

Gender sensitivity in medical curricula

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Abstract

BOTH SEX — THE BIOLOGIC ASPECTS OF BEING FEMALE OR MALE — and gender — the cultural roles and meanings ascribed to each sex — are determinants of health. Medical education, research and practice have all suffered from a lack of attention to gender and a limited awareness of the effects of the sex-role stereotypes prevalent in our society. The Women's Health Interschool Curriculum Committee of Ontario has developed criteria for assessing the gender sensitivity of medical curricula. In this article, the effects of medicine's historical blindness to gender are explored, as are practical approaches to creating curricula whose content, language and process are gender-sensitive. Specific areas addressed include ensuring that women and men are equally represented, when appropriate, that men are not portrayed as the prototype of normal (and women as deviant), that language is inclusive and that women's health and illness are not limited to reproductive function. By eliminating or at least addressing the subtle and often unintentional gender stereotyping in lecture material, illustrations and problems used in problem-based learning, medical educators can undertake a much-needed transformation of curriculum.

Résumé

LES ASPECTS BIOLOGIQUES, LES RÔLES CULTURELS ET LES SENS ATTRIBUÉS À CHAQUE SEXE SONT des facteurs déterminants de la santé. L'éducation en médecine, la recherche et la pratique ont toutes souffert d'un manque d'attention accordée au rôle des sexes et d'une sensibilisation limitée aux effets des stéréotypes sexuels qui prévalent dans notre société. Le Women's Health Interschool Curriculum Committee de l'Ontario a établi des critères d'évaluation de la sensibilité spécifique aux sexes des programmes d'études en médecine. Dans cet article, on étudie les effets de la cécité historique de la médecine face aux spécificités des sexes, tout comme les méthodes pratiques d'établissement de programmes d'études dont le contenu, la terminologie et le processus tiennent compte des différences entre les sexes. On y aborde des aspects précis, notamment la façon d'assurer que les femmes et les hommes sont représentés également, le cas échéant, que les hommes ne sont pas décrits comme le prototype de la normalité (et les femmes, de la déviance), que les textes sont inclusifs et que la santé et les maladies des femmes ne sont pas limitées à la fonction de reproduction. En éliminant les stéréotypes sexuels subtils et souvent non intentionnels qu'on retrouve dans les documents de cours, les illustrations et les problèmes utilisés dans l'acquisition du savoir fondée sur la solution de problèmes, ou du moins en s'y attaquant, les éducateurs en médecine peuvent amorcer la transformation qui s'impose des programmes d'études.

The Women's Health Interschool Curriculum Committee of Ontario is a group of 15 to 25 faculty members, medical students, residents and community participants who share a particular interest in developing gender-sensitive medical curricula. Its goals and objectives for medical education about women's health emphasize awareness of the physical, behavioural and psychologic effects of the social phenomenon of gender. The committee has stated that the willingness to recognize and undo the permeation of gender stereotypes throughout much of medical pedagogy and practice requires:¹

- the ability to identify and give examples of gender assumptions in assessment, hypothesis generation, diagnosis, treatment and conceptualization of health and illness;



Education

Éducation

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- the use of gender-sensitive language and behaviour to minimize the negative impact of gender stereotypes;
- the ability to identify and respond effectively to communication patterns and styles that may reflect gender socialization; and
- the knowledge and skills to design research that is inclusive and that recognizes difference by including participants of both sexes and of different races, ages and other characteristics when relevant.²

The committee's goals and objectives provide a theoretic framework, rather than a template, for curriculum transformation. This article describes practical strategies for implementing objectives related to the gender sensitivity of medical curricula. Our work builds on an assessment of its medical curriculum conducted by the University of Ottawa Faculty of Health Sciences in 1995.

Presumably, most medical educators would refuse to use learning materials that discriminate overtly on the basis of sex, religion, race, sexual orientation or ability, or that show a complete lack of gender sensitivity. Our criteria address the more hidden, subtle and perhaps problematic aspects of gender issues. These examples of what is sometimes called "systemic discrimination" are often unintentional and often go unnoticed because they are built into prevailing norms, values and ideologies.³ Despite their subtlety, gender stereotypes can and do force both men and women into rigid roles that inhibit development, communication and well-being.

Why does gender matter?

In any culture there are behaviours, ways of interacting, values or activities that are seen as specific to 1 sex. "Gender" — both the real relations between the sexes and the cultural renderings of those relations⁴ — refers to the socially determined expectations of men and women and of their relationships. "Sex," by contrast, refers to the biologic aspects of being female or male. Both sex and gender are determinants of health and well-being as well as illness.

The history of medicine is predominantly about men and their health. In the past, medicine, and particularly medical research, has been "gender blind." Increasing awareness of gender issues in medical education, research and practice has resulted in a disproportionate focus on women. This focus is not meant to minimize the significance of gender on the health of men but rather to correct existing imbalances.

A wealth of literature documents the failure of traditional medical education to examine adequately the health needs of many groups, including women,⁵⁻⁷ aboriginal people, gay, lesbian and bisexual people,^{8,9} members of visible minorities,¹⁰ people with disabilities,¹¹ elderly people

and poor people. Instead, the research findings about the prototype — the white man — have been extrapolated, generalized and applied to others.^{12,13}

Gender awareness goes beyond recognizing differences in risk factors and responses to interventions.^{14,15} Men and women experience socially mediated problems, such as poverty or sexual abuse, differently, with different resulting effects on health. Certain diseases and conditions are unique to, more prevalent in or more serious among members of each sex. Women generally outlive men but appear to suffer more ill health and chronic illness than men. Stereotypes about men may have limited our understanding of their emotional needs and risk-taking behaviour and of the connection between gender and shortened life expectancy. The narrow confines of "male as normal" that have shaped research and practice exclude or "pathologize" (treat as abnormal) not only women but also anyone who fails to conform physically, psychologically, racially or sexually to the norm.

Gender sensitivity in the medical curriculum requires that the full scope of what it means to be male or female and the effects of that gender socialization are addressed, understood and, in some situations, challenged.

Content, language and process in medical education

We began by examining how information is conveyed in medical education and how each component of that information transfer — content, language and process — could be used to increase gender awareness rather than to reinforce stereotypes.

Content — the information conveyed in lectures, seminars, clinical encounters or individual teaching — must not imply that men are the norm but should instead be inclusive.¹⁶

Language should be examined to determine whether the words used to convey information subtly promote and maintain stereotypes about either sex or are emancipatory.¹⁷⁻²¹

Process refers to the meaning embedded in the delivery of the content. What is the "hidden curriculum" when examples about women are appended in parentheses, are always presented after those about men or are limited to reproductive issues?

The messenger's individual delivery style, subtle bias and choice of words or emphasis, although part of process, cannot be assessed solely by examining written curriculum. They are, however, central to the attitudes students absorb in medical school and to the creation of an inclusive learning environment. Although not addressed in this article, this unwritten curriculum should not be ignored.



Guidelines for assessing the gender sensitivity of curricula

Content

- In general, all written material used for lectures, problem-based learning and other teaching should be inclusive, with appropriate attention paid to both women and men. One summary of the areas of medical curriculum that require particular attention can be found in *Women's Health in the Curriculum*.²²
- Female and male patients should be represented in equal numbers in examples, problems and case studies.
- Bias or exclusion of women from the research on which information is based should always be explained, as should the limitations of findings.
- Differences in the normal anatomic, biochemical, microbiologic or physiologic characteristics between males and females or among races should be presented as such, with no one sex or group treated as the norm.
- Faculty members should avoid presenting first all female or all male patients as examples.
- Patients described in problems and presentations should reflect the diversity of race, class, ability, sexual orientation and other characteristics of people in Canada, and cases or problems should highlight the resulting diversity of presentations and causes of illness.
- Occupational and family roles of men and women should be highlighted equally. Sex-role stereotypes should be avoided. The variety of occupations and family types that exist in our society should be reflected in the information presented.
- Relationships between the sexes should be portrayed as equal when possible, although inequities that are prevalent in society can be included to provide opportunities for discussion and education.
- Any teaching about violence must be carefully thought out to avoid blaming the victim, to identify the perpetrator, to separate the violence from possible associations such as drunkenness, and to examine the roots, effects and prevention of violence. Society's responsibility for the perpetuation of violence should not be overlooked.
- Any illustrations used should present both women and men. If the anatomic or physiologic aspects being illustrated are common to both sexes, then illustrations should represent both sexes. If processes being illustrated are sex-specific, the illustrations should be labelled to indicate this (e.g., if an illustration is labelled generically as, for example, "normal adult abdomen," it should not include sex-specific terms or organs such as the testicular artery or the scrotum).

Language

- When the sex of a person is unknown or irrelevant, gender-neutral terms such as "s/he," "human" or "person" should be used.
- Sex-specific terms used generically, such as "mankind," should be avoided. Exclusive titles such as "chairman," "mailman," "freshman" and "clergyman" should be replaced with gender-inclusive terms.²³
- Sex-specific terms should be used when speaking of only 1 sex. (For example, "It is controversial whether *people* should have yearly Pap smears" should read "It is controversial whether *women* should have yearly Pap smears.")
- Women and men in parallel situations should be described with the use of parallel terms (e.g., if a man is referred to as Mr. X, then a woman should not be called by her first name, Miss, or Mrs.; the terms should be made parallel by referring to a man as Mr. and a woman as Ms., or by using first and last names for both).
- Terms that trivialize or stereotype women should be eliminated (e.g., "girl" or "lady" or suffixes such as "ess" and "ette," which belittle women's roles by making them sound smaller and less demanding).
- Sex-specific words should not be used in a demeaning or stereotyped way (e.g., the term "girlish appearance" should be replaced with relevant and appropriate details).
- When both sexes are mentioned together, 1 sex should not consistently precede the other.
- Discussion of the 2 sexes with the use of different grammatic modes should be avoided (e.g., "a 40-year-old professional man" but "a 23-year-old woman who works as a medical secretary"; in this case, the second example should be changed to "a 23-year-old medical secretary" to place equal emphasis on each person's occupation).

Process

- Overall, women and men should be equally represented in teaching about illnesses or treatments when the diagnosis applies to either sex. If women are represented as patients in cases or problems only when the diagnosis relates to female genitalia, the implication is that women's health is limited to breasts and the reproductive system. Faculty members can enrich learning opportunities by changing the sex of the patient and "replaying" problems when the diagnosis is not sex-specific.
- Teachers should beware of implying that the process of decision-making is determined by gender rather



than by the range of a person's characteristics. For example, if a male patient considered in problem-based learning refuses a particular treatment, whereas his female counterpart accepts it without question, this may reinforce stereotypes that women as a group, rather than some people, are passive and unquestioning.

- The social, economic and emotional components of health and illness should be integrated into all teaching settings and materials. Teachers should be careful not to overemphasize the psychologic status of female patients or underemphasize that of male patients.
- Teachers should be aware of the subtle shift from epidemiologic evidence to stereotyping. Although some diseases are more prevalent among particular groups, curriculum must not imply that all members of that group, sex, class or race have the disease in question. (For example, if the patient in a presentation on HIV is gay, can the presenter avoid implying that all men with HIV infection are gay, that all gay men have HIV infection or that HIV infection is the first diagnosis to consider when a gay man is ill?)
- When describing women or men, teachers should include family roles equally. This can have the effect of "role breaking" and can help to undo the stereotype that women are defined primarily by their relationships whereas men are defined by their work.
- Teachers should ensure that details of marital status, occupation and appearance are documented in parallel ways for men and women. Referring to the marital or parental status of women only (e.g., "a 29-year-old single woman" v. "a 36-year-old man") is inconsistent. If this information is relevant, it must be relevant for both men and women.
- Teachers should beware of reinforcing limited and stereotyped responses in scenarios rather than allowing women and men to express a wide range of emotions.
- Teachers should avoid implying that male presentations of an illness are the norm and that women with the same illness present differently. Instead, symptoms and signs specific to each sex should be discussed.

Transforming medical curricula

The formal curriculum of any medical school is only one of the sources of information that shapes students' learning. We hope that the committee guidelines will assist in development of gender-sensitive materials for use in lectures, seminars and problem-based learning. The criteria may also assist educators in reflecting on the unintended and unspoken messages conveyed by the process, manner and tone of their teaching and interactions. Faculty members who provide role models for gender sensitivity deliver an important and powerful message to their students.

Canadian medical schools are at varying phases in the process of curriculum transformation. Many have recognized that a special emphasis on women and their health is a required component of a balanced, inclusive education. This focus allows female physicians and patients to gain a place of their own in the content and process of education and research. Ultimately, the development of new and innovative medical school curricula will provide an opportunity to examine the full range of determinants of health for both sexes.²⁴ Multidisciplinary contributions to health from sociology, psychology, economics and other related fields will facilitate this development. Working toward a more inclusive and holistic understanding of and approach to health and illness will improve the well-being of both women and men.

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