

Gender-based relations and mistreatment in medical schools: A pending agenda in Mexico and the world

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The purpose of this review is to describe and analyze the status of gender violence in medical schools around the world, and its consequences in undergraduate students' health and academic development, mainly on female students. The different modalities reported in the literature are presented: gender discrimination, sexism, and sexual harassment, among others. The increase of women in medical schools has not transcendentally improved their condition in these institutions, where androcentrism and gender regimes that favor gender violence reproduce. This type of violence is a public health, human rights, and academic problem. (Gac Med Mex. 2016;152:726-31)

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KEY WORDS: Gender. Medical Education. Undergraduate. Violence.

Introduction

The emergence of the feminist movement awakened the interest on gender violence (GV) and sexism. In 1981, Silver published the first study on violence in medical students (MS) and described the gradual mood and health deterioration in students owing to the abuse they suffered¹. To date, numerous investigations have been carried out, especially in developed countries, reporting the existence of GV against MS, which in this work is conceived as violence exerted against persons as a result of the gender regimens on each society, i.e., it refers to any act that hurts people's dignity or self-esteem at the physical, psychological and/or sexual level. This process implies exercising asymmetric power relations that translate into different forms of domination/subordination between groups or

persons and are socially instituted, unstable, disperse and modifiable. At the macro level, they are structured based on different social institutions and, at the micro level, they are expressed in the school setting, both in the relationship between peers and in the relationship between teaching personnel and the students. It is a structural process that is settled and legitimated in a socio-cultural order that provides subjects occupying the male social field with conditions that make it possible to exert, reinforce and legitimize that violence as a desirable behavior; it is a means of control and not the aim in itself^{2,3}.

The necessity to further know about this set of problems led us to delve into the situation these issues are at the global level, including Latin America and Mexico. Hence, the purpose of this work is to show the panorama of GV lived by medical students and the different axes that shape it.

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This work was carried out at the Public Health Department of the Faculty of Medicine of the UNAM

Date of reception: 16-03-2016

Date of acceptance: 30-04-2016

Methodology

Resorting to PubMed, Ovis, Scielo and several books, investigations published between 1993 and 2015 on GV and sexism against female medical students (FMS) and male medical students (MMS) at different regions and educational institutions were reviewed. Only texts containing data on undergraduate students and disaggregating the information by sex were included.

Results

A total of 40 articles on the subject, referring investigations carried out mainly in developed countries were found; in Latin America, publications are rather scarce, as shown in table 1.

The review showed the existence of GV, gender discrimination (GD), sexism and sexual harassment (SH) as common practice in the school setting of MS; the consequences of this violence are also reported, as well as the role played by gender roles as obstacles for student academic development. All this is next analyzed in depth.

Gender violence

Reflection and introspection is observed to exist in students with regard to their own situation as females and males in the face of violence, and this is related to cultural, familial and social aspects of the contexts where they were brought up⁴, but also to their social origin and ethnic condition. Both females and males report high rates of verbal and emotional violence (70 vs. 66%), which is a little higher among males, as well as physical violence (8 vs. 6%)⁵, but females suffer more GV (47-63% vs. 17-30%)⁶⁻⁹ and show the highest prevalence, regardless of ethnicity, as Rees et al. reported in 2011, 9.4% of black MMS and 16.8% of black FMS reported racial and gender harassment⁹.

Gender discrimination and sexism

It is the most common type of GV in FMS and the most reported by them. Between 10 and 33% of MMS referred being affected versus 15.5-69% of FMS^{6,8,10-12}. In 2014, one meta-analysis showed a significantly higher prevalence in females than in males ($p < 0.05$)¹³. These violence modalities are expressed as contemptuous remarks or sexist insults (FMS: 11.5%; MMS: 3.4%), academic personnel favoritism (FMS: 9.0%; MMS: 2.9%)⁸, mockery, authoritarianism and humiliation¹⁴⁻¹⁷. In general, 16-25% of students have heard

sexist names or remarks¹⁸, which frequently have a homophobic or degrading hint for lesbian FMS¹¹.

These expressions come from attendings. Faculty, residents and patients during the entire medical training; some of them refer that women belong to the household setting and not to medical school, with statements such as that women should study hair-dressing or design and not medicine, or the teacher asking them what are they doing there when they should be selling vegetables at the market^{11,17-21}.

Their intelligence is also undervalued: "You females and your pea-sized brains!", "Women have lint inside their heads". They are told they are unable to do tasks regarded as being masculine: "You are... a girl... No way you know... to perform this surgical technique"^{11,15}. They are assigned "to bake a cake for the shift" or to "do the dishes because you are the only woman"²¹, or the teacher makes females occupy the rear seats of the classroom¹⁹. They are not given the same attention on their learning than their male schoolmates, which are more encouraged to study and questioning²². Furthermore, FMS perception is that female nurses loathe them^{9,11,23}.

They reported a modality of discrimination described as follows: "They don't let me participate"²⁴. There are physicians-teachers that discourage FMS who want to pursue a specialty²⁵: "You should better open a general medicine practice beside your house so that you can look after your family"¹⁹. Patients also discriminate them, identify them as ancillary or nursing personnel by calling them "miss" or "nurse" instead of "doctor", conversely to MMS, whom they treat as doctors since the beginning^{22,25}. They have less rewards for doing the same work than their male peers only for structural limitations and are evaluated lower for the simple fact of being females^{18,23}, to the point that early in the millennium, 21% of FMS lowest evaluations were owing to gender discrimination (7% was reported in 2012¹⁸).

On the other hand, MMS consider that female residents and physicians, specially from the Obstetrics Department, favor FMS, since they are assigned higher workload and heavier tasks or shown displeasure for MMS^{11,23}. They also believe that male residents and doctors favor their female peers.

Sexual harassment and abuse

SH is any sexual, physical or verbal approach, pestering or pressure that is exerted in any uneven power relationship and that is not wanted by those who receive it, resulting from the possibility of benefits being conditioned and sanctions imposed²⁶. Sexual harassment situations

Table 1. Articles on GV against medical students by country according to level of development

Developed countries		Developing countries	
USA	17	Colombia	5
Canada	5	Mexico	7
United Kingdom	3	Chile	1
Finland	1		
Japan	1		
Subtotal: 27		Subtotal: 13	
Total: 40			

occur at basic (26.34%) and clinical cycles (73.66%)²⁷. FMS are more affected^{11,21} and its occurrence increases with the number of years of study^{8,13,27}; statistically significant differences were found in FMS, especially at fourth and fifth years²⁷. Its frequency ranges from 22.4% to 70% in FMS, with an average of 33% in MMS. Of the FMS percentage, up to 30% experience threats and sexual requests with violence^{6,9-11,15,18}. In the studies that do not disaggregate data by sex, its frequency ranges from 3 to 59.6%^{13,14,28}.

Harassment occurs as invitations from Faculty or attending to go out on a date, improper jokes, leers, questions to female students about their sexual habits, unwanted sexual talks, obscene flirtatious remarks, sexual intercourse insinuations, unwanted sexual attention or academic blackmail^{15,17,21,29}. Some examples cited in investigations are the following: when attending to a delivery, the teacher stands behind the FMS and gets too close¹⁵; a female student who was exempted from an exam, when she refused to come to the front of the room for the teacher to "admire her figure", was forced to undergo the exam¹⁹.

Sexual abuse takes place in 7-28% of students; 46-54% in females and 19-39% in males^{5,10,15}. The referred forms of abuse are: being spied on in bathrooms, being forced to get naked, sex organs flashing, observing masturbation, pressure to practice oral sex, fondling, shoulder, back or leg touching, caressing the back, waist pinching, hand caressing, rubbing or massaging and grabbing the breast^{11,15}.

Scenarios where violence takes place

The most common space are clinical rotations, especially during internship^{6,9,15,28,30,31}. The Surgery Department is where more GV and other forms of violence take place^{6,11,12,32}, followed by Obstetrics & Gynecology rotation and, in general, it is exerted on females.

MMS are most affected at the Gynecology Department³³. FMS referred more violence ($p < 0.001$) at the Surgery, Emergency, Internal Medicine and Neurology Departments^{4,6,15,16}.

Perpetrators

One study reported that 50% of harassed FMS were assaulted by doctors, in comparison with 23% of MMS. During the first years of medical school, the perpetrators are peers, and attendings are from the fourth year onwards⁵. Other studies pointed at males with some power position as the main perpetrators^{9,14,16}, especially clinical clerkship faculty and attending or residents, mainly from the Surgery Department^{11,13-16,23,27,28,32,34,35}, followed by basic cycle faculty or instructors^{13,14,21,27,28,35}, nursing personnel^{13,16,23,28,34} and, to a lesser extent, interns or students^{13,15,23,32,34}. Faculty were mostly pointed at for exerting verbal, psychological and sexual abuse^{21,25}, and peers, for practicing physical aggression²¹. In occasions, aggression came from patients or their families^{11,13,28}.

Perception

More females (48.6-92.8%) than males (50.7-83.2%) have experienced, observed or heard of incidents related to students who have suffered SH, GD or any other type of violence. MMS report more experiences about others and FMS, more experiences of their own at different stages of medical training^{6,11,36-38}. For MMEs, it is harder to identify certain behaviors as being aggressive or violent⁴, whereas for females it is harder recognizing themselves as violence victims, in spite of having information. In addition, they perceive less GD and SH as they advance in their training³⁹. Both groups perceive mistreatment as part of medical training^{34,35}.

Effect on academic performance, health and other consequences

Punishment is globally accepted in medical schools as a “natural” resource for MS training and, according to Castro¹⁹, it is used as an “educational tool”. This chronic mistreatment negatively affects MMS and FMS. Verbal, sexual and academic abuse is associated with significantly lower scores in scales that measure self-confidence, self-esteem, learning ability and ability to provide effective patient care³². In academic assessment, the effects of verbal abuse and discrimination mainly impact on student functioning and on the desire to continue in the same institution for the years to come³². Mistreatment has a significant influence on the selection of certain specialties at residency^{28,26}.

FMS who have experienced SH and discrimination are less satisfied with the quality of their education, are less secure on their clinical skills^{10,40} and are negatively affected to select a specialty even if they have not experienced them firsthand³⁶. A significant number has contemplated abandoning medical school. Around 8% believe the effect will be permanent²¹.

FMS are discouraged in pursuing specialties labeled as “masculine”. Surgery and urology are openly claimed not to be for females^{25,35}. This, added to the lower number of mentors who admit FMS in their classes, it constitutes an important barrier to their professional progress^{41,42}.

FMS who are in a male-exclusive group consider they have to put more effort, not to make mistakes, demonstrate they are entitled to be in that position, show seriousness and professionalism, and are constantly considered less capable than their male peers²³, in contrast with MMS, who have more freedom to express themselves and act²².

Mistreatment also impacts on health in the form of stress, sadness, depression, nervousness, tension, dissatisfaction with activities, guilt, fright/shock, violent impulses, sleep disorders and/or emotional problems^{19,21,38,34,40,42,43}. Cook et al. observed a high degree of burnout among students that had experienced recurrent mistreatment from faculty and residents ($p < 0.01$). Students exposed to abuse exerted by their superiors showed no recovery and displayed more depression and stress³⁴. Females appeared significantly more affected on their mental and physical health; those who suffered discrimination showed lower self-confidence and self-esteem and more isolation^{19,21,42}.

Institutional response and student coping strategies

This problem is generally belittled⁴. There is poor response of authorities to this situation, and they even go as

far as being somehow reluctant to diffuse this problem, since they consider it can affect the institutional image^{15,42}. Most students do not seek institutional support for several reasons: fear of reprisals from somebody who is in a position of power, lack of knowledge on regulations, lack of time, shame, fear of not being believed, belief that the perpetrator has the right to pick on them, because they are “the lowest”, ideas that it is not possible challenging a superior, lack of trust in authorities and belief that these behaviors are a necessary part of medical training^{9,13,19,22}. Students cope with the conflict in different forms: passively accepting it, avoiding the action, using verbal defense or seeking a mediator to solve it^{28,37}, but, in this scenario, females perceive the least support²⁷.

Discussion

This review shows that GV and GD, as well as other types of violence, are common practice in the context of medical education at the global level, with Mexico included. All investigations agree that its magnitude and severity are higher in females than in males, that it occurs in a generalized form in different departments and that it comes from different agents.

The investigations also show that these practices have been “naturalized” and even adopted as a “necessary” tool for medical training⁴⁴, that they are transmitted via a hidden curriculum and materially and symbolically legitimated by a medical *habitus* that reproduces gender inequality. This indicates the persistence of a hierarchical structure in medical schools and a traditional vision of education that uses punishment as a means of control and domination by means of asymmetric power relations in the entire educational process⁴⁵. Within this structure, students occupy a subordinate position and their mechanisms of resistance usually have a low impact on the weight their actions acquire in a highly hierarchically organized society. Although every act of resistance benefits the students by delegitimizing the power structure, there is a tendency to deny and negatively judge it⁴⁶, since, frequently, it worsens teachers’ violence against those who tend to challenge their power.

Although the presence of violence in medical schools and teaching hospitals is part of a social context that legitimates gender asymmetries, the practices thereat routinely reproduced are part of an academic culture, transmitted for generations, that reproduces perception, thinking and action forms that tend to maintain females and femininity in the undervalued space of non-power. Therefore, according to Castro⁴⁴, violence is the result of the configuration of a medical *habitus* that has been legitimized for

generations by means of an educational structure and academic culture where GV is part of the institutional logos that is transmitted since early years of student training and until the professional practice of medicine.

Medical schools also reproduce the hierarchical power relations between genders that become apparent in the form of GD and GV against females and males who fail to meet masculinity social standards. This violence endures openly as part of university institutional culture⁴⁷ and subsists in medical schools as an open rejection of some teachers who still consider that women should remain in the domestic space and look after the family or choose related careers.

The numeric increase of women in medical schools has not importantly improved their position thereat⁷, which can be attributed to the highly hierarchical and androcentric nature of the medical field. The violence and discrimination they experience is the consequence of the position of inferiority and subordination granted to females in gender regimens under the standard of male superiority over female and that permeates the medical field in the form of androcentrism, which institutes masculinity as the standard for all human activities and minimizes femininity^{48,49}.

Additionally, discrimination and rejection of homosexual MMS and FMS at these institutions is a reflection of the homophobia existing in society. Homophobia was originated when heterosexuality was established as the standard for "normal" in the 19th century⁵⁰, placing the difference as socially unacceptable. Acceptance of sexual diversity would be part of the solution for this problem.

SH exerted by some faculty and attending manly males, against FMS, is the result of an inequitable gender system, and not an individual act as often conceived⁴⁷. Sexual violence is considered to be a corporality device, the existence of which is driven by a strategic need to control female bodies⁵¹, and is perpetrated against women for the simple fact of being women for the simple fact of being who they are, because their perpetrators consider them deprived of the minimum right to freedom and respect. On its perpetration, there is also intervention of male subjectivity, which is socially structured within a gender order and driven men to desire and possess women at any cost, but that escapes from stakeholders' consciousness⁵². All this occurs within a context of hierarchical and asymmetric gender relations that make up socially vulnerable bodies "as a place of desire and physical vulnerability"⁵¹.

For this reason, male students receive more physical and verbal violence, as a result of male socialization where males learn to solve their conflicts by means of physical aggression. This makes it harder for males to

consider certain behaviors as being aggressive or violent, since they adjudicate them a customary or traditional conventional value. In turn, females perceive violence less because they conceive many of these acts as normal within their culture; these are socially legitimated behaviors that are not regarded as being wrong (symbolic violence). The lack of the victim's tolerance to violence is condemned rather than the aggression itself^{23,39}. It is necessary to be made visible the subjective factors that underpin this violence, as well as to transform the asymmetric power relations that place females and some males in a position of vulnerability.

Educational institutions' limited involvement in the generation of public and preventive policies to solve these problems and students' lack of trust to inform about mistreatment, probably originate in institutional tacit acceptance of discipline as being formative and necessary in education⁵³, as well as, the reproduction of gender regimens and female body and sexuality gender conceptions at these schools.

Conclusions

GV in medical schools constitutes a human rights, public health and academic problem for due to its effects on students' physical and mental health and its consequences on their academic trajectory, especially in female students, in whom sequels are deeper, more severe and long-lasting. Generating public policies that denature and make violence visible is indispensable, as well as modifying asymmetric gender relations in medical schools and teaching hospitals. It's very important to modify the significance of FMS body and sexuality and granting them the status of rights-bearing subjects is ineluctable. Creating specialized and reliable complaint centers that support students with effective solutions, ensuring confidentiality without fear of reprisals is required, as well as making the magnitude and importance of the problem visible. At the same time, policies addressing violence experienced by male students owing to their gender condition should be generated.

We hope this review allows for academic and health-care personnel to reflect and become aware of GV and other types of violence experienced by students at medical training, and to take measures to solve this problem.

Acknowledgements

The authors would like to thank Dr. Enrique Luis Graue Wiechers for reviewing this manuscript and for his valuable suggestions and comments. We also

thank Dr. Antonio Rafael Villa for his review of the manuscript, as well as Nelly Yared Alvarado León for her participation in the collection of data.

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