

## STUDENTS' CORNER

## Gender perspectives in medical education

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**Abstract**

*Medical students have to go through an incredibly vast number of voluminous textbooks in their undergraduate years. But most of us learn next to nothing about the intricacies of the social determinants of health and the larger socio-political-cultural spaces we will have to negotiate. Without any exposure to the larger patriarchal, economic and historical systems, which are bound to collide with our textbook learning, we will be highly unprepared to locate our own biomedical skills within the larger context. The objective of this article is to analyse the current level of gender sensitivity in the textbooks being used for undergraduate medical training, and the potential impact that this has on developing attitudes towards a gender and rights-based approach.*

**International commitments to integrate gender into Medicine**

Gender sensitive medical training aims at rectifying the imbalance and injustice in systems of knowledge that have failed to acknowledge the issues women face as a result of their gendered lives. The International Conference on Population and Development (ICPD) in Cairo, Egypt, in 1994 followed by the Fourth World Conference on Women in Beijing, China, in 1995 identified gender-based inequalities as crucial determinants of health (1,2). The 2006 WHO Gender, Women and Health (GWH) meeting report documented examples of international efforts at integrating gender studies across all years of the undergraduate medical curricula. Gender studies was integrated into the curriculum for medical education in the Chulalongkorn medical school in Thailand in 2003–2004, followed up by a questionnaire-based evaluation of the new gender-integrated programme in 2006. The evaluation showed that most of the respondents had a positive attitude to gender issues, and applied gender concepts in their work and in their personal lives (3). Other noteworthy attempts at inclusion include: making gender considerations an integral part of topics such as sexuality,

sexual and reproductive health (Turkey and China), and intimate partner and family violence (Philippines), using web-based teaching modules, building faculty capacity, promoting and winning institutional support (3).

In India, the National Health Policy, 2017, provides for gender sensitive healthcare facilities and promotion of equity, but there is no direction on how it is to be achieved (4). The policy does not address the need for gender sensitive medical education, nor does it mention sexuality when speaking of reproductive and sexual health. A rights-based perspective, when talking about reproductive and sexual health, and its linkage to health as a fundamental right, is totally absent. This is one of the reasons why medical education in India is lagging behind in gender sensitivity training, and thus in the provision of effective and equitable healthcare services.

**Objectives of medical training**

Medical training needs to guide students not only to arrive at a clinical diagnosis and plan the appropriate treatment, but also to imagine healthcare frameworks that can lead to a better quality of life. There are important biological, social and behavioural factors tied to unequal gender relations between people of different gender identities, coupled with social inequality and economic deprivation, affecting the manifestation, epidemiology and pathophysiology of diseases and access to healthcare.

For example, women who seek healthcare from a gynaecologist may also need support or protection from intimate partner violence, or for ensuring that she can use contraception of her choice without family members controlling her options. It is necessary to remember that these women approaching the public healthcare system are often survivors of socio-economic injustices, making them vulnerable to discriminatory treatment and potential exploitation (5). Medical textbooks should therefore be able to tackle issues related to gender and sexual inequalities, violence, and culturally defined norms that adversely affect the health of women in society. Textbooks are the cornerstone of the learning process and can shape the approaches and attitudes of readers and learners. Thus, it is important that women's health needs are addressed with sensitivity.

**Review of literature**

This paper reviews the latest editions of undergraduate textbooks (edited or written by Indian authors only) of Obstetrics and Gynaecology, Forensic Medicine and Preventive

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and Social Medicine from a gender perspective, with a focus on women's health, social determinants of health, and topics related to gender-based violence, and compares it to the 2005 analysis that appeared in the *Economic and Political Weekly*<sup>1</sup>. The textbooks reviewed are commonly used by teachers and undergraduates as well as postgraduate students across most medical colleges in India. Given below are examples of the language in medical textbooks which reflects the attitude—or even prejudices—of the authors, that reinforce patriarchal biases in the minds of students who have never been exposed to other perspectives.

### **Rape**

For ages, young girls have been taught to be passive and boys to be aggressive. In a male-dominated society, these stereotypes strengthen the assumption that women want to be sexually dominated by men, and that men have a right to ignore consent, demand sexual compliance, and control a woman's body and sexuality.

*The material facts to be considered are the conduct and behaviour [sic] of the victim. It is not rape where a woman initially objects, but subsequently gives her consent to sexual act.”(6:p 385)*

The social behaviour of rape victims is often generalised, without recognising that the social realities of women who survive rape are varied, and their reactions will be diverse with varying degrees of fear, embarrassment, guilt and anger. But anything considered inconsistent or *bad fit* can get interpreted as a false accusation, a mental disorder, or just dismissed (7). When a woman is seeking medical attention after a sexual assault, healthcare providers often ask hostile and irrelevant questions concerning her clothing, marital status, sexual history, and level of resistance, dwelling on the victim's gender and the sexual aspect of the assault instead of simply acknowledging it as an act of violence (8, 9). Doctors may convey a sense of disbelief causing delay or reluctance in getting medical help and reporting the act (7). But whether or not a rape victim intends to report an attack to the police, medical care and counselling should be provided.

*Rape and gender – in law, rape can only be committed by a man, and a woman cannot rape a man... (6:p 388)*

The definitions of rape/sexual violence exclude marital rape, and men as victims of sexual violence (6); and rape laws are different for married and unmarried minors. Men are not seen as being susceptible to sexual violence. Men being victims of rape is considered incompatible with their masculinity, particularly in societies where men are discouraged from talking about their emotions. Society assumes that a man should be able to protect himself and deal with the consequences of the attack “like a man”. Although these findings relate to sexual violence against men committed in time of peace, there is nothing to suggest that it does not also pertain to times of conflict (10). Sexual violence is often (wrongly) presented as a proof of individual masculinity and power, especially if a man feels his masculinity is being questioned or challenged. Such situations are not presented

in medical textbooks; thus, students often lack the perspective to understand sexual violence against men. Despite section 377 IPC being scrapped, sexual violence against men persists as a taboo topic. Community and service providers often react negatively to the sexual orientation of male victims and the gender of their perpetrators (12). Due to this, male victims tend to hide and deny their victimisation due to the fear of stigma and persecution (11-13). Eventually, male victims may be very vague in explaining their injuries when they are seeking medical or mental health services. Male victims of sexual violence have reported a lack of services and support, and that legal systems are ill-equipped to deal with this type of crime (10, 12, 13). Laws dealing with sexual violence and rape should be gender-neutral.

*Many lesbians are masculine in type, possibly because of endocrine disturbances and are indifferent towards individuals of the opposite sex. The practice is usually indulged in by women who are mental degenerates or those who suffer from nymphomania. (6: p 401)*

Textbooks make no efforts to clarify that sexual orientation and expressions of gender identity occur naturally and are an essential component of one's identity. Without any scientific basis, homosexuality is being wrongly described as a pathological condition using offensive and discriminatory words like “mental degenerates”, harming their dignity, self-worth, right to privacy and protection.

### **Virginity**

Rape survivors in India continue to be subjected to intrusive tests like the two-finger/virginity test for assessment of sexual violence.<sup>2</sup> These tests are performed under the belief that genitalia habituated to sexual intercourse has a specific appearance. Textbooks do not take into consideration that the vagina is a dynamic muscular canal that varies in size and shape depending on individual, developmental stage, physical position, and various hormonal factors such as sexual arousal and stress. A WHO study by Olson and Garcia-Moreno (14) shows that the size of the hymenal opening is an unreliable test for vaginal penetration, as it varies with the method of examination, the position of the examinee, the cooperation and relaxation of the examinee, and the examinee's age, weight, and height. It was also found that most hymenal injuries heal rapidly and leave no evidence of previous trauma. The study indicates that the inspection of the hymen cannot give conclusive evidence of vaginal penetration, or any other sexual history. Further, virginity testing can cause serious physical, long-term psychological effects of self-hatred, loss of self-esteem due to the violation of privacy, and the fear and trauma the examination causes. The prevailing social rationale for testing is that an unmarried female's virginity is indicative of her moral character and social values, bringing in shame and dishonour to families and communities, and a way to separate “pure” from “impure” females (14).

*VIRGINITY: A female is called a virgin (Virgo intacta) if she has never experienced any sexual intercourse. (15: p 351) (6: p 364)*

Virginity, as a concept, exists for men too but without the same social implications or significance. Textbooks are perpetuating this negative gender stereotype without offering a sociological explanation for a patriarchal society's need to control women's sexuality and the stigma around pre-marital sex for women. Virginity is thus a social construct and not a medical fact. Why is it still being taught to medical students when it has no medical relevance? From a human rights perspective, virginity testing is a form of gender discrimination, as well as a violation of fundamental rights, and when carried out without her consent, a form of sexual violence.

The Forensic Medicine textbook (6) in fact has a table explaining the differences between a virgin and "deflorate", which is not just offensive labelling but also factually incorrect and legally of no relevance to rape. The focus should be more on victim and witness testimonies, rather than physical examinations for injuries, because absence of injuries is frequently equated with the absence of assault, denying victims their rights and autonomy (14).

### **Contraception**

*The aims of family planning are:*

(1) *To bring down population growth, so as to ensure a better standard of living.*

(2) *From economic and social point of view – already existing population of nearly 1027 million are deficient in their basic needs of food, clean water, clothing, housing, education and proper health care. Spacing of birth and small family norm will improve the health of the mother and their children, so that a healthier society can emerge.*

(3) *To reduce the maternal and infant mortality rates...* (16: p 494)

This text assumes that the main goal and justification for providing women access to contraceptive methods is population control, rather than facilitating women's control over their own bodies. It does not consider unequal distribution of resources and inadequate public sector spending on health as a barrier to better standards of living, nor does it reflect upon the politics of the globalised world where consumption patterns of the global North are ignored and only birth rates of the global South are in focus. Despite India being a signatory to the International Conference on Population and Development (ICPD) programme of action (Cairo 1994), which ushered in a paradigm shift from population demographics to individual sexual and reproductive rights and health, access to contraception is being projected as a solution to population growth (1).

The use of the phrase "family planning" instead of contraception also assumes a heteronormative married couple as the basis of a family. This excludes any discussion around other sexualities and family structures, and fails to apprise medical students of how unequal gender relations put women at risk of unwanted pregnancies and how they affect women's mobility, decision-making and access to contraceptives. For example, students need to be aware of the difficulties that

women face in negotiating condom use, such as the fear of violence, accusation of infidelity, and abandonment.

*Indications (of female sterilization): (1) Family planning purposes: This is the principle [sic] indication for most of the developing countries. (2) Socio economic: An individual is adopted to accept the method after having the desired number of children. (3) Medico-surgical indications (therapeutic): Medical diseases such as heart disease, diabetes, chronic renal disease, hypertension, are likely to worsen, if repeated pregnancies occur and hence sterilization is advisable. During third time repeat caesarean section...., sterilization operation should be seriously considered.* (16: p 513)

In the section on female sterilisation (16), only the procedure has been described and there is very little guidance on the difference between female and male sterilisation or the need to promote male sterilisation as a less invasive, safer procedure. Surely, if the woman should avoid future pregnancies because she has serious heart disease, it makes sense not to do an invasive surgery on her but instead encourage the male partner to undergo a vasectomy? At various places under the section on sterilisation, camps are mentioned but without reference to safety provisions that need to be ensured<sup>3</sup>, or even the "standards to sterilization" published by the Government of India in 1992 (17). There is no guidance on how to determine whether or not a woman has made an independent decision free of pressure or coercion.

*If a woman is considered unfit to bear children, and permanent method considered, a written opinion regarding psychiatric problem should be obtained. The written consent should be obtained from the husband or guardian, as the psychiatric patient may not be mentally aware of the nature of sterilization.* (18: p 286)

Shaw's textbook states without justification that a psychiatric disorder is an indication to undergo sterilisation. Using phrases such as "unfit to bear children" to describe patients suffering from mental illnesses and promoting sterilisation are violations of their reproductive rights, including the right to make decisions regarding sterilisation and contraception.

Contraception counselling should be given more attention in both textbooks and practice. The woman should be presented with all options and empowered to make a choice. In India, the decision to remove an intrauterine contraceptive device (IUD) is not always in women's hands, and providers often hesitate to remove IUDs. It would be desirable that textbooks guide students about the rationale for choosing each method and about the right of women to discontinue an unsuitable contraceptive method, irrespective of non-medical reasons such as family/husband/partner opposition. These textbooks need to educate students about areas where the reproductive rights of women are likely to be violated during the provision of contraceptive services, like overt or covert coercion for sterilisation or IUDs, coercion for contraceptives while providing MTP services or caesarean section and so on (19).

There has been considerable scientific progress in the area of contraception, liberalising the medical eligibility criteria and increasing access to contraception. The textbook (16) on the other hand, recommends unnecessary and excessive requirements for starting use of a contraceptive, which reduces access for women. For example, Dutta's textbook (16) suggests that breast, blood pressure and pelvic examination are mandatory before starting oral pills. However, recent WHO guidelines do not consider these necessary and state that oral pills can be started even by non-medical persons by using a checklist (20).

*Adolescents are often tempted to respond to their physical and emotional changes by indulging in high-risk sexual behavior to gain peer group approval, they are often ignorant of the consequences that may follow or wilfully choose to ignore them. It is not unusual to find them in relationship with multiple partners and failing to use barrier contraceptives. (18: p 168)*

With words like "high-risk", "consequences" and "ignore", the focus of the text is on abstinence as contraception for adolescents, further stigmatising consensual sexual activity. It does not talk about the importance of sex and sexuality education in providing young people with honest, age-appropriate information, and the ability, and comfort to manage their sexual health and relationships throughout life in an empowered way. The needs of adolescent patients and the difficulties they face in terms of lack of information about contraception and sexuality, talking to adults, financial barriers, and stigma around pre-marital sex that delays seeking healthcare, should be kept in mind as part of medical training. Doctors should be trained and sensitised to address a woman's contraceptive needs, expectations and concerns, while clearing misperceptions about contraceptive methods in a way that is compatible with the patient's health literacy, regardless of their age or sexual history. Access to and use of emergency contraception should routinely be included and an adolescent patient should at no time be forced to use a method chosen by someone other than herself, including a parent, guardian, partner or healthcare provider.

### **Abortion**

Dutta's textbook (16) does not explain the rationale behind abortion services (such as the lack of access to safe abortion) and the Medical Termination of Pregnancy (MTP) Act in 1971. Apart from mentioning that the husband's consent is not required, there is little information on the implications of this Act for women patients and service providers (19). Textbooks should include sections on various important provisions related to confidentiality and consent that give women space for informed decision-making, as well as on the interpretations of the Act. Currently, there is no section on pre-abortion counselling and provider-patient communication for abortion. It is important that women with unwanted pregnancies are provided counselling on whether they wish to terminate or continue, and issues related to the procedure such as pain, time taken, cost, choice of procedure etc.

*It is worth emphasizing that in India, when a newly married couple in a stable relationship presents with an unplanned pregnancy and is considering the alternative of MTP, it is worth spending time with them. Counseling them about all aspects of MTP, giving them time to mull over their decision and encouraging them to continue the pregnancy unless there are pressing needs to the contrary. In practice, it has been seen that more than 50% of such couples opt out for continuation of pregnancy and that they have not later regretted their decision, whereas a frivolous decision on the part of the couple often ends up in regret. All patients undergoing MTP should be counseled to accept contraceptive advice in order to avoid future unplanned pregnancies. (21: p 582)*

Textbooks encourage doctors to accept the ideal of a heteronormative family, meant for the purpose of reproduction. Healthcare of young, single women is often compromised because their decision to abort is judged as frivolous and textbooks urge doctors to counsel the women to continue the pregnancy. Women seeking abortions, especially in public facilities, or coming in for repeated abortions are pressurised to adopt certain methods of long-term contraception and may even be pressurised to go in for sterilisation (19). There is no mention of inequality and gender-based violence as a high-risk factor in continuing the pregnancy (22, 23). These textbooks fail to note that power imbalances faced by women may necessitate terminating unwanted pregnancies and that repeated abortions may be a marker of intimate partner violence. Women, especially from poor and rural areas, face multiple constraints in accessing abortion such as: obtaining approval from the family, not having any free public sector services nearby, not being able to afford the cost of services in the private sector, lack of mobility, issues related to confidentiality and lack of information. This simply does not allow for rights-based access to safe abortion. Textbooks should sensitise medical students about women's lack of decision-making power regarding sex, contraception and pregnancies, and while taking histories, students should also be taught to enquire about the woman's social relations, family, support or lack thereof, history of violence, or other anxieties.

*Drugs inducing abortion produce congestion of the uterine mucosa and then uterine bleeding, followed by the contraction of the uterine muscle and expulsion of fetus, or they cause uterine contractions by stimulating the myometrium directly. There is no drug which when taken by the mouth causes abortion without endangering the life of the woman. (6: p 376)*

Reddy's textbook grossly mis-informs readers about the abortion pill, which is the safest non-invasive method for performing an abortion. Mifepristone and Misoprostol were registered in India in 2002. These pills can be used by practitioners who are not skilled in surgical abortion and offers advantages in terms of improved access. In the developed world it has in fact become the preferred method of termination (24), even as textbooks here continue to describe

outdated, less effective or dangerous methods for abortion like aspirotomy and intra-amniotic instillation. Ethacridine lactate, which is widely used in India for second trimester abortion, is no longer considered an appropriate choice (19).

### **Pregnancy and labour care**

In most developing countries including India, maternal morbidity and mortality remain major public health challenges despite multiple efforts aimed at improving the quality of maternal healthcare delivery and creating an approachable environment for women seeking reproductive healthcare. Erratic availability of medical resources and unethical practices among health workers adversely affect the quality of maternal healthcare service delivery and utilisation.

*Encouraging the patient to discuss her fears, apprehensions, expectations, and perceived problems-opportunity to allay anxieties and emphasize co-operation. (21: p 59)*

While the point of providing comfort to the woman seeking antenatal care (ANC) is put forth, the ways to organise ANC in a woman-friendly way—ensuring privacy, maintaining the dignity of the woman, winning the confidence of the woman, getting her informed consent for various examinations and procedures, communicating properly and with empathy, encouraging men's participation—are not described (23, 25). There is no mention of the misbehaviour of healthcare providers for reasons as varied as coming too late to the hospital, having multiple pregnancies (having more than two children), seeking services from unsafe abortion providers, opting for home delivery. Inappropriate language is also commonly seen in our textbooks, where women coming to healthcare facilities for ANC services, with normal pregnancies and in a state of normal labour are addressed as "patients". Tags like "multi-" and "primigravida", while medically relevant, are used to address women on a general basis and are examples of casual objectification of women (22).

Chapters on physiological changes during pregnancy and endocrinology of pregnancy discuss physiological and anatomical changes. However, there is no mention of the psychological changes that occur throughout the different stages of pregnancy (22).

*...In India where nearly 40-90% of pregnant women are considered anemic. The most common cause of anemia in India is nutritional anemia. Causes: Diminished intake of iron- faulty diet habits... (21: p 104)*

When talking about anaemia and nutrition, the text does not highlight intra family gender inequality in food distribution and calorie consumption which majorly contributes to the poor nutrition levels in women and young girls in general and especially during pregnancy (22, 26). Studies show that nearly 40 per cent of women suffer from domestic violence and violence during pregnancy is an important cause for delay in seeking antenatal care, poor weight gain, low birth weight and bleeding during pregnancy (27). This role played by gender-based violence in various complications during pregnancy is not addressed anywhere in the textbook (22, 23, 25).

*Many HIV infected women choose to become pregnant, continue their pregnancies despite of counseling and making MTP services available to them. (18: p 166)*

The textbook fails to provide guidance on non-discriminatory and non-judgemental behaviour towards HIV positive patients (19). By calling them "HIV-infected", denies them dignity and implies that she was infected in isolation, since there is no mention of confidentiality and partner counselling. Many pregnant women who are HIV-positive drop out of these programmes or don't adhere to medical protocols because of the stigma and resultant social barriers.

### **Summary and conclusion**

Even after more than a decade since the Review of Women's Studies that appeared in the *Economic and Political Weekly* in April, 2005, while there have been minor changes in the texts, most of the aforementioned observations are still relevant, and biases highlighted in the 2005 review continue in the textbooks.

- The texts lack a rights-based approach to reproductive and sexual health, in terms of contraception and access to safe and legal abortion.
- There is no mention of the role of the father/partner/husband during pregnancy.
- There is no discussion on how the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act (amended in 2003) is confused with the Medical Termination of Pregnancy (MTP) Act, thus targeting abortion services rather than sex determination by using the term "sex-selective abortions".
- Some texts have statements such as: "Sometimes, false charges are made by a consenting woman, when the act is discovered by the parents or someone else, when she becomes pregnant or for purposes of revenge or blackmail" (6: p 395), showing deep rooted misogyny (28).
- Women's health issues are addressed only under "maternal and child health", failing to understand her health needs as a separate individual.
- The texts constantly idealises a patriarchal family with well-defined gender roles.
- There is a general lack of research on women's health issues and evidence-based studies (29, 30).

Gender differences in health and illness are due to biological, psychological, social, cultural and political factors, and they affect how healthcare is provided, organised and accessed. It is critical that doctors are aware of gender norms, values and power relations affecting the provider and the patient, influencing the nature and quality of their interaction. Medical professionals witness rights violations on a daily basis and are key players in advocating for sexual and reproductive health rights. As healthcare providers and leaders, doctors are in a position of privilege from where they can act as agents of change, by creating an environment that is respectful, safe and effective, providing dignified care that is suited to

and responsive to their needs as individuals. As research and evidence is critical to changing attitudes in medicine, there is a need to strengthen research on gender differences, critically evaluate new information through a gender lens, demonstrate an understanding of the gendered nature and impact of healthcare systems on populations and individuals receiving healthcare, and adopt best practices that incorporate knowledge of sex and gender differences in health and disease. Even if textbooks don't change easily, critiques should be offered by sensitised medical faculty members during the process of training. Integrating a gender perspective in medical education in a systematic and progressive manner at all levels will result in greater gender awareness among future doctors.

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#### Notes

- <sup>1</sup> The 2005 *Economic and Political Weekly* (Vol 40, Issue 18) review of women's studies appears here: <https://www.epw.in/taxonomy/term/17680>
- <sup>2</sup> While the two-finger test has been officially delegitimised by the Ministry of Health and Family Welfare, according to a study by Human Rights Watch (HRW), doctors continue to conduct this test for rape survivors in India. See: <https://www.hrw.org/news/2017/11/09/doctors-india-continue-traumatise-rape-survivors-two-finger-test> <https://www.hrw.org/report/2017/11/08/everyone-blames-me/barriers-justice-and-support-services-sexual-assault-survivors>; Guidelines and Protocols for medico-legal care for survivors/victims of sexual violence-<https://mohfw.gov.in/sites/default/files/953522324.pdf>; <https://www.thehindu.com/news/national/No-two-finger-test-for-rape-SC/article12141055.ece> <https://scroll.in/article/857169/doctors-in-india-continue-to-traumatise-rape-survivors-with-the-two-finger-test>
- <sup>3</sup> In 2014, 83 sterilisation procedures were carried out in six hours, violating all guidelines, at a Bilaspur sterilisation camp leading to the deaths of 15 women. See: [https://en.wikipedia.org/wiki/2014\\_Chhattisgarh\\_sterilisation\\_deaths](https://en.wikipedia.org/wiki/2014_Chhattisgarh_sterilisation_deaths); <https://indianexpress.com/article/india/india-others/bilaspur-8-women-dead-20-others-in-a-serious-condition/>

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