**Gender Perspective In Medical Education**

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**Abstract**

It is a universally acknowledged truth that medical students have to go through an incredible number of pages of textbooks in their undergraduate years. But most will learn next to nothing about the intricacies of the social determinants of health and the larger socio-political-cultural spaces they will have to negotiate. Without any exposure to the larger economic, patriarchal and historical systems which are bound to collide with their book learning, they will be highly un-prepared to locate their own bio-medical skills within the larger context. If we would want a society where doctors are sensitive, aware and empowered to bring about change not just in healthcare, but in the health and well-being of the community, then it is critical to ensure that they learn about these spheres of functioning alongside the clinical medical training, thus helping students understand everything that influences a person's health. The objective of this article is to analyze the current level of gender sensitivity in the textbooks being used for undergraduate medical training and the potential impact that has on developing attitudes towards a gender and rights based approach.

**What should be the Objectives of Medical Training?**

Medical training needs to guide students not only on arriving at a clinical diagnosis and planning the appropriate treatment of a condition, but also needs to guide them about the healthcare frameworks which can lead to a better quality of life. They need to understand that several health needs are a result of gender inequity coupled with social inequality and economic deprivation. Medical textbooks are the cornerstone of the learning process and can shape approaches and attitudes of the readers and learners. Here are some examples of the language in the textbooks which reflects not only facts but the attitude or even prejudices of the authors, thus creating a bias in the minds of students who have never been exposed to the other perspectives related to the issue in discussion.

**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…” (Dutta’s textbook, p 610)*

This text assumes the notion of population control is the goal and it is the main justification for providing services such as contraception rather than seeing contraceptive methods as facilitating women’s control over their own bodies. It also does not offer the perspective of unequal distribution of resources and inadequate public sector spending on health as being a barrier to a better standard of living. It does not reflect upon the politics of the globalized world where the consumption patterns of the Global North are ignored and only birthrate of the Global South is focused on. Despite the International Conference on Population and Development (ICPD) held in Cairo in 1994 which ushered in a paradigm shift from population demographics to individual sexual and reproductive rights and health, and India being signatory to the ICPD PoA, access to ‘family planning’ is being projected as a solution to population growth.

The use of F.P. rather than contraception also assumes a heteronormative married couple as the basis of a family and precludes any discussion around other sexualities and family structures. There is no discussion to orient medical students as to how the 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, in the section on condoms, students need to be aware of the difficulties that women face in negotiating condoms use; and adverse consequences (fear of violence, accusation of infidelity, abandonment etc.) they might face if they insist.

*Indications (of female sterilization): (1) Family planning purposes: This is the principle 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.*

*(Dutta p 633)*

In the section on female sterilization, only the procedure (how to carry out the surgery) has been described and there is very little guidance on the comparison of female and male sterilization or the need to promote male sterilization as a less invasive and safer procedure. Surely if the woman should avoid future pregnancies because she has a serious heart disease, it makes sense to not do an invasive surgery on her but instead encourage the male partner to undergo vasectomy?

There is no guidance on how to determine whether or not a woman has made an independent decision free of any pressure or coercion. For each of the medico-surgical conditions listed, long term reversible methods could also be a reliable alternative and certainly each one of their husbands can undergo vasectomy. It would be desirable that the textbook guides students about the rationale for choosing each method and guide the students on the right of the woman to discontinue a contraceptive which does not suit her or for non-medical reasons such as family opposition or death of a child. At various places under the section on sterilization, there is mention of camps, but there is no reference to quality issues that need to be taken care of during camps. There should be reference to “Standards to sterilization”, published by Government of India in 1992, which students may consult for further information.

There has been considerable scientific progress in areas of contraception, leading to the liberalization of medical eligibility criteria, which has the potential to considerably increase access to contraception. The textbooks, on the other hand recommend unnecessary and excessive requirements for starting a contraceptive, which reduces access for women. For example, Dutta's textbook 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. This would have been a good place to mention the high incidence of child marriages still taking pace illegally in our country and the need to address the contraception needs of that vulnerable population.

**Abortion**

Dutta’s textbook does not give any information on the rationale to provide abortion services, e.g. lack of access to safe abortion and high levels of illegal abortion nor the rationale behind the passing of the Medical Termination of Pregnancy Act in 1971. There is very little information on the implications of this Act for service providers, except for mentioning that the husband's consent in not required. It also judges the decision as ‘frivolous’ and urges doctors to counsel mainly to get the women to continue the pregnancy. This simply does not create a rights based framing for providing safe abortion access.

*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. (Holland and Brews, p 582)*

Textbooks encourage doctors to accept the idea of an ideal family as heteronormative and for the purpose of reproduction. There is no reference to the relationship between gender inequality and the power dynamics of married women in our society and women’s need for terminating an unwanted pregnancy, nor to repeated abortions sometimes being a marker of intimate partner violence. Textbooks should sensitize medical students on the women’s lack of decision making power regarding sex and contraception, its relation to unwanted pregnancies and the constraints that women, especially poor and rural women face in seeking access to abortion. This could be due to the need to obtain approval from the family, not having any free public sector services in their area, not being able to afford the cost of services in the private sector, lack of mobility, issues related to confidentiality and lack of information.

*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. (Forensic Medicine, Reddy p 402)*

Reddy’s Forensic Textbook gives gross mis-information about the medical abortion pill which is the safest and non- invasive method for performing an abortion. Mifepristone and Misoprostol were registered in India in 2002. Medical abortion using these pills offers several advantages in terms of improved access, and its potential to be used by practitioners who are not skilled in surgical abortion. In several countries in the developed world it has in fact become the preferred method of termination.

**Rape**

*Rape and gender – in law, rape can only be committed by a man, and a woman cannot rape a man… (Forensic Medicine, Reddy, p 415)*

Rape of males is still a [taboo](https://en.wikipedia.org/wiki/Taboo) topic since there is no recognition of consensual se between two males due to the Section 377. Community and service providers often react negatively to the [sexual orientation](https://en.wikipedia.org/wiki/Sexual_orientation) of male victims and the gender of their perpetrators. Due to this male victims try to hide and deny their victimization. Eventually, the male victims may be very vague in explaining their injuries when they are seeking medical or mental health services. It is difficult for a male victim, heterosexual or gay, to report the [sexual assault](https://en.wikipedia.org/wiki/Sexual_assault) that was experienced by him. Male rape victims reported a lack of services and support, and legal systems are often ill-equipped to deal with this type of crime. Rape laws should be gender-neutral.

**Virginity**

***VIRGINITY:*** *A female is called a virgin (Virgo intacta) if she has never experienced any sexual intercourse. (N.G.Rao, p351, Reddy, p389)*

Virginity as a concept exists for men also but it doesn’t have the same social implications or significance at all. The textbook is perpetuating this negative gender stereotype without offering any counter position or explanation of the need for a patriarchal society to control women’s sexuality and hence the stigma around pre-marital sex for women.

Virginity is thus a social construct and not a medical fact. Why is this still being taught to medical students when it has no medical relevance?

The FMT textbook in fact shares a table to explain the difference between a virgin and a ‘deflorate’ which is not just offensive labeling but also factually incorrect and legally of no relevance to rape.

**Conclusion**

* Gender differences in health and illness are due to biological, psychological, social, cultural and political factors. Doctors’ awareness of these issues aims toward better health for everyone and contributes to equity and equality in health.
* It is critical that doctors be aware of the gender dynamics affecting the health of and access to health care by women.
* Integrating a gender perspective in medical education at all levels will result in greater gender awareness among future doctors.

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