known cause, compared to "men's diseases" that have clear-cut symptoms and are diseases of vital organs. For instance, fibrositic diseases and depressive neuroses rank the lowest and these diagnoses are more fre-

quent in women than men. In Norway, despite its reputed national medical insurance system, women may run the risk of getting less recognition, receive less monetary compensation, and thus poorer quality service. The disease patterns differ between men and women in several ways. Some diseases strike women and men at different ages e.g. women tend to contract cardiovascular diseases at an older age than men; some disease are more prevalent in women than in men e.g. thyroid gland disorder, anaemia lupus, eating and musculo-skeletal disorders; while some diseases like osteoporosis and rheumatic diseases are more serious in women than in men; and some diseases or conditions affect only women, such as, dysmenorrhoea, cervical cancer, infections due to unsafe birth deliveries and abortions, female circumcision, reproductive tract infection (RTI) and urinary tract infection (UTI) due to poor sexual hygiene [Norwegian Board of Health, 1995, E. Royston & S. Armstrong, 1989].

Despite these facts, women's health needs are often regarded to be restricted only to reproduction. The gender bias is reflected clearly, such that, within medicine, women's health is relegated to only obstetrics and gynaecology; and within public health, all women's health needs are expected to be met by maternal and child health programs. This is because women are primary seen as mothers and wives, rather than human beings having health needs. Thus, women's non-reproductive health is either invisible or not emphasised. For instance, despite women having been part of the labour force for so long, their occupational health have often been ignored. Not only is women's health defined by their reproductive role, it is often misunderstood because women are always viewed as a homogenous group. In reality, women's health or illness, pertaining to reproduction or not, are differentially experienced according to social class, race/ethnicity and so forth. For instance, while among older women, breast cancer is more common among the rich, cervical cancer tends to affect more poor women than the affluent. Research has shown that black women, within each income level, are more likely to suffer from hypertension than white women

[Krieger N. & E. Fee, 1994; Sivanesaratnam V. & ST. Teoh, 1996]. Such a social patterning of disease points to the general fact that women's health issues cannot be explained by sex/biology alone.

Instead, Doyal [1994] posits that women's health and sickness be understood in the context of the patriarchal and capitalist nature of society - what she calls socialist feminist epidemiology. In looking at major occupational diseases affecting women, she pointed to the relationship between female socialisation and female roles on women's health. Depression is found to be a major occupational illness among housewives because women are brought up to express their problems in the form of depression [L., Doyal 1994]. In reproductive health, such as contraceptive use and family planning, women lack decision-making power to negotiate about sex, childbearing and contraception as husbands assume sexual access and control. While a husband can, and often does, refuse to use contraceptives despite his persistent sexual demands, women find themselves caught in their conflicting roles as solely responsible for family planning, and at the same time are expected to be sexually available to their husbands. In some developing countries, ill women still need their husbands' approval before they can go out to seek medical treatment or health care. Or, when they do arrive at the hospital, there are numerous medical procedures that require their husbands' signatures. Thus, it is clear that gender roles and male-female power relations rather than biology underpin women's health and well-being.

MEDICAL EDUCATION AND RESEARCH: GAPS AND GENDER BIAS

Medical education: The preceding account showed how women's health and ill-health have been reduced to a matter of their biology, and how disregard for women has permeated throughout medical practice and the health services. It is reported that in the United States, such views were institutionalised within scientific medicine and the new public health by the first few decades of the 20th cen-

ture. Thus, biologically deterministic views of sex/gender differences have since become a natural and integral part of the curriculum and research agenda in medical and public health practices [Krieger & Fee, 1994, p151.] Although the Hippocratic Oath, with its explicit clause of not giving women "pessary to produce abortion", can be said to be generally outdated and not quite held up as the exemplary standard to emulate, the 1983 amended Declaration of Geneva adopted by 35th World Medical Assembly still refers to "colleagues as my brothers" [British Medical Association, 1988].

Although the proportion of female students admitted to medical schools has been increasing from about 5 percent in the mid-1970s to 40 percent in the 1990s in America, the medical curriculum, however, does not "speak to women's health concerns". Moreover, both lectures and clinical skills are more often than not taught by white men, about white men and for white men. Gender bias is apparent even in the teaching of basic science and biomedical subjects, such as normal human body and its functions. For example, lectures on male genitalia could be spread over three days but none on women's sexual organs, because "men and women are basically the same". Medical textbooks still consider the male as the norm or reference point for all courses and regard women as exceptions to the male [Nechas E. & D. Foley, 1994, p41].

The disregard for women's health in the medical curriculum is best reflected in the teaching of basic clinical skills, such as physical examinations. Medical students are taught how to examine the entire body, the head, neck, abdominal areas, the cardiovascular and neuromuscular systems, except the breast and pelvis. Instead, students have to resort to learning such basic skills vital to women's health care by practising on poor patients with breast illness who are already in pain. Alternatively, it has been alleged that students have been taught to do pelvic exams on anaesthetised patients who were undergoing a surgical procedure [Nechas E. & D. Foley, 1994], p. 431. These medical teaching practices have at least two serious impli-

cations that are adverse for women's health care. When statistics reveal that breast and cervical cancers are one of the top causes of death for women, such teaching methods of clinical examinations of women's breast and pelvis certainly would not contribute to the treatment or prevention of these top killers of women. The other more long-term insidious effect is that the habit of examining a woman in pain has come to be the basis of medical students' learning experience of women's health in particular. Thus, until very recently when and where the use of teaching associates is practised, teaching medical students how to do competent, sensitive and painless breast and internal examinations for women have not been an integral part of the medical teaching practice. This explains why women expect and experience pain during what should be routine internal examinations, one of the many examples of unnecessary suffering which women endure when undergoing medical examination or treatment.

However, about 25 percent of medical schools surveyed showed that they do offer women's health electives, which are optional courses that address health concerns having special impact on women, such as, osteoporosis, incontinence, heart disease, breast cancer and menopause [Nechas E. & D. Foley, 1994]. It is not clear if such women's health electives touch on gender perspectives and gender analysis of health.

Surveying the medical curricula from two established medical schools taught at public universities in Malaysia showed that there have been recent attempts to balance the biomedical bias towards integration of the patient into the family, community and society. For instance, this is reflected in the objectives of the medical courses "to produce competent doctors with a holistic approach to the practice of medicine", and "...who would be part and parcel of the health care team and the people" [UMMC, February 1998, p 2; Rashidah Shuib & Roziyah Omar, 1996, p 4]. Despite such integrative innovations in the medical curricula, the latter is still strongly biomedical, with psychosocial and cultural courses being regarded as "soft subjects"

[Rashidah Shuib & Roziyah Ornar, 1996, p11]. With regards to clinical examinations vital to women's health, breast examination is taught by the general surgeon using women patients with diseases, such as abscess or tumours, formerly in groups of ten students but now with only one student at a time. Students learn about vaginal examinations while observing/assisting birth deliveries during the Obstetrics posting, and when women patients are anaesthetised for surgical procedures during the Gynaecology posting. It is said that for the male medical students, breast and pelvic examinations present considerable problems due to the relative unfamiliarity with the female anatomy, hang-ups about the female sex and sexuality, and patient's reluctance to be examined by trainee students. There are no specific courses on women's health, whether integrated into the medical curriculum or as an elective. Women are studied as part of the family, especially as mothers in courses such as Family Health, once again stereotyping women's health only in the context of reproduction. Moreover, the approach to women's reproductive health is still predominantly biomedical. For instance, it is the biomedical aspects of side effects of various contraception methods that are emphasised to medical students. Although the latter are exposed to cultural and religious barriers to family planning given the multi-ethnic background of our patients, the underlying issues of male-female power relations affecting sex, sexuality and contraception are seldom discussed or even raised in the classroom.

It is heartening to note, however, that some innovative inroads have been made in transforming the biomedical bias of medical education in some of the other countries in the Asia Pacific region. For instance, the private medical college of Aga Khan University, in Pakistan, has introduced gender in the context of primary health care through its Department of Community Health Sciences (CHS). During the non-clinical years, medical students are taught subjects, such as, 'Role of women in health' and 'Women and environment'; and nursing students are exposed to social issues in health pertaining to women under the Culture,

Health & Society course. The CHS has recently initiated a network called the Pakistan Reproductive Health Network (PRHN) consisting of medical and non-medical professionals, to promote reproductive health in the country and to benefit from the different (presumably including non-bio-medical and more gender sensitive) approaches to women's health (Zaman R. & K. Marvi, 1996). While in the Philippines, the public University of the Philippines, Manila (UPM) is rather committed to innovative programs that are responsive to the social aspirations and health needs of the Filipino people. Its College of Medicine offers the Integrated Liberal Arts-Medicine program which aims to provide medical students with as much social sciences and humanities as possible, so as to inculcate social awareness among them (Ramos Jimenez P. & F Castillo, 1996). Although it is not certain whether social awareness necessarily includes gender awareness, at the very least the UPM medical curriculum seems less biomedical than some of the more conventional medical education taught in the region.

With regards to education for other health professionals, particularly nurses, it can generally be said that the curricula contain relatively more social science courses pertaining to health behaviour and patient care. However, whether they are informed about the gender perspective would depend very much on the respective teaching institutions and instructors.

Medical Research: Despite the fact that diseases, such as heart disease, depression, AIDS, affect women and men differently, many medical studies on diseases, treatments, and outcomes whether of low or high cost, short or long-term, have been carried out using all male subjects. It has been alleged that not only has gender bias "infected" medical research, but women have been systematically excluded from medical studies. This is evidenced by the following observations: women were not included in studies of heart disease; lack of funding on diseases which disproportionately afflict women, viz. breast cancer; and the safety and efficacy of drugs being tested only on men but which would be dispensed to women as well. It has been

reported that the National Institute of Health, the U.S. government's largest funding organ for medical research, had spent only about 13 percent of its total budget on women's health issues. A NIH-funded five year Physician's Health Study on intake of aspirin and reduction of heart attacks had studied 22,071 men and no women. A prospective study on health and ageing included only men during its first twenty years, despite the fact that majority of those over sixty-five years are women. As incredulous as it seems, one Rockefeller University project on the impact of obesity on the tendency for women to develop breast or endometrial cancer had only men as its study subjects [Nechas E. & D. Foley, 1994].

Generally, there certainly have been comparatively more critical or feminist analyses of medical research done and published in the developed countries than in the developing world. It is, however, important to note that particularly in the area of health research related to family planning in developing countries, gender relations are very often not considered for study. The Knowledge, Attitudes & Practice (KAP) survey research methodology that was universally used to determine the infamous "unmet need" for family planning in developing countries during the 1960s have been severely criticised to be both eurocentric and culturally biased [JW. Ratcliffe, 1976]. Unmet need is conventionally defined as wanting no more children or wanting to postpone childbearing, but using modern contraception, such as the oral contraceptive pill, intrauterine device, condom and sterilisation. The unmet need estimate arising from KAP and the USAID-funded Demographic and Health survey data had become an important policy tool for conceptualising and designing population policies and family planning programs all over the developing world in the 1960s and 1970s [R Dixon - Mueller, 1993; Wong Y. L, 1995]. My contention with the conventional definition of unmet need lies in its dependence on modern contraceptives as the sole criterion for an effective means to either space or limit births, without any consideration for the prevailing use of traditional and non-program methods, such as, breastfeeding and withdrawal. In addition to its cultural

bias, this universal measure gives no recognition to fertility regulation practices currently used by both women (such as breastfeeding) and men (such as withdrawal) in developing countries. Not only do such local methods lack side effects, are user-controlled, and involve men, but their success and sustainability have been based on some pre-set negotiations and understanding between the partners in their sexual relations. Such intimate and power relations between men and women are often ignored in family planning programs promoting modern contraceptives, which may explain why the latter have met with more failures than successes [YL Wong, 1995]. It is in such genderinsensitive family planning programs that both women and men's sexual and reproductive rights have been blatantly forsaken for achieving the economic and demographic goals of state population policies.

These gaps and gender biases in medical education and research mean that doctors have been practising men's health on women, which not only compromise the health and healthcare of women but may well endanger women's lives. Yet, scientists and medical researchers who exclude women in their research argued that it was really to protect a woman's foetus since she could become pregnant during a clinical trial - for "women's benefit so to speak. Women's menstruation would also complicate research and increase cost, not to mention the fear that such hormonal fluctuations would contaminate their data with confounders and outliers. These so-called reasons once again reflect the distorted view of what are normal body functions unique to women to be a "disease or medical condition". What is worse is the perpetuation of the mistaken but widely held theory that women's ill-health is due to their biology, to which nothing very much can be done to change or improve women's health and well-being - so, why bother to include women in medical research?

The underlying reason for all-male medical research and studies is that what is valuable to medicine is what is valuable to society; and it is the man, not woman [E. Nechas & D. Foley, 1994]. This is a part of the continuum

of unequal gender relations, whereby society values men's work and lives over those of women. If all this while it is men's lives we are made to study in history, politics and the arts, why should it be different in medicine? Indeed, it has been alleged that the institution of scientific medicine does not only reflect discrimination against women in wider society, but through medical knowledge and practice, it serves to create and maintain gender divisions in society [L., Doyal 1994, p 68].

GENDER-SENSITIVE MEDICAL EDUCATION AND RESEARCH

What will be the new philosophy, values, or objectives, contents, teaching and learning strategies of these changes to the medical education and research, so as to guarantee the successful implementation of the 1995 Beijing Platform's recommendations on women and health, and mainstreaming gender into the health sector? The preceding discussion on gender inequalities in health and gender bias in medical education compels us to adopt a gender approach to medical education that would take full account of existing gender differences in health care provision at all levels. It would also emphasise on women's participation in the health system. The objective ultimately is to "train doctors to treat women from head to toe, and not just from the waist down" [E. Nechas & D. Foley, 1994].

Much can be learned and culled from the success and achievements of the women's health movements for the past twenty-five years. Through a network of social-action groups and women's health centres providing health care by and for women, the women's health movement struggled to demystify medical knowledge and had made it more widely available through non-elitist and non-authoritarian means. Validating women's own experiences of their bodies and their own observations of the physiological processes happening in their bodies, women challenged medical doctors' "objective" clinical knowledge and argued instead that their own "subjective" knowledge is relevant to the understanding of women's health problems. In this way, the

women's health movement have initiated the feminist health education practice, based on the development of these new skills and new areas of knowledge [L. Hunt, 1997; L. Doyal, 1994].

Lynne Hunt [1997], after studying 73 women's health agencies in nine western countries, posited that the women's health movement have indeed developed a distinctive women's health care speciality (WHS). She has identified eight key features of the speciality and they are: women-only services; creation of woman-space; self-help and holism; feminist counselling and woman-to-woman support; feminist teamwork; diversified health care; information sharing and social action; and lastly, accessibility. For instance, Hunt explained that diversified health care refers to the different variations in women patients or users of health care -varied social class, sexual orientation, culture or ethnic groups and so forth. Whereas the medical care model treats women as a homogenous group. The Women's Health Speciality considers it important to create woman-space in a social, physical, and temporal sense. In this woman-space, women not only feel safe and valued, the home-like setting puts women at ease so as to avoid the impersonal clinical atmosphere associated with the medical setting. According to Hunt, the three ideologies of feminism empowerment and the social model of health are the hallmarks of the women's health movement, and the pillars of the WHS. Yet, the application of these principles varies in accordance with each local situation. Under the WHS, the concept of health has been broadened from its biomedical base to incorporate the social context of women's lives. Hunt calls strongly to incorporate the WHS into tertiary curricula, stipulating that both feminist principles and empowering practice be taught within the framework of the social model of health. Difficulties will abound, especially those pertaining to appropriation and monopolisation of these principles, making real the risk that they will be co-opted and medicalized [L. Hunt, 1997]. Although the model of a women's health centre as it exists in Australia, Canada or the USA is not as widespread in the South-east Asian region, there are several women health

groups and organisations focusing on reproductive health, particularly in Indonesia and the Philippines (personal communication with Lynne Hunt). Apart from the voluntary family planning associations in Malaysia, relatively few women organisations can be said to provide specific health services and health education to women. There is also relatively less information on the extent to which the experiences of such women health groups could be integrated into medical education in the region, due to lack of access to published studies or research.

Indeed, integrating the gender perspective into the medical curriculum by incorporating the principles and practice of women's health speciality described above will be a good beginning. Yet, how do we actually translate and operationalize Hunt's WHS model within a medical setting? Firstly, such a transformation will involve drastic ideological changes, not mere reforms in the curriculum. Presently, medical students tend to concentrate solely on acquiring clinical skills without questioning the underlying values and philosophy of medicine. To many medical students admitted to medical programs which require no basic or general education in the liberal arts, and who have so far been streamed into the 'hard' sciences, concepts of social justice, feminism-4 empowerment and social action are mere new terms and would have no meaning. Generally, medical students either do not or cannot conceptualise what they are learning because they are not taught to do so. How can this ideological gap be bridged and the appropriate pedagogy be applied?

Secondly, what explicit teaching methods and courses are needed in the lecture halls so that upon graduation, the doctor not only is competent in reproductive medicine and technology, but also could empower a woman patient to exercise her rights to abortion? How could a medical student, intern, a nurse or qualified doctor in the hospital save the mother who is lying at home, dying of postpartum haemorrhage but cannot come to the hospital without her husband's permission since he has gone out of town? Will they be able to recognise her rights over her own body and

stand up against her husband and her husband's family, in a culturally-acceptable way? Thus, not only do medical students need to learn new ideologies and gender concepts, they must put them to action and bring change to the existing unequal male-female power relations that cause inequalities in women's health and health care. Thirdly, closely related to teaching methods is assessment. What innovative assessment will be suitable to measure the above values, attitudes, and commitment of gender-sensitive doctors-to-be?

With regards to strategy, is it better to set up a women's health speciality separate from medicine? Or, will integrating the gender perspective spirally throughout medicine be more effective? As much as health services specific to women need to be provided, will a separate women's health speciality, however, merely be "preaching to the converted"? Or, will it just become like any branch of specialised medicine?

Lastly, how do we mainstream gender into the health sector when gender inequalities remain the norm in the rest of society? Will this mean the conditional need for wider political change?

These are some of my burning questions with regards to integrating the gender perspective into medical education in general, and implementing women's health speciality model in the medical practice in particular.

CONCLUDING REMARKS

We understand now that not only have the biomedical and gender-biased medical education and research system failed to address women's health concerns, they have also created and contributed to gender inequalities in health and sexism in medicine. As a result, sensitive and painless breast and pelvic examinations for women have not been an integral part of medical teaching practice and how this has caused unnecessary suffering for women undergoing treatment. Similarly, it is clear that due to the all-male basis of much medical research, doctors have been prac-

tising men's health on women, which both compromises women's health care and puts women's lives in danger.

Thus, we certainly cannot allow the gender inequalities in health and gender bias in medical education and research to continue. We must act promptly and globally towards a paradigm shift from that instilled since the eighteenth century, when medical education was first organised to mass produce medical doctors.

I would now wish to discuss the above questions on changes in the medical education and research with all present here today and jointly develop an action plan for gender-sensitive medical education and research.

References

- British Medical Association. *Philosophy and Practice of Medical Ethics*. London: British Medical Association. 1988.
- Dixon-Mueller R. *Population Policy & Women's Rights*. Westport: Praeger. 1993.
- Doyal L. Women, health, and the sexual division of labour: a case study of the women's health movement in Britain. In: Fee E & Krieger N (eds). *Women's Health Politics, And Power: Essays on Sex/Gender, Medicine And Public Health*. New York: Baywood Publishing. 1994.
- Fee E & Krieger N (eds). *Women's Health, Politics, And Power: Essays on Sex/Gender, Medicine And Public Health*. New York: Baywood Publishing. 1994.
- Krieger N & Fee E. Man-made medicine and women's health: the biopolitics of sex/gender and race/ethnicity. In: Fee E & Krieger N (eds). *Women's Health, Politics, And Power: Essays on Sex/Gender, Medicine, And Public Health*. New York: Baywood Publishing. 1994.
- Hunt L. The women's health speciality: curriculum implications. *Women's Health Issues*. 7(2): March/April 1997: 116-120.
- Nechas E & Foley D. *Unequal Treatment: What you don't know about how women are mistreated by the medical community*. New York: Simon & Schuster. 1994.
- Norwegian Board of Health. *Women's Health in Norway*. Oslo. 1995.

Ramos-Emenez P & Castillo F. Country Report on Teaching of Health Social Science Philippines. Paper presented at Sexuality and Reproductive Health and Fora on the Teaching of Health Social Science Conference, January 8-13, 1996. Asia and Pacific Regional Network on Gender. Cebu City, Philippines.

Rashidah Shuib & Roziah Ornar. Country report on teaching of health social science Malaysia. Paper presented at Sexuality and Reproductive Health and Fora on the Teaching of Health Social Science Conference, January 8 -13, 1996. Asia and Pacific Regional Network on Gender. Cebu City, Philippines.

Ratcliffe JW. Analyst biases in KAP surveys: a cross-cultural comparison. *Studies in Family Planning*. (7): 1976: 322-330.

Royston E & Armstrong S (eds). *Preventing Maternal Deaths*. Geneva: WEO. 1989.

Sivanesaratnam V & Teoh ST. The role of health education in the management of gynaecological cancer in developing countries. *Medical Journal Malaysia*. 51(2): June 1996:175178.

UMMC (University of Malaya Medical Centre). *Report: New Integrated Curriculum for Medicine*. 20 February 1998.

Wong YL. The political and cultural determinants of fertility and reproductive health in Peninsular Malaysia: evidence from the Second Malaysian Family Life Survey. Doctor in Public Health Thesis. University of California, Berkeley. 1995.

Zaman R & Marvi K. Country Report on Teaching of Health Social Science Pakistan. Paper presented at Sexuality and Reproductive Health and Fora on the Teaching of Health Social Science Conference, January 8-13, 1996. Asia and Pacific Regional Network on Gender. Cebu City, Philippines.

□ □ □

**INNOVATIONS IN MEDICAL
EDUCATION AND BEST
PRACTICES IN WOMEN'S
HEALTH CARE**

A WOMEN'S HEALTH CURRICULUM FOR AN INTERNAL MEDICINE RESIDENCY

Janice L. Werbinski, MD Sandra J. Hoffmann, MD

This women's health curriculum was developed as a specialized track within the internal medicine residency at Michigan State University/Kalamazoo Center for Medical Studies. It is designed to provide the knowledge, attitudes, and skills needed to deliver care to women and to foster interest in women's health research. Specific objectives include: 1. Management of conditions unique to or more common in women or for which there are differences in diagnosis and treatment. 2. Ability to take an appropriate history and perform a complete, sensitive, and comfortable exam. 3. Knowledge of factors determining women's wellness and disease prevention and recognition of psychosocial, economic, and violence factors influencing women's health. 4. Knowledge of reproductive choices to counsel patients regarding personal choice. 5. Promotion of the patient practitioner partnership in clinical decision making and education. 6. Critical evaluation of new research data and its impact on women's health care. The knowledge, skills, and attitudes of residents completing this track will be compared to those in the traditional program. If successful, this model will be used to train residents in other specialty areas, as well as medical students and other health care professionals in our community.

The development of curriculum focusing on gender-specific care of women in both undergraduate and graduate medical education has been proposed and supported by educational, governmental, and political institutions." Recently, the US Public Health Service's Office on Women's Health published a listing of educational institutions offering residencies, fellowships, and electives

in women's health.⁷

Women's health currently is not a recognized specialty or subspecialty, and we find no existing specialty that adequately addresses the needs of women throughout the life cycle; nevertheless, training for board certification in internal medicine can provide a solid base for both primary and specialty care of women from adolescence to their geriatric years. Therefore, Michigan State University / Kalamazoo Center for Medical Studies (MSU/KCMS), recognizing a need for trainees to improve health care delivery for women, established a specialized curriculum in women's health in 1995. Preliminary descriptions of that effort are presented here.

PROGRAM DESCRIPTION

MSU/KCMS provides graduate and undergraduate medical education and continuing medical education and assists in multidisciplinary training for nurses, physician assistants, social workers, and pharmacists. A committee of interested faculty in medical and other health-related fields organized institutional goals and objectives for our women's health curriculum. We chose the internal medicine residency as the pilot for this institutional effort because of the excellent ambulatory and subspecialty training already offered and the faculty commitment to women's health. The goal of this curriculum is to prepare residents (or other health care professionals) to comprehensively care for women, provide a solid database on which to build competency in delivering care to women, and foster interest in research and teaching in women's health.

Objectives include: 1. Resident will recognize and manage conditions unique to or more common in women, for which there are differences in diagnosis and treatment. 2. Resident will know how to take an appropriate history from women and how to perform a complete, sensitive, and comfortable physical examination. 3. Resident will know factors determining "women's wellness" and be able to assist women to participate in disease prevention.

4. Resident will recognize and manage psychosocial, economic, and violence factors that influence women's health. 5. Resident will promote the patient-practitioner partnership in clinical decision making and patient education. 6. Resident will know about reproductive choices so (s)he can properly counsel female patients to achieve maximum personal choice. 7. Resident will critically evaluate new research data and its impact on women's health care.

After setting goals and objectives, we reviewed competencies in women's health developed by the National Academy on Women's Health Medical Education⁴ and the American Board of Internal Medicine. Using the strengths of our community resources, we developed five month-long elective rotations with gender-specific training. These women's health rotations are designed to enhance and expand on basic knowledge, skills, and attitudes taught in our residency, especially in the areas of preventive medicine, doctor-patient relationship, and basic examination and procedural skills. The electives are: Women's Behavioral Medicine, Adolescent Female, Advanced Women's Health/Office Procedures, Women's Cardiology, and Perinatology. The literature was searched, and a bibliography of readings was created for each elective.

For the competencies not pertinent to these five electives, we developed an ongoing, monthly "feminar" grand rounds series that is open to any health care professional or trainee. Topics covered in this lecture series are rotated on an 18-month cycle and include: gastroenterology, rheumatology, urology, breast disease, endocrinology, infectious disease, gynecology, psychiatry, allergy, dermatology, pharmacology, radiology, pathology, sports medicine, violence, addiction medicine, preventive medicine, and neurology. A local pharmaceutical company sponsors the series, and speakers are recruited both locally and regionally.

DISCUSSION

Since the program is only in its third year and graduated its first resident in 1998, no formal process or

outcome evaluations have been completed. We have developed a knowledge, attitudes, and skills survey that will be administered to all residents in the program at the end of the current academic year. Interest in this curriculum has been overwhelming, and soon residents in family practice and pediatrics will also complete a modified women's health curriculum. One medical student has already completed a specially designed elective that will continue to be offered. The curriculum will be expanded into a fellowship program for residents and multidisciplinary training for other health care professionals.

□

Whether or not an individual, board-certifiable specialty in women's health is developed, it is clear that educational programs in medical school, residencies, and other health care settings should be encouraged to incorporate comprehensive, interdisciplinary programs in women's health. This women's health curriculum at MSU/KCMS is a leading example of such an educational program.

References

1. Waths L. Why a curriculum in women's health? *J Women's Health*. 1991;2:55-59.
2. *Council on Graduate Medical Education Fifth Report. Women and Medicine*. Washington, DC: US Department of Health and Human Services, Public Health Service, Health Resources and Services Administration; 1996.
3. Dotioghue G, ed. *Women's Health in the Curriculum: A Resource Guide for Faculty*. Philadelphia, Pa: National Academy on Women's Health Medical Education; 1996.
4. Association of Professors in Medicine. What internists need to know. Competencies in women's health. *Am J Med*. 1997; 102:507-512.
5. *Guidelines for Women's Health Care*. Washington, DC: The American College of Obstetricians and Gynecologists; 1996.
6. *Medical Student Educational Objectives*. 6th ed. Washington, DC: Association of Professors of Gynecology and Obstetrics; 1993.
7. *Directory of Residency and Fellowship Programs in Women's Health*. Washington, DC: US Public Health Services Office on Women's Health; 1997.

(Source : *Journal of American Medical Women's Association* Vol. 53, No. 3, 1998)

□ □

THE DEVELOPMENT OF A PRIMARY CARE CURRICULUM FOR OBSTETRICS/GYNECOLOGY RESIDENTS

Kelly S. Parsey, MD, Lori A. Bastian, MD, MPH,
Grace M. Couchman, MD, Kenneth D. Slack, MD,
David L. Semel, MD, MHS

In order to develop a primary care curriculum for obstetricians and gynecologists, a needs assessment was performed to determine those topics in which additional training was needed. We used a Likert scale comfort score (0-40) for evaluating or treating 14 primary care areas. The results of the 30 completed surveys showed that topics traditionally emphasized in obstetrics/gynecology training received very high comfort scores, while scores for traditional internal medicine problems were very low. We chose six areas with the lowest comfort scores as targets for primary care education immunizations, skin cancer screening, diabetes mellitus, hypertension, musculoskeletal complaints, and depression and designed a seven-week rotation for obstetrics/gynecology interns. The rotation includes practical ambulatory experiences in gynecology and internal medicine, mental health assessments, thorough breast care in the breast clinic, and individual didactic instruction. The curriculum has been well received by the interns, who report more comfort in providing general women's health care. We suggest that a systematic assessment of the weaknesses and strengths of each residency can serve as the basis for curriculum planning.

The recent focus on primary care and disease prevention, coupled with the recognized need for improved training in women's health, has led many programs to reappraise their residency education. Possible educational paths include establishing a new interdisciplinary specialty in women's health, relying on women's health fellowships, expanding curricula in family practice and internal medicine residency programs to focus on women's reproductive care, and expanding curricula in obstetrics/gynecology

residency programs to focus on women's general health.' Women's health residencies and fellowships already exist in small numbers,' and whether women's health will eventually be established as a specialty is currently a matter of dispute (New York Times. June 22, 1997:20)^{3,4}

In a 1994 survey, 190 obstetricians and gynecologists reported that 63% of their patients discuss general health problems with them.⁵ Yet, graduate training in obstetrics/gynecology confers only 26% of the competencies needed to deliver primary care.⁶ Conversely, studies clearly document that non-gynecologist physicians do an inadequate job of providing pap smears, pelvic and breast exams.^{7,8} Both internal medicine and obstetrics/gynecology residency programs will need to respond to this disconnected and outdated approach to the comprehensive treatment of women. In 1994, the American College of Obstetricians and Gynecologists (ACOG) published Primary and Preventive Care-A Primer for Obstetricians, formal training in primary care is now required of all residency programs in obstetrics/gynecology.

The purposes of the Duke University study were 1) to

Table 1
Median Comfort Levels of Obstetricians and Gynecologists in Treating Selected Medical Problems

Medical Problem	Median Comfort Score	Interquartile Range
Safe sex	10.0	10.0-10.0
Abdominal pain	9.0	8.0-10.0
Risk factors for osteoporosis	8.0	7.0-9.5
Risks for coronary artery disease	8.0	5.0-9.0
Domestic violence	7.5	5.0-9.0
Upper respiratory illness	7.0	6.0-8.0
Cotorectal cancer screening	6.5	5.0-8.0
Smoking cessation	6.0	4.5-9.0
Nongestational diabetes	5.5	3.0-7.5
Immunizations	5.0	4.0-7.0
Skin cancer screening	5.0	5.0-6.0
Hypertension	5.0	3.0-7.0
Musculoskeletal disorders	5.0	3.0-6.0
Depression	4.0	3.0-5.0

determine topics in which obstetricians and gynecologists might require additional training in order to increase their comfort in providing primary care, and 2) to guide the planning of a primary care curriculum for obstetrics/gynecology residents.

SURVEY

Methods: A needs assessment survey was distributed during grand rounds to obstetrics/gynecology faculty and resident physicians at Duke University in July 1995. The anonymous survey collected demographic information and current level of training. The questionnaire asked how comfortable respondents were with 14 common diseases seen in primary care. The topics were selected from the ACOG guidelines in primary care to represent a range of common conditions encountered in women's office visits.

The survey used a Likert scale with a range of 0 to 10; 0 being no comfort and 10 being complete comfort. We hypothesized that certain primary care content areas would be more comfortable than others for obstetricians and gynecologists. Items relating to primary care general medicine and having low comfort scores would be appropriate educational targets for an interdisciplinary primary care women's health curriculum. Surveys were conducted anonymously in an attempt to obtain frank opinions.

Results: Thirty surveys were completed (6 interns, 6 residents, 4 fellows, 14 attendings), a response rate of 43% for residents and 45% for departmental faculty. Some of the residents and faculty were not present at the grand rounds where the survey was distributed. The anonymity of the survey prevented us from following-up to improve the response rate. The average age of respondent was 35.7 years (range 25 to 61). The median year of graduation from residency training was 1994 (range 1965 to 1999). Women were 57% and generalists 53.5% of respondents.

The results of the comfort score section (Table 1) showed that topics traditionally emphasized in obstetrics/gynecology training, such as evaluation of abdominal pain and counseling on safe sex practices, received very high

comfort scores. Alternatively, the comfort scores for traditional general medicine problems such as hypertension and diabetes were very low.

CURRICULUM DEVELOPMENT

Based on the results of the needs assessment, we designed a seven-week required rotation at the multidisciplinary women's clinic at the Durham Veterans Affairs Medical Center that incorporates primary care training. In addition to practical ambulatory experiences, didactic instruction focusing on the primary care of women is provided in individual teaching sessions. The major goals of this program are to expand the primary care training of obstetrics/gynecology residents and to expose them to a multidisciplinary approach to women's care.

The clinical experiences in the multidisciplinary women's center are designed to encompass four broad areas appropriate for first-year obstetrics/gynecology residents. Ambulatory gynecology: Working with gynecologists in the women's clinic, the interns learn to incorporate the internal medicine training into their outpatient gynecology practice. Breast disease: Under the direction of a surgical oncologist, interns follow patients with both benign and malignant breast disease and receive training in breast examinations, mammography, and breast biopsies. Preventive care: Interns work with a family nurse practitioner in her clinic, participating in both wellness assessments and counseling for healthy behaviors. Primary care of the adult woman: Working in conjunction with a general internist, obstetrics/gynecology interns are exposed to a primary care women's clinic that includes both continuity and acute care visits.

The rotation includes the following clinical time structure: 60% non-gynecological clinics (general medicine, breast, and preventive counseling, including mental health assessments), 20% primary health care in an ambulatory gynecological setting, 10% didactic conferences (obstetrics/gynecology and internal medicine grand rounds, and a primary care journal club), and 10% individual instruction

by the women's health fellow or faculty covering a systematic review of common problems encountered in the outpatient setting.

We concentrated our curriculum on the six areas with the lowest comfort scores: immunizations, skin cancer screening, diabetes, hypertension, musculoskeletal complaints, and depression. Age-specific immunization requirements are reviewed in didactic sessions, and updated immunization records are kept on wellness flow-sheets in the patients' charts. Screening for early detection of skin cancer is also covered in teaching sessions, and patients are counseled on "safe sun" practices. While obstetricians routinely care for women with gestational diabetes and hypertension associated with pregnancy, in women who are not pregnant, diabetes mellitus and essential hypertension are different diseases and are managed very differently. Guidelines for monitoring and treating these common internal medicine problems are reviewed with emphasis on unique aspects of these conditions in women. Residents evaluate musculoskeletal injuries in the acute care setting and follow geriatric women with degenerative joint disease in the general medicine clinic.

Improving women's mental health is a designated women's clinic program goal, but the obstetrics/gynecology residents and faculty reported the least comfort with diagnosing and managing depression. Given the prevalence of mental illness and the lifetime risk of depression in women, 10 patients are screened for depression and substance abuse in the women's clinic." The residents work with the multidisciplinary team of psychiatrists, psychologists, and social workers to make assessments and establish treatment plans for women with psychosocial issues.

DISCUSSION

Although ACOG has mandated training in primary care, individual residency directors are given the task of determining how this should be provided. A systematic assessment of the weaknesses and strengths in each resi-

dency can serve as the basis for primary care curriculum planning. This approach forces program planners to consider the needs perceived by the trainees themselves, rather than focusing solely on the needs they perceive. Our survey confirmed that obstetrics/ gynecology residents and faculty are less comfortable providing primary general medical care than primary gynecological care. We designed a curriculum based on the findings of our survey and have implemented this program in our multidisciplinary women's clinic.

Seventeen obstetrics/ gynecology interns have completed the primary care rotation since it was implemented in July 1995. It has been well received, and the interns report more comfort in providing general women's health care. Specifically, they report gaining valuable clinical experience in the management of hypertension, diabetes, and osteoarthritis. We are planning to systematically evaluate this rotation in July 1998, using a competency examination based on primary care internal medicine board review questions.

References

1. Cassel CK, and the American Board of Internal Medicine Committee on General Internal Medicine. Training internists in women's health. *ABIM News Update*. Summer 1995:1-3.
2. Blumenthal Sj. *Directory of Residency and Fellowship Programs in Women's Health*. US Public Health Service's Office on Women's Health, Department of Health and Human Services; April 1997.
3. Hofftnan E, Johnson K. Women's health and managed care: Implications for the training of primary care physicians. *J Am Med Assoc*. 1995;277:17-19.
4. Wallis IA. Women's health: A specialty? Pros and cons. *J Women's Health*. 1992; 1:107-108.
5. Hale RW, Bailey J. The ob/gyn as a primary care physician. *Primary Care Update Ob/Gyn*. 1995;2:190.
6. Hentich JB. *Academic and Clinical Programs in Women's Health*. Bethesda, Md: Council on Graduate Medical Education, Bureau of Health Professionals, Health Resources

WOMEN'S HEALTH CURRICULUM AT STANFORD

Jodean Nicolette, MD and Marc Nelson, MD, PhD

As health care for women receives national attention, medical educators have come under increasing pressure to train physicians to provide optimal care for their female patients. Stanford University has responded by creating a clerkship in women's health. This interdisciplinary clerkship is two or four weeks and explores women's health chronologically from adolescence to old age. Students enjoy both didactic and clinical experiences, and learn about such topics as violence against women, prevention, and breast, sexual, mental, and cardiovascular health. This clerkship is currently elective, with the hope that it will become part of the required curriculum.

Health care for women is receiving national attention. Congress, the media, health care providers, and, most importantly, patients, call for physicians who are better trained to provide comprehensive care for women. Faced with this call, medical educators are now challenged to improve training in the face of ever increasing time and financial constraints.

Women's health advocates suggest three main areas for improvement in medical curricula: 1) incorporate newly emerging risk, prevention, and treatment data about women in a timely manner; 2) include conditions and illnesses more common in, more serious in, or exclusive to women (such as domestic violence, menopause, osteoporosis); and 3) repair the arbitrary and inaccurate fragmentation of women's medical care that divides "systemic" health from genitourinary care and from mental health. With these goals in mind, medical educators have already made important changes in the content and the structure of medical education that can only serve to further improve care for women patients.¹

A variety of creative and scholarly solutions, none

and Services Administration; 1994.

7. Bartman BA, Weiss KB. Women's primary care in the United States: A study of practice variation among physician specialties. *J Women's Health*. 1993; 2:261-268.
8. Coodley MK, Coodley GO, Levinson W, Rosenberg MR, Dull VT. Internal medicine training in ambulatory gynecology. *Arch Intern Med*. 1993;153:2588-2592.
9. *Primary and Preventive Care-A Primer for Obstetricians*. Washington, DC: American College of Obstetricians and Gynecologists; 1994.
10. Paier K. New strategies in the treatment of depression in women. *J Clin Psychiatry*. 1995;56(S2):30-37.
11. Spitzer RL, Wilhams JB, Kroenke K, et al. Utility of a new procedure for diagnosing mental disorders in primary care: The Prime-MD 1000 Study. *JAMA*. 1994; 272:1749-1756.

(Source : *Journal of American Medical Women's Association* Vol. 53, No. 3, 1998)

□ □ □

mutually exclusive, has been proposed to improve medical education with respect to women's health. The published literature currently lists 16 graduate and postgraduate fellowships and 4 residency tracks providing a focused experience in women's health;² many more are in progress. In addition, many of the nation's leading advocates for women's health reform have been engaged in the creation of an interdisciplinary specialty in women's health.³⁻⁵

Many medical schools now offer preclinical and clinical opportunities in women's health.⁶ Examples include such courses as Harvard University's "Women, Health, and Medicine" and Stanford University's "McCann Women and Health Lecture Series." Clerkship opportunities include the University of Massachusetts Medical School's inter clerkship on domestic violence⁷ and ambulatory care clerkships offered by many medical schools at local women's primary care centers. These educational opportunities are generally electives, and, although valuable to individuals with an interest in women's health, they tend to preach to the converted, missing the future physicians that may need them most.

The Medical College of Pennsylvania/Hahnemann is one of the few medical schools that has made strides in instituting an integrated core curriculum in women's health in both medical school and residency training.⁸ Stanford University's Department of Medicine is undergoing the same integrative process (Nicolette JD, Jacobs MB, unpublished data, 1997). Such integrative efforts are essential at all medical training programs to insure that women's health is assigned the appropriate priority in all learning experiences.^{1,9,10}

To improve training in health care for women at Stanford University, we have created a unique interdisciplinary format for our women's health curriculum. The primary goals of our curriculum are: 1) to educate medical students on the major health issues of women, paying particular attention to ethnicity, class, age, and sexual orientation; 2) to encourage critical thinking with respect to sex inclusiveness of clinical research (Does a study that

includes men only generalize its results to women? Or vice versa?); and 3) to recognize the interdisciplinary nature of women's health and provide the skills necessary to comprehensively and sensitively treat all women.

Our women's health curriculum is a two-to four-week, elective, interdisciplinary clerkship, created by the joint effort of students and subspecialty faculty (who serve as content experts in their fields). The clerkship begins with introductory lectures addressing the doctor-patient relationship and the health-careseeking practices of women. Students learn, through both didactic and clinical experience, about women's health chronologically from adolescence to old age. Specific topics include violence against women and sexual, mental, breast, and cardiovascular health. Integrated throughout the curriculum are specific sessions on biological, psychological, and sociological transitions. The clerkship concludes with a focus on prevention and health maintenance to emphasize the wellness model of women's health.

The training sites emphasize ambulatory care and include specialty services such as Planned Parenthood, breast, and rheumatology clinics. In addition, the students have the opportunity to participate in several ongoing clinical research studies such as the Women's Health Initiative (WHI), the Heart and Estrogen Progestin Replacement Study (HERS), and the Postmenopausal Estrogen/Progestin Interventions trial (PEPI).

We structured the clerkship not only to educate students about specific current issues in women's health, but also to increase students' sensitivity to differences among all individuals that affect the course and management of disease. On the subject of cardiovascular health, for example, students are instructed in the differences and similarities of heart disease, not only between men and women, but also among various cultural and ethnic groups, and how these differences may result in suboptimal treatment and prevention. An epidemiology seminar highlights clinical studies that are sex inclusive.

The Women's Health Clerkship takes two to five students per period, and it has been offered four times per year for the last two years by the Division of Family and Community Medicine. The feedback has been overwhelmingly positive, with negative comments limited to individual lecture style and time allotted for certain topics. This clinical experience has been so well received that the Department of Internal Medicine has requested permission to adapt it for its residents. We do not interpret this preponderance of positive feedback to mean that our work is finished. Rather, we attribute it to the enthusiasm of the students and residents, who clearly have long felt the absence of such important training. Plans are underway to evaluate knowledge, skills, and attitudes of trainees before and after the clerkship experience, in order to gauge its educational value and identify areas for improvement.

We have limited time in which to educate our students on women's health, and we cannot cover every aspect of this new and rapidly developing field in one learning experience. The clerkship is currently offered as an elective, with the hope it will become part of the required curriculum. It is only one part of our efforts to ensure that Stanford students are comprehensively educated in women's health. We are working with all our faculty to ensure that women's health is more equitably represented in all clinical and preclinical experiences. In addition, women's reproductive health issues such as normal development, birth and pregnancy, and gynecological cancers are covered in the gynecology and obstetrics clerkship. It is our hope that all these efforts will result in a more complete education for the students here, and better health care for all women and men in the future.

References

1. Wallis LA- Why a curriculum in women's health? *J Women's Health*. 1993;2:55-60.
2. *Directory of Residency and Fellowship Programs in Women's Health*. Washington, DC: US Public Health Service Office on Women's Health; March 1996.

3. Johnson IC Women's health: Developing a new interdisciplinary specialty. *J Women Health*. 1992;1:95-99.
4. Harrison M. Women's health as a specialty: A deceptive solution. *J Women's Health*. 1992;1:101-106.
5. Wallis L. Women's health: A speciality? Pros and cons. *J Women's Health*. 1992;1:107-108.
6. Montgomery K, Moulton AW. Medical education in women's health. *J Women's Health*. 1992;1:253-254.
7. Jonassen JA, Doepel DC, Punaire MP. An inter clerkship course on domestic abuse. *Acad Med*. 1997;72:422-423.
8. Levison SP. Teaching women's health: Where do we stand? Where do we go from here? *J Women's Health*. 1994;3:387-395.
9. *Fifth Report. Women and Medicine*. Washington, DC: US Public Health Service Council on Graduate Medical Education; July 1995.
10. Lowey NM. Women's health and medical school curricula. *Acad Med*. 1994;280-281.

(Source : *Journal of American Medical Women's Association* Vol. 53, No. 3, 1998)

□ □ □

SEXUAL COERCION AND PID IN SLUM WOMEN OF MUMBAI: ROLE OF THE HEALTH CARE PROVIDER

**Renu Khanna, Korrie de Koning, Swati Pongurlekar,
Usha Ubale, Manjiri S.**

The problem of family violence, especially violence against women, is not a new one and evidence of such violations can be found throughout history in recorded documents. Abuse of female partners is referred to in the Bible and condoned in the Koran. Manu's patriarchal laws which dictated that a woman has to be under her father's guardianship in childhood, husband in youth and son in old age, resulted in 'deviant' women being beaten and abused. Although violence against women is an age-old problem, it has only recently been positioned in the international public policy area as a human rights issue. This position has grown out of the work of pro-democracy movements in Latin America and parts of Asia. Women who were part of these movements realized that the violence they faced often in private spheres, was completely invisible in the mainstream framework of human rights, which had till then concentrated on civil and political rights. This catalyzed the international women's movement to push the definition of human rights to include gender-based forms of violence, such as domestic and sexual violence.

Through the early 1990s, preliminary data began suggesting that violence against women is also a health issue. Amartya Sen's work on the missing females and declining sex ratios in countries where females are discriminated against, indicated the missing females are victims of female feticide, selective malnourishment of girls and lack of investment in women's health, and various forms of violence. Subsequent work in the early 1990s on gynecological morbidities also began to be related, in some part, to violence against women. And in 1994 the ICPD at Cairo in its Programme of Action placed violence against women, fully

on the reproductive health agenda.

Box 1 Impacts of Violence on Women's Sexual and Reproductive Lives

- STDs and HIV
- Unwanted pregnancy
- Abortion-related injury
- Fear of sex/loss of pleasure
- Miscarriage and low birth weight from battering during pregnancy
- Violent sexual initiation
- Premature labour
- Gynecological problems
- Inability to use condoms
- Genital mutilation
- Forced abortion of female fetuses
- Suicide or homicide related to stigma of sexual violence.

Source: Lori Heise et al (1995)

As Box 1 shows, gender-biased violence is a profound health problem. At the most basic level, violence affects women's bodies and psyches throughout their life cycle. Ill-health is a direct consequence of violence. Thus violence, in addition to being human rights, is also a health issue. Violence is an issue of power relations between men and women. It can be conceptualised as an issue of control of women, each of the forms in which it is seen serves to keep individual women within the control of individual men. Collectively, the sum total of violence against women can be viewed as one of the many forms of patriarchal social control. If reproductive health aims to empower women, programmes must address violence against women. Violence takes away control of the body. The reproductive health concept includes the notion of reclaiming control over the body, thus violence against women must be incorporated into its definition.

This paper looks at one aspect of gender-violence, sexual coercion in consensual relationships. The paper examines data from a research study on Pelvic Inflammatory Disease

among slum women in Mumbai, in order to define what the role of health care providers can be.

THE STUDY

The study was undertaken in Mumbai between October 1993 and December 1995. It was a collaboration between the BMC and the Liverpool School of Tropical Medicine, U. K. and was funded by Overseas Development Administration of the U. K. The data was primarily of women who approached the health care facilities of Brihanmumbai Municipal Corporation for mainly curative services. The study women were recruited at three centres located in three neighboring wards. Most cases were recruited at Lokmanya Tilak Municipal General Hospital (ward F/N).

And most controls from Mahim Maternity Home (ward G/N) and Parel Post Partum Centre (ward F/S).

Women were defined as cases if they presented for gynecologic investigations, either with symptoms of acute pelvic infection (suspected PID) or a history of infertility. Such women were suspected to have a reproductive tract infection. Controls were fertile women seeking tubal ligation and having no symptoms of gynecological disease.

A total of 3588 women were screened. A social questionnaire containing socio-demographic information (marital status, religion, migrant, history, education, and income) contraceptive use and sexual history of the woman and her partner was the first instrument to be used. This was followed by a clinical questionnaire, Gynecological examination and microbiological assessments. In-depth interviews of 240 women were done. Around 23 group discussions were also done.

A total of 30 Auxiliary Nurse Midwives (ANMs) were seconded by BMC to the research project and trained to enhance their skills in questioning women on their sexual behaviour. The social questionnaire was developed with the ANMs through a process of careful piloting, asking open-ended questions on pre-determined issues, until closed

and Hindi in separate quiet rooms where confidentiality could be maintained. Interviews were always conducted by two ANMs — one who asked questions, while the other recorded the responses. This procedure allowed one ANM to give full and sympathetic attention to the women while ensuring careful recording of answers.

The in depth interviews were conducted by pairs of the trained ANMs at the homes of the women. Most interviews were spread over two meetings. At the homes too, attempts were made to ensure privacy and confidentiality. The group discussions were conducted in rooms of the municipal health facilities, a few meetings were conducted in common community spaces.

The data from the in depth interviews was coded and analysed using the ZYINDEX qualitative research package.

FINDINGS

Analysis of the data around sexuality issues and relationships with their husbands revealed that at one level women experienced feeling supported and cared for by their husbands; they described the concern exhibited by their husbands towards their illnesses. At another level, women spoke about how men exerted control and power over them.

SUPPORT AND CONCERN

Most of the women felt that their husbands were really concerned about their ill health. The concern was reflected in many of the husband's helping out in doing the 'harder' domestic work e.g. fetching water, looking after the children, cooking for them. Gouri mentioned that her husband was very worried during her second pregnancy. She was admitted in a hospital after delivery and he used to do all the housework, take care of the children and so on, she felt that her husband is unlike other husbands. When she even a little sick, he does everything in the house right from filling water to cooking and taking her to the doctor immediately.

A woman with infertility spoke about how her husband especially bought her to Bombay from the village for treatment. For the previous eighteen months, they were taking treatment from the hospital. Another one mentioned that “he forces me to take medicines and himself takes me for a check up (even) if I (only) have fever.” Yet another woman mentioned that her husband restrained from having intercourse with her (even though he had the desire) because he feared that her symptoms would get further aggravated.

Against the perception of high degree of concern and support mentioned by the above women, there are others who think that while their partners are supportive, they could be more so. Take for instance, Shanti, a woman who had secondary infertility. She stated that her husband supports her against the abuse of her mother-in-law and says that one child is enough, he does not accompany her for treatment. In her frame of reference, it appears that accompanying her for treatment is a sign of support and concern.

On the other side of the spectrum are husbands like Kanta’s.

“...he is very shakki (suspicious) when I got safed paani ki taklif (white discharge), he was very angry and said that I must be ‘going out’ with someone else.”

The following story is typical of the pattern of many women’s lives. The group discussions also repeatedly brought out the themes of the man’s irresponsibility and physical abuse.

Sumitra lives with her husband and children in a single room. Her husband refuses to work and demands money and food from her. “He drinks, smokes, eats tobacco, everything..., quarrels..., he says that the wife should earn and the husband eat. He beats me every day because he drinks, just now, too, he has gone out after beating me.” Sumitra feels that she does not have any support from either her parental hime or her inlaws. She works as a domestic worker but the income is not sufficient. She always feels pressurized about money and food for the chil-

dren. Her husband has complete control over her, “I don’t get to go out. If I go out without asking him, he will not let me enter the house, I have to take his consent before going out, even if he is a drunkard.”

SEXUAL COERCION

Sexual coercion is defined as the act of forcing (or attempting to force) another individual through violence, threats, verbal insistence, deception, cultural expectations or economic circumstances to engage in sexual behaviour against his/her will. The touchstone of coercion is an individual women’s lack of choice to persue other options without severe social or physical consequences (Heise, 1995).

An analysis of the material in the 240 in depth interviews with the study women revealed the following about women’s responses to sexual intercourse with their husbands.

Table 1
Women’s responses to sexual intercourse initiated by husbands (n = 240)

Don’t want and can’t speak out	026
Don’t want and husband does not listen	024
Forced intercourse	003
Don’t want and husband understands	054
No information	133

Some of the responses which illustrates the first category of ‘don’t want sex and cannot speak out’ are as follows:

“When my husband tells me he wants relations, I cannot say no to him. He has got me by marriage. When my parents have given me in marriage to him, how can I tell him not to have relations? I get scared to tell him.” — Maya

Maya appears to have internalised the societal diktats about marriage. Marriage is a contract in which a woman passes from parental care to custody of the husband. He is supposed to provide for her, look after her and she has to keep her side of the contract by servicing his needs.

Another example of internalisation of society’s norms is

reflected in Sheila's views that: *"men have more sexual desires than woman... one sees this all the time in movies, that the man is forcing the woman... a husband has a right to sex and say 'no' to him is out of the question."*

Infertile women are more vulnerable as guilt of not having a child making them think that they have no right deny the man sex, as having a child and sex are believed to be the only two purposes of marrying. Mamta, a woman with infertility is tormented by the guilt of not giving him a child. Her husband appears to use her guilt as a weakness, and forces himself on her.

"Even if I do not wish and he wishes, then he does it (has sex). I say (no) but he doesn't listen. Sometimes, I am in trouble. I don't feel like (it). But if he wishes, he gets angry, gives me bad words. Then I have to be ready. I always think that I eat and he gives, whatever I wear has been given by him, then how can I go against his will? I do not even have one child of my own. On what basis can I go against his wish?"

Men appear to have several ways of getting to submit to non-consensual sex. As Nisha said *"if we don't want and we say no, he will 'rooth jayega (sulk)."* Sulking and making a scene is a common way of getting the wife to submit. Voicing doubts about a woman's sexual fidelity is yet another way of having a woman give in. Kanta has a prolapsed uterus and experiences pain during intercourse. Her response to our question 'why do you keep sambandh (have intercourse) when you suffer so much?' was typical. She said:

"What could I do? He is a man, matlab (which means) will he listen? Even after telling him, sometimes he understands. But if this is what I have every time, how long will he keep quiet? There were misunderstandings and quarrels in the house. He sometimes felt that I have some other relations outside (of this marriage),... If we have to stay in the family, we have to stay according to them, isn't it?"

Verbal and physical abuses were also ways by which men got their wives to submit to unwanted sex. Krishna

said that her husband gets very annoyed when she says 'no'. *"He beats me like a dog, kicks me with his feet and forces me"*. Madhavi said *"he doesn't listen. Sometimes he gets up to beat me. But he has to keep quiet because of the children. But sometimes when I am alone, then I cannot control him."* Ganga said, *"My husband wanted to have sex after a month and a quarter of her delivery. I refused because I felt that my stitches were still wet. So he beat me up"*. There are situations, however, where women are able to assert themselves. One such illustration of strength and assertiveness is Kavita. Kavita described how her husband would drink and then want to have sex. *"I told him if he stopped drinking, we would have relations."*

Sushma's way of getting out of unwanted sex is by saying, *"I am not feeling well, then he doesn't bother me"*. It appears as though 'I am not well' is a major protective strategy that women use when they do not want to have sex. This is something that they can get away with perhaps because of their husband's concern for their physical state of health.

SEXUAL COERCION AND REPRODUCTIVE HEALTH SYMPTOMS

How do men and women negotiate sexual relations when the wife has reproductive health symptoms? The picture is quite mixed. In spite of having problems, most women cannot say 'no' to sex because they feel that then husbands have got them in marriage and therefore the husbands have the right to use the women's bodies as and when they desire. Gita says, *"when it pains, I don't (usually) tell. When I cannot bear, when it pains a lot, then I tell him. He says 'if it pains, what can I do 'He still has it!'"*

Pushpa has a prolapse uterus. She feels that her uterus comes out when she coughs and also after intercourse. In spite of these problems, she feels that she cannot say 'no' to her husband.

In most causes, women do not tell their partners about the pain or troublesome symptoms. They express in the

interviews that they definitely do not wish to have sex during such symptoms not only because it is troublesome or painful but also because they fear that their husband would get their infection. As Madhavi said:

“Madhavi: We have fights over keeping sexual relation

Interviewer: Well, do you then have intercourse or not?

Madhavi: Yes. I do not want to have intercourse with my husband because I am afraid. If I am suffering from anything he should also not get infected.

Interviewer: Does he listen to you?

Madhavi: He does not... sometimes he gets up to beat me...”

Kaushalaya, during one of the groups meetings, spoke about sexual relations during her health problems. There seem to be two fears linked to refusing to have sex. One is the fear that the husband will go to another woman and desert her. This in turn appears to be directly related to the economic control or power that the man has over her. Kaushalaya said

“Man does not agree to keep away when the wife has health problems. The wife may have tension and go away to her mother’s home. But he can’t live (without sex). He will come after her like a dog, or if, the wife is not around, there’s always the side bazaar. He’ll go there and catch AIDS. We try and persuade them, don’t go here and there. If you go, you will die, not I. But even if he dies, we will have trouble. Our suhaag will ugro (we will become widows). what will I do with four children? Beg? So even if it (sex) is difficult for me, let it be. Take what you want from me, but stay the way I want.” A number of other women mentioned the fear of their husbands ‘going out’ as a reason for submitting to their unwanted sexual advances.

“During white discharge, sambandh is regular. You can’t say anything about it (sex). We never can say about gents... if we don’t give (sex) to them, they may find it outside.”

Some women also describe instances when the men

either stop having sex or reduce the frequency when the woman tells them about their pain or infection. Mamta described her situation as follows:

“I feel as if I have suj (inflammation, swelling) at the lagviche jagya (vagina)... Then we do not have sambandh. My husband is good... he agrees.”

DISCUSSION

The narratives of the women indicate that there are a significant number of women who are forced into having sex with their partners even when they have symptoms of reproductive health problems. The reason why they submit to unwanted sex appear to range from internalised societal values of a woman’s subordinate position in the institution marriage, and their perceived obligations in the contract of marriage, to fear of physical violence if they resist, and discomfort at having the man sulk around the house and create scenes. The data from these in depth interviews indicates that sexual coercion is a small slice of violence that these women experience in their marital relations. The narratives also include descriptions of other kinds of violence, beating and physical and verbal abuse that the women face in these relationships.

Under-reporting of sexual coercion and violence at the hands of the husbands by women can be expected. It is known that women tend to under-report sexual violence both because forced sex by husbands or intimate partners is not perceived as violence and because shame and other factors inhibit them from admitting the experience (Jeejeebhoy, 1997). As we had mentioned earlier, this data is drawn from a limited sample of those who sought services from the BMC’s health care facilities i.e. the users. Data from community-based studies (which would include users and non-users) would possibly reveal that the problem of gender-violence is much larger than what we see through a small section of our data.

What then are the implications for action? Strategies to combat violence must address not only the immediate

health needs of battered women but also the root cause of violence-unequal gender relations and the way these relations reinforce women's powerlessness. We know that many women contact health services only when they need assistance with a reproductive health concern, and there is evidence that abuse increases during and after pregnancy or because of disputes over family planning. For these reasons, reproductive health services, such as antenatal clinics, maternity services and family planning services must be particularly alert to the possibility of gender violence among their clients. Gynecology clinics, STD clinics must also address the issues of sexual practices, especially forced sex. Counselling of partners where necessary must become a routine practice. In our study several women mentioned how the doctors' talking to their husbands about restraining from sexual intercourse, strengthened their own position in negotiating unwanted sex.

At the same time community education efforts directed towards adolescents, women, men and family elders must forcefully convey the need for gender equity and respect for women's rights generally including their right to be free from violence. People also need to be made aware of the various means—legal, social supports and health care—available to women for protecting themselves against violence.

There is also need to highlight the likely consequences of domestic violence of women's lives and health and on the lives of the infants that they bear. The aim should be to reverse the social attitudes and beliefs that legitimise male violence with promotion of responsible sexual and gender attitudes among men. Efforts must promote women's understanding of their strategic needs and empower them to resist abuse.

Including violence against women as a health agenda has various implications on the roles of health care providers. The community health worker, who is closest to the women in the community, will have as her task, organizing women around the issue of violence, identifying legal and social support agencies in the neighbourhood where

women could be referred. The community health worker, as a link person between the woman and the health care system, can also provide valuable information to the doctors and nurses about the violence inflicted on the client. Since the CHV lives in the community and understands the cultural mores, she can be a credible vehicle of educational efforts directed at the adolescents and men on reconstructing masculinity and femininity.

Male health workers are the second level of health functionaries who have a key role to play in addressing the men on issues of violence against women and transforming the notions of masculinity and male sexuality from the currently accepted social norms to more gender equitable constructions. The role of the male health worker has not been given much importance till now, it is time that this role to be recognized and thought be given to how male health workers can be prepared and equipped to become role models for men in the community.

And finally doctors and nurses need to address violence during their consultations. Assessment of all forms of violence against women should take place for all women entering the health care system. A thorough assessment garners information on physical, emotional and sexual trauma from violence, risk for further abuse, cultural background and beliefs, perceptions of woman's relationships with others and the woman's stated needs. Women should be asked directly if they have been or are currently in an abusive relationship either as a child as an adult. They should also be asked if they have ever been forced into sex that they did not wish to participate in. Shame and fear often make disclosure difficult. Verbal acknowledgement of the seriousness of the situation and emotional and physical support assist women in talking about past or current circumstances. After the assessment, the interventions should be decided on the principle of helping the woman to make decisions and take control of her life.

To conclude, guidelines and protocols should be developed to assist physicians and other health staff to address the issue of partner violence. Gender-based violence

**WOMEN HEALTH CARE
WORKERS**

should be included in the basic and postgraduate training of health practitioners.

Source : Paper presented in International Conference on Preventing Violence, Caring for Survivors : Role of Health Profession and Services in Violence. Organised by CEHAT in 1998.



ETHNICITY, GENDER IDENTITY, STRESS AND COPING AMONG FEMALE AFRICAN-AMERICAN MEDICAL STUDENTS

**Denese O. Shervington, MD, MIPH, Irma J. Bland, MD,
Amanda Myers, MPH**

The rigors of medical education are extremely stressful for all students, with academic factors, particularly the fear of failure, rated as the greatest source of stress. A study of first-year medical students by Coburn and Jovaisas¹ found certain demographic variables were more highly correlated with stress than others. Students from subgroups differing from the “mainstream” reported more stress than their mainstream counterparts.

African-American medical students often feel isolated and alienated in predominantly white medical establishments. A majority of 147 black medical students in the northeast studied by Bonnett² felt that 1) the administration’s attitude toward them was less than enthusiastic; 2) white students perceived their abilities as average; 3) minority patients were not treated with the same degree of concern as whites; 4) white students were better able to relate to white faculty; and 5) white faculty were unfair to minority students.

Female African-American medical students are faced with the double challenges of racism and sexism. Usually beginning in the clinical rotations in the third year of medical school, gender inequities can at times be more stressful than those relative to race. Minority status/prejudice, lack of role models/mentors/sponsors, and role strain have been identified as major sources of stress for women physicians.³

A qualitative study of 20 African-American first-and second-year female medical students attending a Southern medical school was conducted in January 1996. It yielded some interesting preliminary information for medical educators.

First- and second-year medical students were brought together in a focus group. A questionnaire about ethnic and gender identity, academic performance, and stress was read aloud by the facilitators, and the medical students anonymously and confidentially wrote their responses.

The Kluckholm and Pinderhughes models^{4,1} were used to assess students’ orientation to values and ethnicity, respectively. On completion of the questionnaire, the facilitators moderated a group discussion of the pertinent issues.

The students’ perceptions of their African-American group values differed from the values of mainstream white Americans in respect to time, social and activity orientation. Being, rather than doing, past orientation rather than future, and group relatedness rather than individuality were reported by most as the African-American group norm. On the other hand, the students perceived their individual behaviors as different from their ethnic group values in certain areas. Many perceived themselves closer to the mainstream white values in respect to time and activity orientation; they were future and goal/action oriented.

The majority of respondents reported pride in their ethnic group. As African Americans, they felt they belonged to a culture rich in values. Being African American also meant being “special, unique, and diverse.” African-American culture was highlighted as being collateral and cooperative, with great emphasis placed on family, religion, and education. Perseverance and pride were considered notable group strengths.

The first experiences of being different as African Americans occurred at two nodal points. Most first became aware of their difference at preschool or early elementary school. The second nodal point was at the beginning of high school. These young women attributed their first images of race and color to the media and/or specific incidences of feeling different or isolated as a result of being confronted by peers.

When the students compared their sense of racial identity with that of whites, two themes prevailed. Their perceptions were that whites felt superior and, at the same time, both threatened and fearful, and that whites had no sense of racial identity because they never thought of their color. One respondent wrote, “A smug superiority maybe without a full awareness of the advantages that it brings them.” Another, “I don’t feel that they ever consider their race/color unless otherwise put in compromising settings.”

All respondents except one felt very positive about being female. Femaleness was associated with “power, strength, and nurturance.” Among the first-year students in particular, the ability to cope well with adversity was strongly associated with being female. One woman noted that as a woman, she had never felt academically inferior to men. Only one student reported that if given the opportunity she would consider being male, as men had it much easier in society.

The majority of the students identified their stress level as average. Most (80% to 90%) attributed their stress to academic pressures, while only 10% to 20% cited race and/or gender. Those who identified their stress levels as above average usually rated race and gender higher. The higher stressed group also had experienced a course failure or considered dropping out of medical school more often.

The group discussions afterward, however, were dominated by the stress of racism-racial isolation, alienation, negative stereotypes, and negative assumptions about black intellectual abilities. Several cited examples of being overlooked by their white classmates and professors when answers or instructions were being sought. Many were frustrated by the current anti-affirmative action sentiment held by many of the dominant culture. They felt intense pressures to prove themselves worthy and intelligent. Many were afraid to fail, seeing their individual failures as not just a personal issue, but as one affecting African Americans as a whole. There was much pressure not to fail so as not to reflect negatively on blacks.

For these students, all of whom were still in the classroom, gender issues seemed overshadowed by the intensity of racism. In fact, several felt that being female was somewhat protective—that they were better able to cope. For those second-year students who were beginning to get involved in clinical rotations, however, subtle gender issues were beginning to emerge. Several reported the frustration of being mistaken for nursing or other allied health workers, for example.

As a group, these African-American female medical students appeared to have reached a healthy degree of reconciliation with themselves, their pasts, and with the futures that they were charting for themselves. They did not deny that being black and female carried its burdens or provided distractions that siphoned off their energies. On the contrary, it meant “struggle, hardship, challenge, and tolerance.” As one respondent explained, “Being an American of African descent means living among the dominant culture and constantly having to overcome obstacles.” They had all accepted this challenge, however, and because of it felt an enhanced sense of pride and power. On their way to becoming physicians, they felt both special and powerful to be African American.

Even while pursuing the American dream at its highest—becoming doctors—these African-American women were still very much subject to institutional racial and gender inequities. W.E.B. DuBois’s statement of almost a century ago still seems to hold true, “It is a peculiar sensation, this double-consciousness, one ever feels his two-ness—an American, a Negro; two souls, two thoughts, two unreconciled strivings, two warring ideals in one dark body, whose dogged strength alone keeps it from being torn asunder.”⁶

Despite the intensity of their feelings about racism that emerged in the discussions, the majority of these young women were not distracted from their goal. In coping with both the academic rigors of medical school and a devaluing, alienating, and hostile environment, group support seemed key to their coping mechanisms. When students

have a context in which they feel understood and have their experiences validated, they are less likely to engage in internal struggles that undermine their sense of self. Connecting with their cultural/ethnic group through family, community, or other social involvements also reduces the sense of alienation. Medical educators should recognize that such support group activities act as positive reinforcers of coping mechanisms and should not allow them to be stigmatized as indicative of deficits.

References

1. Coburn D, Jovaisas A. Perceived sources of stress among first-year medical students. *J Med Educ.* 1975;50:589-595.
2. Bonnett A, Douglas F. Black medical students in white medical schools. *Soc Policy.* 1983; 14:23-26.
3. Bowman A, Allen D. *Stress and Women Physicians.* New York, NY: Springer-Verlag, 1990.
4. Barnouw V. Cross-cultural studies of values and attitudes. In: *Culture and Personality.* 4th ed. Chicago, Ill: The Dorset Press, 1985:188-194.
5. Pinderhughes E. Teaching empathy: Ethnicity, race and power at the cross-cultural treatment interface. *Amer J Soc Psychol.* 1984.
6. Dubois WEB. *Souls of Black Folks.* Chicago, Ill: A-G McClurg; 1903.

(Source : *Journal of American Medical Women's Association* Vol. 51, No. 4, 1998)



HARASSMENT OF WOMEN PHYSICIANS

Melissa Schiffman, Erica Frank, MD, MPH

This paper reviews current knowledge about the prevalence, characteristics and costs of sexual harassment of women medical students and physicians. It also addresses the limited research on other forms of physician and student harassment, and notes the kinds of information that are still needed.

DEFINING SEXUAL HARASSMENT

In reviewing the medical literature, one must keep in mind that authors of different studies may employ varying definitions of sexual harassment. For example, some investigators include sexist teaching materials as a form of harassment,^{1,2} while other authors would probably classify these as discriminatory but not harassing³. One's sense of which behaviors constitute harassment may depend on cultural, experiential, contextual, and individual factors, and even the legal definition allows room for personal interpretation.

Legal Definitions: In 1980, the Equal Employment Opportunity Commission presented a definition of sexual harassment that has been accepted for prosecution of cases under Title VII of the Civil Rights Act of 1964 for workplaces, and Title IX of the Education Amendments of 1972 for schools and universities. The E-EOC guidelines state: Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when (1) submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, (2) submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or (3) such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.⁴

The first two scenarios represent “quid pro quo” rewarding of academic or career benefits in exchange for compliance with the harasser’s sexual demands. This is blatant sexual harassment. The third scenario, however, leaves room for individual interpretation of what is “intimidating, hostile, or offensive.”

Perceptions of sexual harassment may involve contextual factors, including power differences between participants, the nature of previous interactions, severity and frequency of the behavior, and its perceived intention.^{5,6} One’s readiness or reluctance to label an act harassment also depends on personal parameters, including feminist identification, social and economic vulnerability (such as being newly hired or highly dependent on the salary source), and, perhaps most importantly, gender.^{5,7}

A 1993 survey of faculty, housestaff, and medical students using a 14-item environment scale found that, on average ($P < .001$), women perceived “a lack of gender fairness” at their Virginia medical school, while men did not.⁸ Another study⁹ presented medical students at a Midwestern school with a variety of gender- and sex-related scenarios related to medical training. The 160 women respondents tended to see these situations as more harassing than did the 146 men.

Because of gender differences in perspective, the Ninth Circuit US Court of Appeals ruled in 1991 that a “reasonable woman” standard should be used in cases of sexual harassment. An action should be considered harassment if it would seem “intimidating, hostile, or offensive” to most women.¹⁰

Variation among “Reasonable Women”: Even “reasonable women” may disagree as to which behaviors constitute sexual harassment. Researchers may attain different estimates of prevalence by asking if women have been harassed as opposed to asking if they have experienced specific behaviors. Describing this phenomenon in studies of college students, Dzeich and Weiner explain that

to many women, the words “sexual harassment” seem too legalistic, too political, too combative ... [A] woman student usually prefaces description of a sexual harassment experience with, “I’ve never been sexually harassed, but,” Then she proceeds to give a classic example of the behavior.”

This attitude may extend to the medical environment. An example is the American Medical Women’s Association (AMWA) study,¹² in which 55% of women physicians reported unwanted sexual attention in the past year. Although other studies have defined this as sexual harassment,^{13,14} only 27% of the AMWA respondents said they had been sexually harassed.

Reluctance to label behaviors as harassment may serve as a coping mechanism. Many women tolerate harassment by refusing to acknowledge its existence or seriousness.¹¹ “In a study where 77% of women physicians reported harassment by patients, 35% of the physicians felt anger about the harassment and 26% felt fear, but only 22% believed the issue was serious.”

Other women may not label experiences as sexual harassment because the words seem too formal for such a familiar event. In a 1993 study,⁹ more advanced medical students and residents tended to rate the same scenario as less harassing than did students in earlier stages of training. The authors suggest that advanced students may perceive less harassment because “the organizational culture is accepted over time.” Alternatively, these results could reflect a cohort effect.

Acceptance of sexual harassment may begin long before medical education. Studies have estimated that male faculty sexually harass 20% to 30% of women during college.” A 1993 survey by the American Association of University Women⁹ found that 85% of girls (and 76% of boys) in grades 8 to 11 had been sexually harassed at school with behaviors such as sexual comments, gestures, jokes, touching, and grabbing. Thirty-two percent of students were harassed in or before sixth grade. Although classmates perpetrated most of the harassment, 25% of the

girls' harassers were teachers or other school employees.

Even if she does not label an incident as sexual harassment, a woman may feel offended, intimidated, or threatened by the behavior. Alternatively, not all sexual or gender-based interactions are harassment. A "primer" on sexual harassment and gender discrimination stresses that behaviors comprise a continuum of severity, from illegal actions to inactionable though often painful "microinequities."³ Another distinction must be made between harassment and enjoyable flirtation. Sexual harassment differs from flirtation, as Gossetin explains, by a lack of reciprocity.¹⁷ Sexual attraction in the workplace is not problematic, she states, as long as it follows "models of interactive behaviour based on equality and mutual respect." In fact, 44.8% of married women physicians under age 40 reported that their spouses were also physicians. " Presumably, many of these couples met within the medical environment.

PREVALENCE AND CHARACTERISTICS OF SEXUAL HARASSMENT AS REPORTED IN THE MEDICAL LITERATURE

An emerging literature is beginning to examine medical students' and physicians' experiences with sexual harassment. Though many of these studies are limited by such factors as small sample size or narrow geographic representation, the articles as a group present a rudimentary picture of the prevalence and characteristics of sexual harassment as faced by this population.

Prevalence: Several recent articles have attempted to document the frequency of harassment within media education and practice (Tables 1 and 2). Surveys have reported that more than half of female and male student respondents at some institutions experienced sexually harassing behavior at least once during medical school. The Association of American Medical Colleges' 1994 Medical School Graduation Questionnaire found that 12.6% of women students had encountered "unwanted sexual advances by school personnel," and 24.3% had "been sub-

Table 1
Studies of Sexual Harassment Prevalence during Medical School

Author	Year Published	Population	N (Response Rate)	Prevalence of Behavior
Baldwin ¹	1991	Senior students at 10 unnamed US medical schools	581 (59%) 219 women 361 men	Experienced at least one incident of sexual harassment (including sexist slurs, sexual advances, and gender-based favoritism), 55% of women and men
Wolf ²	1991	Senior medical students at Louisiana State University	87 (61%) 26 women 61 men	Experienced at least one incident of sexual harassment (including sexist slurs, sexual advances, and gender-based favoritism), 51.7% of women and men
Richman ²⁷	1992	Senior students followed longitudinally through unnamed state medical school	137 (74.5%) 33.5% female	"Experienced discomfort listening to sexual humor by faculty, residents, or other staff" at least once, 61.4% of women, 21.3% of men
Bickel*	1994	AAMC survey of graduating medical students	4950 women 7715 men	"Experienced unwanted sexual advances from faculty, residents, or other staff" at least once, 36.3% of women, 2.5% of men "Subjected to offensive sexist remarks/names directed at you personally," 24.3% of women, 2.7% of men "Been subject to unwanted sexual advances by school personnel," 12.6% of women, 1.4% of men

jected to offensive sexist remarks/names directed at you personally” during medical school (.kA-MC, unpublished data, 1994). Other studies quantified harassment of female housestaff, medical school faculty, and other practicing female physicians` (see Table 2). In a 1989 study of AMWA members living in Massachusetts, 12 27% of respondents reported sexual harassment in the past year. The rates differed by specialty, ranging from 12% of psychiatrists to 50% of general surgeons.

As Tables 1 and 2 show, the medical literature on sexual harassment of women physicians and medical students has been limited by such factors as small sample size, low response rate, and restricted pools of respondents, often representing a single institution, specialty, geographic location, or career stage. Additionally, response bias may stem from a survey’s focus on a single topic, such as sexual harassment, as those who have experienced more harassment may feel more motivated to respond to such questionnaires.

It is instructive to compare the medical literature on sexual harassment with studies of harassment faced by women working in other fields. In the largest and best-designed study of workplace sexual harassment, with more than 20,000 government employees responding, 42% of women and 15% of men reported experiencing “some form of uninvited and unwanted sexual attention” at work in the past two years.²⁰ These numbers were nearly identical when the study was repeated (n= 8,523) in 1987.²¹

Sexual harassment may be more common among women for whom sexist stereotypes interact with other prejudices and sensitivities. One study found that 82% of lesbian women compared to 69% of heterosexual women had experienced at least one sexually harassing behavior in the past year.⁷ A study of students in grades 8 to 11 found that African-American girls were more likely (33%) than white (25%) or Hispanic girls (17%) to be sexually harassed by school employees.¹⁶ No studies have looked at the differential experience of sexual harassment by physicians of various racial groups or sexual identities

Characteristics: The definition of sexual harassment is not clear cut, as behaviors that may be acceptable or encouraged by some women may be deeply offensive to others. Many studies consider sexual harassment to include a range of behaviors, from lewd looks and gestures to jokes and comments to propositions, touching, and assault. 12, 13, 20, 21 “Sexist slurs” were the behaviors most commonly reported by women in two surveys of fourth-year medical students 1, 2 (61.5% in both studies). Also commonly reported by women in these two studies were sexual advances (28.9% and 38.5%), sexist teaching materials (25.7% and 46.2%), and ‘favoritism’ involving the preferential treatment of men in the awarding of grades or attention (46.3% and 53.8%). 1, 2 Notably, 24.2% and 26.2% of male respondents in these studies reported favoritism toward women. In the AMWA study,¹² more than 50% of respondents had encountered “sexual comments” in the past year, and almost 20% had been touched or pinched.

Although no one is immune from sexual harassment, certain characteristics may increase its likelihood. Studies show that women are harassed more often than men.^{13,21} The AMWA survey¹² found harassment most frequently reported by women who were unmarried, childless, and younger. The most important predictor of sexual harassment of women in this study was younger age. Harassment was also more likely to happen to women whose work groups contained a higher proportion of men.

Few studies have examined the characteristics of people who commit sexual harassment.⁵ Usually, harassers of both men and women are men. In a study of internal medicine residents, only one woman was sexually harassed by another woman, while about half (6/11) of the men were harassed by other men in what respondents defined as the “most troublesome episode.”¹³ Of the women’s 35 harassers, 16 were attending physicians; 10 were interns, residents, or fellows; and 9 were other staff, students, or patients. Other studies similarly found that female medical students were most likely to have experienced harassment

at least once from clinical faculty, residents, or interns.^{1,2}

Another source of physician harassment is patients. In a study of ten medical schools, 53% of women medical students reported sexual harassment by patients, as did 68% in a study at a Louisiana medical school. A study of women family practice physicians in Ontario, Canada found a higher rate: 77% of 417 respondents.”

COSTS OF SEXUAL HARASSMENT

Sociological Implications: Some individuals resist the concept of sexual harassment, or believe that only quid pro quo situations are problematic or actionable. They may consider “harassment as an unavoidable manifestation of sexual attraction and may blame women who decry sexual harassment as humourless or overly, sensitive. Others accept many harassing behaviors as a price women must pay for entering the work force. One article proposes that sexual harassment may be an inevitable result of sexual attraction, fostered by unique characteristics of the medical environment, such as long, emotionally draining hours, and what the authors described as the “sexually charged” nature of physical exams and the sexual history.” These kinds of explanations may underestimate the sociological implications of harassment.

Many legal experts and sociologists believe that sexual harassment of women, like rape and other forms of sexual victimization, are not about sexual attraction so much as power and enforcing gender roles.^{5,7,11,23} Frances Colony, MD, a neurosurgeon nationally recognized for combating sexual harassment in medicine, writes, “We must remember that harassment based on sex is a power play, and one manifestation of power is the ability to exclude those who are powerless.”²⁴ Many authors see sexual harassment in the school and workplace as a refusal to accept women as professional equals. One author explains:

“Sometimes protection of turf and preservation of conventions and the status quo are the primary forces underlying harassment. This is the reason that women who

enter nontraditional fields suffers so much verbal abuse. Consciously or subconsciously, instructors may try to punish females for intruding (on) their ranks, for entering the locker room uninvited.”¹¹

Sexual harassment of women, whatever its conscious intent, reinforces the concept of medicine as a male domain where women are still not entirely welcome.^{25,26} In several studies, many male medical students reporting sexual harassment were either gay or perceived as less masculine than their peers.^{1,27} Like women, they were not fully accepted in a medical system where power and prestige have historically dependent on masculinity.

Psychological Effects

Women who experience sexual harassment and sex discrimination may report a variety of stress - related psychological and physical symptoms. These include sleep disturbances, headaches, loss of appetite, chronic fatigue, tension, anxiety, nervousness, depression, and feelings of anger, fear, humiliation, alienation, or vulnerability.^{3,15,28,29} Some authors advocated recognition of sexual harassment as a psychosocial stressor rated 4 (severe) to 5 (extreme) on axis IV of the Diagnostic and Statistical Manual of Mental Disorder, III-R. DSM-IV includes “difficult working conditions,” “job dissatisfaction,” and “discord with boss or co-workers” as occupational problems that may be reported on axis IV. Sexual harassment could contribute to these kinds of workplace stresses.

Some women react to sexual harassment with symptoms characteristic of post-traumatic stress disorder. They may experience dissociation, panic attacks, and intense psychological distress along with flashbacks of the harassment. In the 20% to 30% of women with an abusive history, flashbacks of rape, incest or other experiences may also occur, exacerbating the psychological distress caused by harassment itself.

Unfortunately, reporting sexual harassment often increases a woman’s psychological distress and physical symptoms. She may encounter disbelief, blame, or lack of

support from co-workers, family, and friends. The arduous process of legal action can produce additional strain, including retaliation. Reporting or confronting harassment may incite retaliatory behaviours. Not surprisingly, few women officially report harassment. Only 1% to 7% of women harassed in the civilian work force will pursue a formal complaint or seek legal assistance. At our institution, 63% of women faculty and 71% of women housestaff who were surveyed believed that reporting sexual harassment would negatively affect their careers.

Organizational Considerations: Sexual harassment has economic as well as personal costs. The US Merit Systems Protection Board reported that from May 1985 to May 1987, sexual harassment cost the federal government \$267 million by “conservative” estimates. At a time when medicine’s costs are under intense scrutiny, sexual harassment is an eliminatable and unnecessary source of expense.

Sexual harassment decreases the productivity of organizations that allow it to occur. Victims may quit their jobs, and others may be transferred, reassigned or fired in retaliation or in response to declines in work performance. In addition to the personal sequelae described, harassment may detract from women’s productivity by producing an inability to concentrate, decreased self-esteem, and lowered job satisfaction, organizational commitment, and motivation. A 1991 survey of Massachusetts physicians (n=188) suggested a correlation between sexual harassment and low morale. Given the statement, “I’m proud to tell others that I am a member of my institution.” 90% of women who had not been sexually harassed agreed, but only 69% of harassed women agreed. Similar gaps of about 20% existed for the statements: “My school/workplace inspires the best of me in terms of academic/ professional performance” and “I’d recommend my institution to a prospective student’ physician who is the same race / gender as I.”

Legally, sexual harassment is a form of sex discrimination, an illegal behaviour that creates differential barriers

for women as opposed to men. Sexual harassment presents women as a group with an onus of stress, distraction, and dissatisfaction not experienced by most men. As described earlier, sexual harassment also defines women as somehow different from the men who constitute the majority of the inner power circle. In these ways, sexual harassment impedes women’s educational and career progress. Additionally, fear of harassment may limit women’s aspirations, as with medical students who may avoid male-dominated specialities where sexual harassment is thought to be especially pervasive.

It is in the best interest of schools and workplaces to develop policies on sexual harassment is thought to be especially pervasive.

It is in the best interest of schools and workplaces to develop policies on sexual harassment that will promote appropriate collegiality and avoid hypervigilance, which may create an atmosphere of mistrust. Such policies should also recognize that men may be sexually harassed.

HARASSMENT BASED ON OTHER CHARACTERISTICS

Although sexual harassment is the form best studied and documented, other types of harassment also taint the medical profession. In a survey of ten medical schools, 19.7% of 581 respondents had experienced racial harassment during medical school. The authors did not report the harassment incidence for students who classified themselves as a race other than white. Harassment of lesbian and gay students and physicians may also be widespread. The literature documents a high rate of homophobia among physicians, with 35% of a sample of primary care physicians agreeing that “homosexuality is a threat to many of our basic social institutions, and 30% of responding members of the San Diego Country Medical Society answering “No” to the question, “Should a highly qualified homosexual applicant be admitted to medical school.

Medical students of both genders are often harassed on the basis of their low status in the medical hierarchy. A

study of 184 medical students entering “a state college of medicine” in 1987 found 72% reporting at least one verbally or physically abusive experience before graduation¹². In two other studies,² more than 95% of respondents reported at least one form of mistreatment during medical school, including public humiliation, threats, and shouting. Much of the harassment was perpetrated by residents and interns, who only recently were medical students themselves.^{1,2,27}

Mistreating medical students may train new physicians in the art of harassment. Devaluation of physicians and students for reasons unrelated to medical competence can only hurt medicine’s ability to meet the needs of patients and practitioners. Just as physicians must stay current with new medical theories and technologies, so should they attend to social mores by adapting behavior to the changing workplace and educating themselves about sexual harassment and other forms of discrimination.

FUTURE RESEARCH

Many questions about the prevalence and correlates of sexual harassment remain unanswered. The Women Physicians’ Health Study (WPHS), a cross-sectional survey of 10,000 women physicians who graduated from medical school between 1950 and 1989, will help answer many such questions. WPHS is the largest study ever completed on the nature and extent of harassment — as well as many other experiences — of women physicians. The main effects papers will be submitted for publication shortly; the sexual harassment paper will be submitted in 1996. The design and objectives of WPHS were described in a previous issue of *JAMWA*.³⁶

A novel feature of WPHS is the differentiation of several types of harassment: gender (but not sexual), sexual, life-style, and ethnic. The study is also unique for the representativeness of the sample and the comprehensiveness of the data about each respondent, including specialty, practice type, age, marital status, career stage, sexual identification, ethnicity, and other characteristics. The

data will also permit correlation of the experience of harassment with psychosocial factors such as the physician’s self-rating of physical and mental health, career satisfaction, stress level, and body image. Additionally, the sexual harassment item on this survey is placed in a long list of other survey items, reducing the likelihood that women who are especially concerned with sexual harassment issues would be more likely to respond to the survey.

We hope that the WPHS and other investigations will increase knowledge and awareness of harassment and will bring us closer to eradicating it from the medical workplace.

References

1. Baldwin DC Jr, Daugherty SR, Eckenfels, Ej. Student perceptions of mistreatment and harassment during medical school: A survey of ten United States schools. *West J Med.* 1991; 155:140-145.
2. Wolf TM, Randall HM, Von Almen K, Tynes LL Perceived mistreatment and attitude change by graduating medical students: A retrospective study. *Med Educ.* 1991;25:182-189.
3. Lenhart SA, Evans CH. Sexual harassment and gender discrimination: a primer for women physician & *Am Med Wom Assoc.* 1991.46:77-82.
4. Equal Employment Opportunity Commission. Guidelines on discrimination because of sex, *Fed Reg* 1980; 45: 74676-74677,
5. Charney DA, Russell RC. An overview of sexual harassment. *Am J Psychiatry.* 1994;151:10-17.
6. McCann ND, McGinn TA. Harassed. *100 Women Define Inappropriate Behavior in the Hornewood.* Ill: Business One Irwin; 1992.
7. Schneider BE. Consciousness about sexual harassment among heterosexual and lesbian women workers. *Journal of Social Issues.* 1982;38:75-97.
8. Hostler SL, Gressard RP. Perceptions of the gender fairness of the medical education environment. *J Am Med Wom Assoc* 1993;48:51-54.
9. Nora LM, Daugherty SR, Hersh K, Schmidt 1, Goodman 41.

What do medical students mean when they say “sexual harassment”? *Acad Med* 19930: S49-S51.

10. Ellison v Brady, 9th Cir 924 F2d 872. 1991.
11. Dziech BW, Weiner L. The Liederous Professor. *Sexual Harassment on Campus*. Boston, Mass: B,2con Press; 1984.
12. Lenhart SA Klein F, Falcao P, Phelan E, Sinith K. Gender bias against and sexual harassment of AMWA members in Massachusetts.) *Am Med Wom Assoc*. 1991;46:121-125.
13. Koniaromy M, Bindinan AB, Haber RJ, Sande MA. Sexual harassment in medical training. *N Engl Med*. 1993; 328322-326.
14. Farley MM, Kozarsky P. Sexual harassment in medical training (letter). *N Engl J Med*. 1993; 329-661.
15. Phillips SP, Schneider MS. Sexual harassment of female doctors by patients. *N Engl J Med*. 1993;329:1936-1939.
16. Bryant AL. Hostile hallways: The AAUW survey on sexual harassment in America’s schools. *J Sch Health*. 1993;63:355-357.
17. Gosselin HL. Sexual harassment on the job: Psychological, social, and economic repercussions. *Can Ment Health*. 1984;32:21-24, 32.
18. American Medical Association. *Women in Medicine in America: In the Alaiostream*. Chicago, Ill: American Medical Association: 1991.
19. Bennett NM, Nickerson KG. Women in academic medicine: Perceived obstacles to advancement. *J Am Med Wom Assoc*. 1992;47:115-118.
20. US Merit Systems Protection Board. *Sexual Harassment in the Federal Workplace. Is It a Problem?* Washington, DC: US Government Printing Office; 1981.
21. US Merit Systems Protection Board. *Sexual Harassment in the Federal Workplace. An tipdate*. Washington. DC: US Government Printing Office. 1988.
22. Paul EF. Bared buttocks and federal cases. *Society*. 1991;28:4-7.
23. MacKlimon CA The social causes of sexual harassment. In: Edmund W, ed. *Sexual Harassment. Confrontations and Decisions*. Buffdo, NY. Prometheus Books: 1992:121-136.
24. Conley FK. Sexual harassment in medical training (1letter). *N Engl J Med*. 1991:329:663.

25. Lenharr S. Gender discrimination: a health and career development problem for women physicians. *J Am Med Wom Assoc*. 1993:48:155-159.
 26. Lorber J. Why women physicians will never be true equals in the American medical profession. In: Elianne R, Wegar K. eds. *Gender, Work and Medicine. Women and the Afederal Division of Labour*. Newbury Park. Calif. Sage Publications; 1993-62-76.
 27. Richman JA, Flahem, JA, Rospenda “L Christensen ML. Mental health consequences and correlates of reported medical school abuse. *JAMA*. 1992:267:692-694.
 28. Shrier DIC Sexual harassment and discrimination: Impact on physical and mental health. *NJ Med*. 1990;87:105-107.
 29. Gutek RA, Koss MP. Effects of sexual harassment on women and organizations. *Occup Med*. 19918:807-819.
 30. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4 th ed. Washington, DC. American Psychiatric Press; 1994.
 31. Hamilton JA. Emotional consequences of victimization and discrimination in “special populations” of women. *Psychiatr Clin North Am*. 1989;12:35-51.
 32. Cotton P. Harassment hinders women’s care and careers. *JAMA*. 1992:267:778-779,783.
 33. Gerbert B. Maguire BT, Bleecker T, Coates TJ, McPhee SJ. Primary care physicians and AIDS: Altitudinal and structural barriers to care. *JAMA*. 1991;266:2837-2842.
 34. Mathews, WMC, Booth MW, Turner JD, Kessler L Physician’s attitudes toward homosexuality—Survey of a California county medical society. *West J Med*. 1986;144:106-110.
 35. Rosenberg DA, Silver UK. Medical student abuse: An unnatural and preventable cause of stress. *JAMA*. 1984; 251:739-742.
 36. Frank E. The Women Physicians’ Health Study: Background, objectives, methods. *J Am Med Wom Assoc*. 1995;50:64-66.
- (Source : *Journal of American Medical Women’s Association*, Vol. 50, No. 6, 1995)



GENDER DIFFERENCES IN MEDICAL SCHOOL ATTRITION RATES, 1973-1992

Kevin M. Fitzpatrick, *PhD*, Marilyn P. Wright, *MA*

Retention is a critical problem in medical school education. We report here on research that examined gender differences in attrition rates between 1973 and 1992. Using secondary data compiled from the annual reports on undergraduate education published in JAMA, both descriptive and inferential analysis of medical school attrition rates were conducted. Data show that medical school attrition rates have steadily increased across the country since 1973 and that women drop out of medical school at consistently greater rates than men. These results highlight the importance of future an analysis attempt to delineate the causes as well as the consequences of dropping out of medical school for women and the institutions that support them.

Women are entering medical school in significant numbers. Enrollment of women in medical school for the 1991-1992 academic year reached a record high of 40%, a significant increase over the 20% reported in 1973-1974.^{1,2} In fact, some medical schools actually reported a majority of female students in entering classes for the 1991-1992 academic year.¹ With female enrollment increasing, much research has focused on the problems these women face.” Unusually high stress levels, psychiatric symptomatology, and financial pressures have all been mentioned, and while these concerns are certainly important, there is a conspicuous absence of research regarding the proportion of female medical students who do not graduate.

Earlier studies have suggested that women drop out of medical school more frequently than men⁴⁻⁶ but none have provided a comprehensive, longitudinal exploration of medical school attrition. This longitudinal approach, which would examine several generations of drop outs, is neces-

sary for understanding the dropout process as a by-product of historical and/or period effects and their role in creating this trend. Cross-sectional examinations of this type of phenomenon fall short of providing a clear picture of the process and its evolution through significant periods of time. Not taking a longitudinal approach would ignore the last 30 years of women’s increasingly important role in medicine and the dilemmas of conflicting cultural roles and expectations, pregnancy and motherhood, and uncertain futures in many medical specialties. While there have been some efforts to examine attrition differences between men and women medical students, this research has often focused on program success and achievement, treating attrition as a secondary issue.^{7,8}

The purpose of this study is to help fill existing gaps in the literature by systematically examining medical school attrition trends at the national level. Specifically, this study addresses two major areas of concern: the scope of medical school attrition nationwide over time and gender differences in medical school attrition over time. As such, we hypothesized that attrition rates would show a steady rise from the time women gained full entry into medical school to the present, and that women would drop out of medical school at a greater rate than men. While this analysis speculates on why attrition trends between men and women medical students exist as they do, this is not a formal causal analysis intended to answer the question of why these differences may exist.

METHODS

Data for this study came from the annual reports on undergraduate medical education published in JAMA.⁹ The reports contain enrollment figures broken down by sex for entering students, intermediate students, and estimated graduating students from each accredited, MD-granting medical school in the United States. Attrition rates were constructed from these data.

White these data are comprehensive, they are not without limitation. First, comparisons before 1973 are not

possible; JAMA only began reporting genderspecific enrollment figures that year. Title IX of the Education Amendments, which removed barriers to female admissions in medical school, was enacted in 1972. Second, attrition rates can only be computed for the four-year medical school period of a cohort, not year by year. Thus we were unable to find out when during the course of medical school students were most likely to drop out.

Attrition measurement is complex, due to the difficulty of obtaining accurate information and applying consistent definitions.¹⁰ Reasons for dropping out may or may not be divided into such categories as academic failure, leave of absence, etc. Such categorizing has advantages and disadvantages. On the one hand, it allows for a more in-depth analysis; on the other, such divisions are not always calculated consistently and are aggregates of individual-level characteristics. A gross measurement of attrition rates, as described below, provides a general picture of attrition in a consistent manner over time, allowing for easy comparisons between cohorts. In addition, gross measurement allows for the inclusion of students who “stop out,” taking leaves of absence for various reasons, as well as students in combined degree programs who graduate in more than the expected four years. There is evidence to suggest that the number of students not graduating in the expected four years is increasing. Nevertheless, these changes are more recent and as an aggregate are unlikely to affect the overall rate(s) being investigated during the specified period (1973-1992).

National and Gender - Specific Attrition Rate Calculation: For purposes of this research, attrition was defined in gross terms as any student who had not graduated from medical school in four years. To calculate the attrition rates, we divided the number of medical school graduates for a given year by the number of entering medical school students four years earlier. The product is subtracted from 1 and multiplied by 100, yielding an easily interpretable attrition percentage rate:

Table - 1
National and Gender-Specific Attrition Rates by Four-Year Cohorts of Medical Students in the United States, 1973-1992*

Cohort	Attrition Percentage [†]		
	National (%)	Male [‡] (%)	Female (%)
1973-1977	2.93	2.47	4.81
1974-1978	3.81	2.57	8.10
1975-1979	2.51	1.49	5.77
1976-1980	3.40	1.30	9.78
1977-1981	2.89	1.75	6.19
1978-1982	3.82	3.55	4.61
1979-1983	7.49	5.90	11.60
1980-1984	4.85	4.08	6.76
1981-1985	.62	4.45	8.24
1982-1986	6.03	4.77	8.76
1983-1987	7.59	6.47	9.86
1984-1988	6.15	4.95	8.52
1985-1989	7.58	6.39	9.87
1986-1990	8.02	6.57	10.72
1987-1991	7.11	6.45	8.26
1988-1992	7.84	6.34	10.38

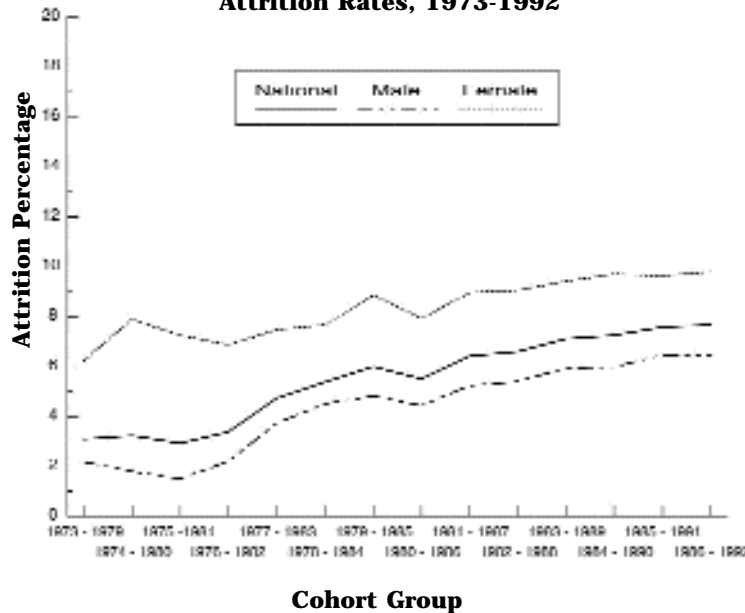
* The data used for this table were compiled from annual reports on undergraduate medical education published in JAMA from 1973-1992.

† The attrition percentages for this table are gross percentages compiled using the following formula:

1- (Number in cohort graduating in fourth year / Number originally in cohort) x 100.

‡ Differences between percentages for males and females are statistically significant at the .01 level for all cohorts.

National and Gender-Specific Medical School Attrition Rates, 1973-1992



Attrition Percentage =

$$\frac{1 - \text{Number in cohort graduating in four years} \times 100}{\text{Number originally in cohort}}$$

Sex differences in attrition rates were tested using a standard test of differences between proportions provided by Agresti and Finlay.¹¹ Given these general criteria, differences in attrition rates between male and female medical students were evaluated using a p<.01 level of significance.

In addition, to present data graphically, we used a three-period, simple moving average technique to track attrition rates (see figure). The three-period, simple moving average is computed by summing the three attrition rates in the first three cohorts (periods) observed. The sum is then divided by the total number of periods, in this case, three. This number then becomes the first data point. For the next data point, the attrition rate for the first cohort is discarded, and the rate for the first cohort is added to the

rates for the second and third cohorts. Again, the sum is divided by three, yielding the second data point. Thus each data point in the figure is an average of the attrition rates for three cohorts or periods.

RESULTS

National Attrition Picture: The table provides gross attrition rates for all four-year cohorts between 1973 and 1992.

Immediately apparent is an increase of approximately 5% in the national attrition rate from 1973 to 1992. Slight fluctuations in attrition rates occurred during the late 1970s and early 1980s, with national rates remaining in the 2.5% to 3.8% range.

Since the 1978-1982 cohort, however, attrition rates have increased fairly consistently. The 1979-1983 cohort showed a dramatic increase, but aside from this anomaly, national attrition rates showed a steady increase with only two exceptions. The 1984 - 1988 cohort had a slight decrease, as did the 1987-1991 cohort. These are decreases of only about one percentage point, however, and do not mitigate the overall trend of increasing attrition rates since the 1978-1982 cohort.

Using the three-period, simple moving average technique,¹¹ the figure graphically illustrates the general increase reflected in the time period observed. The technique allows us to clearly show that, while the net increase in attrition rates has remained virtually the same, there is an increasing trend in attrition rates. As suggested earlier, the figure shows a general increase occurring with several exceptions and the stabilization of the attrition rate since the 1983-1989 cohort.

Gender Differences in Attrition Rates: Of note is that the differences in genderspecific attrition rates are statistically significant at the p<.01 level in every case. This consistent finding across cohorts lends support to our hypothesis that women drop out or medical school at a greater rate than men.

Again, using a three-period moving average technique, the figure illustrates the national gender-specific attrition rate with a superimposed line graph. The gender-specific attrition rates for the 16 cohorts indicate some clear differences from the national attrition rates shown earlier. Until the 1980-1986 cohort, the attrition rates for females are relatively unstable, and the differential between males and females is large. Beyond this cohort, however, female attrition rates show a similar pattern to national attrition rates. It is important to note, however, that the percentages are consistently higher for female than they are for male or national rates, and at no point do the trend lines overlap.

However, even given these attrition rates for female students, we still see an increase in attrition rates for the 1979-1983 cohort. For males, there is a slight decrease in attrition rates until the 1977-1981 cohort. Beyond this cohort, both male and female attrition rates reflect the national pattern, with the male rate consistency lower and the female rate consistency higher than the national rate.

DISCUSSION

The results of this analysis provide support for the hypothesis that women drop out of medical school at a greater rate than men. Using a test of differences between proportions, statistically significant differences between attrition rates for male and female students were found for all 16 cohorts examined. Thus, although medical schools are admitting increasing numbers of female students, they are falling short in retaining them.

Medical school attrition rates seem to have increased over time, for both male and female students. Interestingly, female attrition rates started out rather high, while male rates climbed from low to high over the study period. While our study did not examine the underlying causes, future research may want to examine whether or not these differences are tied directly to gender-related pressures (pregnancy, traditional role expectations, etc) and/or general period effects. These trends require a more comprehensive analysis that can examine the influence of

both individual and institutional variables on the attrition process in medical school.

One of the most significant findings of this study is that higher percentages of women medical students drop out. Medical schools are falling short in their retention of female medical students, and further research should be undertaken to establish at what point women are dropping out of medical school and for what reasons.

While we acknowledge the role of leaves of absence and extensions in women not graduating on time, the possibility that this would be the sole contributing factor to the statistical difference between male and female students seems unlikely. Are women, for example, more willing to recognize and act on an incorrect choice of profession than men? In addition, data on retention of women by medical specialty may provide added insight into our understanding of medical education attrition.

By examining aggregate medical school attrition rates, we found substantive evidence—worthy of further investigation—that women are at a disadvantage in medical school. While specific cohort or more disaggregated analyses are needed to address this issue conclusively, our initial analysis raises a number of issues pertaining to attrition in medical school.

References

1. Jonas HS, Ezzell SI, Banauskas B. Educational programs in medical schools. *JAMA*. 1991; 266:913-920.
2. Undergraduate medical education. *JAMA*. 1975; 231 (suppl): 17-18.
3. Bickel J. Women in medical education. *N Engl J Med*. 1988;319:1579-1584.
4. Braslow JN, Heins M. Women in medical education: A decade of change. *N Engl J Med*. 1988;304:1129-1135.
5. Johnson DC, Flutchins EB. Doctor or dropout? *J Med Educ*. 1966;41:1099-1104.
6. Kris KB. Developmental strains of women medical students. *J Am Med Womens Assoc*. 1985; 40:145-148.

7. Arnold L Willoughby TL, Calkins V. Jensen T. The achievement of men and women in medical school. *J Am Med Wom Assoc.* 1981; 36:213-221.
8. Lanzoni V, Kayne HL. Women graduates of Boston University's six-year combined liberal arts medicine program. *J Am Med Wom Assoc.* 1976;31:285-288.
9. Annual Reports on Undergraduate Education. *JAMA.* (1973-1992)
10. Hammack FM. Large school systems' attrition reports: An analysis of definition, procedures, and findings. *Teachers College Record*, 1986;87:324-341.
11. Agresti A, Finlay B. *Statistical Methods for the Social Sciences.* San Francisco, Calif. Dellen; 1986.

(Source : *Journal of American Medical Women's Association*, Vol. 50, No. 6, 1995)

□ □ □

**MEDICAL EDUCATION
AND WOMEN IN INDIA
SOME STATISTICS**

TABLE - 2
NUMBER OF COLLEGES OF INDIAN SYSTEMS OF MEDICINE
AND HOMEOPATHY AND THEIR ADMISSION CAPACITY

All India						
Year		Ayurvedic Colleges	Unani Colleges	Sidha Colleges	Homeopathy	
130	1971-75	Number of Colleges	89	12	1	NA
		Admission capacity	2980	370	50	NA
	1985	Number of Colleges	99	17	1	125
		Admission capacity	3941	680	75	9765*
	1991	Number of Colleges	98	17	2	97
		Admission capacity	3947	665	150	5259
	1992	Number of Colleges	98	21	2	97
		Admission capacity	3763 (120)	785	150	3490 (1409)

continued

All India						
Year		Ayurvedic Colleges	Unani Colleges	Sidha Colleges	Homeopathy	
	1994	Number of Colleges	101	22	2	97
		Admission capacity	3988	834(50)	150	3116 + 151* (1644) + 25*
	1995-96	Number of Colleges	132	29	2	145
		Admission capacity	5424	1107	155	4294 + 175* (2220)
131	1996-97	For Undergraduate courses				
		Number of Colleges	154	31	2	188
		Admission capacity	6117	1239	155	4318 + 150* (2240)
	1996-97	For Post-graduate courses				
		Number of Colleges	33	3	1	10
		Admission capacity	462	55	35	69

Legend: Figures in brackets indicate admission capacity for Diploma courses

- * 3 colleges in Bihar, 1 in Orissa, 1 in Tamil Nadu have not reported admission capacity
- Admission capacity for graded degree courses
- Diploma in N.I.H.

TABLE - 3
NUMBER OF POST GRADUATE (DEGREE/DIPLOMA)
AWARDED IN VARIOUS DISCIPLINES OF MEDICAL
SCIENCES BY VARIOUS UNIVERSITIES

Year		Degree	Diploma
1995-96	Male	1629	678
	Female	446	386
	Total	2075	1064
	% Female to Total	21.49	36.28
1994	Male	1629	678
	Female	446	386
	Total	2076	1064
	% Female to Total	21.48	36.28
1992	Male	1497	612
	Female	405	353
	Total	1902	965
	% Female to Total	21.29	36.58
1991	Male	1081	186
	Female	319	93
	Total	1400	279
	% Female to Total	22.79	33.33
1985	Male	1968	717
	Female	609	414
	Total	2577	1131
	% Female to Total	23.63	36.60

Source: Health Information of India

TABLE - 4
PERCENTAGE OF FUNCTIONING PHC'S
WITH LADY DOCTORS (ALL INDIA)*

Year	Total Number of functioning PHCs	Functioning PHCs with Lady Doctors	Percentage of Total
1999	23179	2152	9.28
2000	22975	2176	9.47

Source: Rural Health Statistics

* According to all India level Facility Survey (RCH - Phase I, 1999): Out of 7959 PHC's, 20% are having Female Medical Officer.