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Integrating concerns of gender, sexuality and marital status in the medical curriculum

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The introduction of AETCOM (attitude, ethics and communication) (1) is seen as an effort at incorporating Medical Humanities (MH) within the medical curriculum. For the first time, India's medical curriculum includes modules on the patient-doctor relationship, helping doctors to address ethical dilemmas that might arise during medical practice. Despite this progressive step, AETCOM has a number of drawbacks. Gayathri Prabhu (2) has analysed AETCOM as ossified, instrumental, lacking in a critical sensibility and failing to borrow from a humanities methodology. We would like to add to her excellent critique by examining other areas which have been overlooked within AETCOM. Our editorial addresses AETCOM's lack of sensibility towards the diversity of patients in India by focusing specifically on questions of gender, sexuality and marital status. While it is also important to understand how caste, religious, tribal and ethnic backgrounds of patients might be addressed within AETCOM, it is outside the scope of this editorial.

Sections within AETCOM which refer to a patient-doctor relationship do two things: one, they understand both patients and doctors as homogeneous and monolithic categories; two, they describe the different situations a patient might be in, but not the different modes of being of different patients. Patients from different socio-cultural background might have or adopt different modes of being. A failure to recognise and deal with these different modes of being of patients has led to a serious lapse in medical ethics. This has been the case with patients outside the heteronormative fold, including LGBTQ people, single people, women, adolescents and so on.

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Various scholars and journalists have documented these lapses of medical ethics within medical institutions. Neha Dixit (3) recounts the humiliation and trials of pregnant unmarried women who seek medical termination of pregnancy (MTP) in urban and rural India. For fear of judgement by doctors and society, they seek unsafe methods of abortion, putting themselves at risk of serious infections. Similarly, Sreemoyee Piu Kundu in *Status Single* (4) discusses the humiliation women face at the gynaecologists' clinics, for polycystic ovarian syndrome, endometriosis and MTPs. Single women are especially humiliated for not being married, for not wanting to have children, and for being too "reckless and fast". Shilpa Phadke also discusses the difficulties unmarried women face to get medical prescriptions for oral contraceptive pills since "gynaecologists [are] moralistic and disapproving" (5). In this regard, one of us has noted elsewhere that only the "married person is the subject of sexual and reproductive health in India" (6). Chayanika Shah et al (7) and Baba and Sogani (8) discuss the discrimination that LGBTQ people face at the hands of medical practitioners, which includes invasion of privacy, denial of treatment, and harassment.

In the United States, Joan DelFattore (9) discusses the bias she faced at the oncologist's clinic as a single woman. She was denied life-saving treatment for cancer by an oncologist who assumed that, as a single woman, she didn't have any form of social support to see her through the aggressive treatment. Her article establishes the medical community's bias against single people - they are less likely to be taken seriously by the doctor and nurses, or given life-saving treatment. I cite this example from the United States because we do not have any research in the Indian context on the discrimination against single people within medical institutions. When one of us discussed DelFattore's article in her course on Singles Studies, a student raised the question of medical malpractice: Is it ethical to deny someone life-saving treatment based on their marital status? When this question was posed to DelFattore, she replied: "In a field where so much is necessarily left to individual medical judgment in specific cases, and where social support really is a legitimate consideration, a particular doctor's misunderstanding of what social support is and where it comes from would almost certainly not rise to the level of malpractice.[1]" With rising numbers of single women in India (10), one cannot ignore the implications of medical ethics for women who might live alone or be unmarried.

How might these be addressed within AETCOM? We suggest that AETCOM might introduce module(s) to deal with not just lower class groups, but with patients who might be very unlike the doctors themselves and who challenge the doctors' notions of respectability, morality and normalcy. These might include single women and men, LGBTQ people, sex workers, single parents, married women who might not want to have children, and so on. The aim is not to provide an exhaustive list, but to engage in discussions which help medical professionals understand different life worlds and ways of being and living. One way to explore this is to have a module on concepts of the self and the other. In the case of AETCOM, the self is the doctor and the other is any patient who does not conform to the doctor's world view. This is not just developing empathy for a patient's pain or for a particular illness, but having compassion for someone who is very unlike oneself and who might make one very uncomfortable. Here I refer to Soumitra Basu's (11) essay on counselling and the need for a healer to develop detachment. By "detachment" he means the state which "enables one to be compassionate even under unfavourable circumstances." A doctor might experience unfavourable circumstances when confronted with a pregnant unmarried woman seeking MTP, or with someone whose gender and/or sexuality appears unclear. It might be worthwhile to consider Jacques Derrida's (12) work on the laws of hospitality which asks us to say "yes to who or what turns up, before any determination, before an anticipation, before any identification…" While it might not be possible in the clinic to have a perfect "welcome" to all patients, the aim might nonetheless be to have *unconditional* hospitality.

A pre-requisite for welcoming the other is self-reflexivity, a cornerstone of humanities pedagogy. With the introduction of a common National Eligibility Entrance Test (NEET), medical students themselves belong to diverse backgrounds. This diversity within the classroom and hospital has led to conflict. Payal Tadvi, an Adivasi Muslim doctor from Maharashtra, took her life by suicide in 2019 after being harassed by her seniors in Mumbai (13). Despite the increasing numbers of women in the medical profession, there persists a feminisation of labour, as women are relegated to gynaecology, obstetrics, paediatrics, and nursing while men dominate fields like surgery. *Economic and Political Weekly*'s Review of Women's Studies (14) carried articles exploring the gender-insensitivity of obstetrics, gynaecology, and paediatrics textbooks, the absence of gender and other social aspects within the mental health curriculum and community medicine and the overall biomedical focus of medical textbooks at the expense of social aspects of health and medicine. This exposes the inherent hierarchies of gender, class and caste within the medical profession. The *unconditional* hospitality extended to patients might need to simultaneously be extended to colleagues within the profession itself, for instance to nurses, hospital staff, women doctors, unmarried doctors and other non-heteronormative medical professionals. AETCOM might address the relationship between medical staff and doctors themselves, along with the patient-doctor relationship.

Some of the challenges posed by various scholars is that AETCOM will add to the already overburdened medical curriculum. Similar arguments have been made for introducing sexuality education within the school curriculum, with teachers arguing that conversations around sexuality, consent, gender, love, and romance should happen throughout one's schooling and not be restricted to a single session or course. Similarly, Ramaswamy (15) mentions that MH is a "continuous search for connections between medical practice and the realities of our world." We argue that MH is rather an *orientation* which informs the whole of medical education. If conversations on love and romance become part of schooling, conversations on bioethics, empathy and

compassion might pervade the entire medical curriculum, not just AETCOM. Nevertheless, for the moment we recommend introducing module(s) on self and the other, and readings on feminism, gender and sexuality in AETCOM.

Gayathri Prabhu (16) has mentioned a few texts which might be a useful addition to AETCOM, such as Gayatri Reddy's ethnographic account of transgenders in Secunderabad (17), or Foucault's *The birth of the clinic* (18). To these we would specifically add the treatise on a lesbian standpoint by Asha Achuthan et al (19) which traces the historical relationship between medical science and sexual rights; Bella DePaulo's foundational text *Singled out* (20) which addresses single people's lives; and Nivedita Menon's *Seeing like a feminist* (21) which addresses concerns of family, body, desire and sexual violence. More broadly speaking, we would include debates on masculinity which emerged in India post December 2012, turning the lens on men rather than women; and writings on queering the family to introduce kinship systems outside the heteronormative family. These will help medical students to think through the different "others" they might encounter in medical practice, and which might often overlap with their own selves. To think theoretically about self and the other, we recommend portions of Judith Butler's *Giving an account of oneself* (22) to deal with ethical responsiveness, humility, the primacy of the other and the limits of full self-knowledge. These readings, we hope, will go a long way towards beginning a critical conversation with regard to gender, sexuality and marital status within medical practice.

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Note

[1] Facebook comment, January 27, 2020.

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