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PAPER

**GENDER PERSPECTIVES IN THE MEDICAL EDUCATION – A
QUESTION ABOUT THE KNOWLEDGE-PRODUCTION AND THE
SELF-IMAGE.**

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The most elementary part of our self-image is our gender identity. It can be found in all human relations. Sometimes we take it so for granted that we forget its significance, we become gender blind or gender neutral.

In research concerning gender issues this is often referred to as a common problem in the medical science (1), which is marked by "a belief and an ideal of it as neutral" (2).

Deleuze and Guattari (3) reflects over why the medical education has been able to stay "immune" against the gender discussion in the academic world and the rest of society. One reason to this as she sees it, has to do with the hierarchy which surrounds the medical science, something that mirrors how we look upon and practice the medical education. But she also believes the positivistic tradition within science to be another reason.

Gender perspectives in the medical education – an integrating phenomena.

What then does a gender perspective in the medical science mean? Often the term "gender" is used to describe our sex as socially/culturally constructed in opposite to the term "sex" which refers to sex as biologically given.

"Gender...defines a system of meaning which contest of two opposite and excluding categories in which all humans are put into. Gender is based on a cultural interpretation of the biological differences between men and women. It is important to state that it is not the biological differences per se that compose gender, but the interpretations of them" (4).

Yvonne Hirdman describes how this gender system is a power structure, which is "...the condition for other social structures. The categorization of humans into gender has become the base for the social, economical and political structures"(5). This power structure within each sex is also dependent on class, ethnicity, sexuality etc (6).

Though, to try and make a distinction between sex and gender, can be risky since this might lead to making the biological sex invisible. The same goes for the body: "Bodies, in their own right as bodies, do matter. They age, get sick, enjoy, engender, give birth. There is an irreducible bodily dimension in experience" (6).

However, the biological sex and the material body – in the same way as gender- are socially and historically changeable constructions (4).

The understanding of the term "gender" therefore, refers to an understanding of "gender" and "sex" as inseparable from each other (7). "The biological and the social have to be analysed at the same time; what is biological is also socially determined – and vice versa"(8).

This connection between biology and social factors will in this paper define the understanding of the gender system, thus a consideration of the integrating phenomena:

- Biology, culture and hierarchy in reflections concerning patient relations (ex. 9).
- The work situation (ex.10)
- Gender related health-/and illness situations (ex.11)

Consciousness about these integrating phenomena is elementary. The understanding of how our bodies are affected of both social experiences and norms and values is highly relevant in all three of these aspects. For example, patient relations can be seen as an interaction between the patients self-image and the view of the patient from the medical world's perspective. Therefore, in such a meeting it is important to remember how "medicine is full of ambiguity, subjectivity, and risks as it traffics back and forth between the clinic and the world where the people it serves actually live" (3).

According to Sue V Rosser, a feministic critique of science can make young medical students pay attention to the, lack of objectivity and the gender blindness, which actually exists in traditional science (12).

The doctors have a central role for the self-image and attitudes of the student.

The doctors' view upon knowledge and a gender perspective might reproduce a certain self-image, a professional role, among the medical students. According to George H Mead's theory (13), individuals develop their self-image in relation to how they experience the surrounding's attitudes towards themselves. The self-image is also formed from the surrounding's attitudes towards shared activities and obligations. The individual adopt a set of roles and attitudes, which agree with the roles, and attitudes that other individuals in this particular social group have.

This is why it is so elementary for the doctors to see the role they have as role models and to use this to increase the students' awareness.

Not seeing the relevance of the gender system, causes gender blindness or gender neutrality, a point of view which neither agree with the self-image nor the visions the medical students in this study have: to become someone who is able to "take the patients right", to be "caring" and "get the right information".

The purpose of this paper is to show the degree of awareness about a gender perspective and the implementation of it in the medical education. Another purpose is also to try and understand why this awareness is so poor particularly in the medical education.

Method.

In the study, which is being referred to here, qualitative research methods located in the hermeneutical science tradition were used (15,16). The interviews were conducted during the spring term 2000 with individuals attached to the medical education in Lund, and with other doctors possessing knowledge about a gender perspective in medicine. Three types of interviews were conducted:

1. First a so-called informant interview with a key person, lecturing doctor in general practice, was conducted. She could inform me about how the medical education is organised and get me in contact with the Director of Undergraduate Education.
2. Then individual expert interviews with two general practitioners associated with the Institution of Social Medicine was conducted. They both have experience of teaching in the medical education and have also published several articles concerning feministic perspectives and gender perspectives within medicine. Both are women in the upper middle age. Further, I made individual interviews with lecturing doctors, two men and one woman, all in the middle age, from different terms on the education. After consulting the key person and the Director of Undergraduate Education, these persons were chosen on grounds of their coordinating roles at the different terms of the education.
3. Finally, a discussion in a focus group was arranged with seven medical students all together from term four, five women and two men in the age between 20-30- these students already constituted a PBL-group ("problem based learning") and was the first of several asked accepting to participate in such a discussion.

I also tried to get students from term 11 to participate in a focus group. All said no due to the time of the year when it was time for final exams. The choice to interview students from term 4 – even though they mainly have been focusing on molecule biology, anatomy, physiology, etc – is based on the fact that they early in the education have elements of contacts with patients and ethical issues. My assumption was that they ought to have reflected on and adapted to the role as becoming doctors. This assumption was to be confirmed in the interviews.

The decision to interview the PBL-group from term 4 also had to do with my standpoint: if medical students are to learn about a gender perspective in the meeting with patients, that is best realised in the beginning of the education. All the interviews, which lasted from 20 to 90 minutes, were taped.

The analyse methods is inspired by a grounded theory and its coding procedures (17). The taped interviews were transcribed word for word. A read through them developed common themes and patterns that were summarised in different terms and categories, “open coding”. After this, the connections between the different categories in the second step, “axial coding” was found. Finally, themes and categories were vowed together into an analytical whole where the central theme was lifted forward. This was then put into a theoretical understanding that springs from a sociological and gender theoretical perspective.

Results.

When the doctors participating in the study were asked to define a gender perspective at the medical education, all of them said that it could involve different things. They all referred to the situation for doctors at the working market. They also referred to how the spread of male and female students at the education today is approximately 50-50 and they also mentioned differences between the sexes in illness patterns and health conditions. Thus, it was the biological sex that was focused upon. Only the two doctors in the expert interviews mentioned the social gender and its significance in the education.

When I at one occasion suggested that a gender perspective in the medical education might focus also on men and women’s social positions in the society, the informant answered that the education “is exclusively about diseases”. However, the informant mentioned that gynaecologist meet many patients who’s somatic picture, for example venereal diseases and unwanted pregnancies, are connected with their social problems.

In particular one of the interviews there where problems straight through the interview to discuss the importance of an applied gender perspective in the medical education:

“If you see it professionally, which we are to do /.../ it is completely natural that you bring up the differences between male and female where, but in what amount this is brought up in a more, what should we say, psychological way, I don’t...but on a biological level it is brought up in different situations”.

The informant experienced that the gender perspective was put forward as “something incredibly problematic” and that the lack of awareness is put forward “especially as something among the male population”. In this way expectations are created on something which is not so “terrible problematic”.

Except for one of the doctors in the expert interviews, one of the three lecturing doctors was aware that attention to the patient’s, staff’s and one owns gender belonging “have been quite inadequate”. The informant said that there was a greater awareness now, but: “there is not really an existing system in the education /.../ very little anyway”.

Another of the lecturing doctors said that the goals with the education are formulated but that no one finds out what is happening “behind the walls”. One informant in the expert interviews, say that it is important with good role models at the clinics as well. These are the doctors the students take impression of in their aim of becoming doctors themselves.

Not as much resistance as before, some students thought.

When asked to define what a gender perspective in the education could involve, the students associated mainly to their own work situation:

Informant 2: “I think of this how it is to be a young woman and come out as a doctor and what problems that might involve with grumpy nurses who rather help the male doctor, which you have heard about /.../ But you can feel those vibes that it is easier to get into that hierarchies a man (laughter)”.

When defining a gender perspective, the lecturers' treatments of the students were discussed. Just as several of the interviewed doctors the students referred to the fact that half of the students on the education nowadays are women. Some of the female informants therefore thought that it would not become as problematic as earlier to come to the clinics as a female doctor.

When trying to lead the reflections into other aspects there was silence.

The interviewer: "Have you ever thought anything about how gender and the different roles gender have in society affects health and illnesses? (silence) Do you understand what I mean if I say so?"

Informant 1: "You mean if we read more about male illnesses than female ones?"

The interviewer: "No, that maybe a persons position in the society affects how that person feel".

Informant 1: "We have mentioned it but it is nothing we have talked especially about.

Pretty soon someone else gave another example, though. During a lecture UMSD (undefined musculoskeletal pain disorders) had been mentioned as a symptom found in women who were "a bit hysterical". If it was the student who called them hysterical or if she referred to the lecturer's expression was not clear. However it was obvious that the lecture not had been received with great interest. It was referred to as "boring".

When another student started associating to a lecturer who had mentioned that a certain medicine which is cheaper then a the correspondent one, more often is prescribed to women then to men, I asked if the students ever continue these discussions and think about why this could be or what the consequences might be.

Informant 2: "It is nothing we normally discuss further, I think. And I also believe that if you did the class would think, "go back to the stencils..."

Informant 2: "...so that we can do the exam".

Focus on passing the exams.

The time pressure and prioritising of knowledge needed to manage the exams was themes, which returned during the interview with the students and served as an explanation to why it is so difficult for a gender perspective to get attention. Not having "the right people" to talk about these issues was also said to be a reason.

Informant 1: "The big problem with this, I find, is the people who are going to teach you about this, it is only those who are interested in this. Actually, you ought to talk to the male doctor... You ought to talk to the tough guys and not only..."

Informant 2: "It gets a bit silly"

Informant 3: "But maybe it is better to attack the problems when they arise".

Informant 4: " You mustn't exaggerate it either because then people will just get an anti-reaction, you think 'oh no, are those feminist going to come again with their nagging about female oppression here and there' ".

The common attitude among the students was that a gender perspective was not integrated especially well in the education but this was neither experienced as relevant during the pre-clinical terms: "I think that one will find it more relevant starting from term 6 when we start going to the clinics more /.../ Now it is maybe more about concentrating on passing the exams".

When the students talked about what they experienced as relevant to learn, it was the questions that would be asked in the examinations. These questions are formulated from the core curriculum in which a gender perspective not is present. In the focus group with the students a discussion came up concerning female lecturers. A student brought forward that the female lecturers actually had been quite bad. The whole group agreed but finally came to the conclusion that there had been tendencies among the students to put pressure on the female lecturers in another way than male lecturers. This might have resulted in insecurity among the female lecturers.

Actions like this illustrate how incorporated these students are in the patriarchal tradition which is significant for the medical science. However, it also shows that the students are aware of these tendencies and reflect self-critically over them. Afterwards, it occurred to me that I would have liked to ask them why it is allowed to question a female lecturer in a greater extend than a male lecturer.

Even though the students said it would be better to solve the problems when they arise, they found a gender perspective to be relevant and that there are attempts to take it into account in the early patient contact. A male student told me about the positive experiences from the early patient contact: "But in

the group I was during the early patient contact we often discussed this. We had a female 'boss' or what you should say, and she liked to discuss it".

Interviewer: "Did it feel relevant then or was it..."

Informant 1: "Yes, she was very good so it felt relevant".

The students said exactly like the lecturing doctors: It depends on the teachers if a gender perspective is integrated or not.

Discussion.

It has been showed that the difficulties with integrating a gender perspective in the education have to do with a lack of interest among students and among lecturing teachers. It is up to every lecturer to try and integrate a gender perspective in the education. Herein lies the big problem. How are the students to be interested in something that is not considered valuable knowledge or an important role of the medical profession? When a doctor defines the medical profession to be "professional knowledge about biology" and a gender perspective as something "psychological" that probably gives quite strong signals to the students about what is relevant in the medical profession.

Instead of bringing in new knowledge to the medical field, a traditional view upon science is maintained. When attempts are made it gets wrong anyway. The students do not feel that it is relevant to discuss a gender perspective during the pre-clinical terms. The risk with "handling the problem when it arises", as some students suggests, is that the students will not then have the tools to understand the meaning of a patient's gender. An integrated gender perspective is therefore important already from the first terms and continuing throughout the whole education. The students also believe that it is the wrong persons who talk about gender issues. They want someone else than the feminists to integrate a gender perspective in the education. Maybe the students are scared of the political aspects an understanding of the gender hierarchy involves.

Another explanation could be the unwillingness among women to adopt a picture of themselves as victims. Deleuse and Guattari refers to Naomi Wolf's argument: "Wolf (my notice) claims that the feminist emphasis on victimization estranges women, that women are fed up with hearing about oppression and are far more attracted by appeals to their strength, resourcefulness, and sense of responsibility"(3).

In a corresponding degree the unwillingness among certain men might have to do with not wanting to be held responsible for something they are not personally responsible for. The "anti-reaction" one of the students in term 4 was referring to, is maybe typical for the generation she belongs to. Persons who are born in the 60's and 70's have been brought up with the discussion about equality and have heard the second wave feminists so many times that maybe, they take equality between the sexes for granted.

The risk is that women who have been successful in traditionally male dominated areas are looked upon as "proofs" of how the equality question is exaggerated.

There are no difficulties to discuss with the students the different conditions that await them in the clinics. It is the reasons behind this that are difficult to discuss, the gender hierarchy, how the social gender affects our lives on a personal level.

Howard S. Becker (18), a sociologist who in a classical study investigated the student culture on a medical school in Kansas during the 60's, thinks that the best way to develop and change education is to consider the students autonomy. This ought to be the ideal.

However, the students in term 4 are focusing on what will be asked in the exams, thus what the faculty defines as the core curriculum. The lecturing doctors and the students refers straight through about the problem with the time pressure. To get a new element into the education something else has to go, they mean.

But, an integration of the gender perspective does not mean that something is added, but that gender is taken as a factor to analyse health, sickness and life situation from. One of the doctors in the expert interviews emphasize that education in how to integrate a gender perspective is necessary. At the present there are "very few that have knowledge" something which all the doctors were aware of.

The general problem to why it is so difficult to integrate a gender perspective can be described with Faye Crosby's headline (3): "Sex discrimination: How can we correct it if we can't see it? And how can we see it if we're not prepared to correct it?"

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