Medical students' attitudes toward women: Are medical schools microcosms of society?

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See related article page 357

Since the mid-1990s almost equal numbers of men and women have graduated from Canadian medical schools. This fact is but one example of the dramatic changes in the opportunities available to women that have occurred over the past century. These changes reflect and are the result of our altered expectations of men and women. Thus, it is not surprising that Drs. Susan Phillips and Karen Ferguson show considerable congruence in the way medical students perceive men and women now or that male and female students hold similar sex-role perceptions (page 357).[1] Rather, these findings support the view that the social roles of men and women are evolving and that our medical schools are indeed microcosms of the broader society.

We tend to forget how rapidly this social change has occurred. At the beginning of this century women were viewed as "property." The status of women as "persons" under the law and their right to vote have been granted relatively recently. It was in the late 1960s that the term "sexism" (discrimination on the basis of sex or gender) came into use, as women recognized that the subtle and systematic discrimination they faced was similar in its effects to the racism experienced by people of colour. However, we should not blame social stereotypes for sexism. They themselves are not the problem and can in fact be useful in initial interactions. (We all have opening gambits for a conversation with a retired person, a young athlete or a small child that are based on our expectations.) Sexism occurs when our expectations (stereotypical thinking) around sex and gender are erroneous, are maintained in the face of disconfirming evidence and are used to limit opportunity.

We readily recognize blatant sexism, but subtler forms are more insidious. Until this century, women were overtly characterized as inferior, an idea that had prevailed in Western societies since the writings of Aristotle and that was supported by "evidence."[2] A few centuries ago, a widely held truth was that the smaller head size of women confirmed their inferiority. When it was discovered that women's heads were proportionally larger in relation to their bodies than men's heads were, the evidence was used to suggest that women were more childlike.[3] Although we can chuckle now about the way anatomical science was used to support beliefs about women's inferiority and to limit their roles in society, current manifestations of sexism are less easily recognized.

Until recently, sexism in medicine went largely unchallenged. It was found in the way physicians were educated and was pervasive in the textbooks and clinical examples used.[4,5] An unspoken quota was used to limit the number of women admitted to medical schools. Our awareness of the way medicine was built around a masculine prototype is a recent phenomenon[5] and has affected patients as well as physicians. It has taken considerable time for us to recognize that many of the apparent differences in the prevalence of heart disease between men and women may be due to bias in the way physicians and our health care system think of women.[6] Our awareness of the limits to which the results of medical research, which has predominantly used male subjects, can be generalized is also recent.[7,8]

What can Phillips and Ferguson's study teach us? The authors surveyed Queen's University class of 1998 when they entered medical school in 1994 and at the beginning of their final year, 3 years later, to determine whether there were any changes in their stereotyping of sex roles, their willingness to control the decision-making of female patients and their conceptualization of men, women and adults. Although there are no direct comparative data from the past, the extent of the similarity in the perceptions about men and women of first-year male and female medical students is striking in contrast to earlier studies in the 1970s that Phillips and Ferguson cite. Less stereotypical thinking (or rather a new stereotype) regarding the sex of patients is seen at the beginning of medical school. A cross-sectional survey of a comparison group of medical students at 2 other Ontario schools confirms this finding. Further, it is satisfying to see that medical education, traditionally a socially conservative influence,[9] did not re-

verse this attitudinal trend, but rather seemed to enhance it. Students in their final year of medical school became slightly less accepting of old sex-role stereotypes and were more open to seeing women as equally vulnerable to diseases that are not gender specific. They were less likely to be paternalistic toward female patients and more willing to acknowledge patient autonomy.

If such attitudinal changes can survive after these students begin practising medicine and can be generalized, the next generation of physicians will probably behave somewhat differently. They will be more inclined to form true partnerships with patients, to listen carefully and understand the context in which their patients' symptoms arose and to share the decision-making process with their patients. They will be more attuned to the role that sexism has played and may still play in the health care system. They will be more open to disease-specific gender differences in clinical presentation, accuracy of diagnostic tools, physiology and responsiveness to treatment (e.g., as seen in cardiovascular disease).[10]

Unfortunately the relative contribution of various factors to the attitudinal shifts observed by Phillips and Ferguson is not apparent. Although it is tempting to assign importance to recent medical school curricular changes, which have increased the focus on social, environmental, family and psychological concerns,[11] these less stereotypical attitudes about men and women were observed when the students entered medical school. Social changes outside of medicine may have played a major role. Although recent curricular changes may be important to maintaining and strengthening new attitudes, the more equal presence of male and female students may also contribute. The possible influence of postgraduate education, which can be as long as basic medical education, on these young physicians' perceptions has not been studied. We have little appreciation of the extent to which different kinds of postgraduate experiences reinforce or change previous attitudes.

Although we can be pleased with the progress made, there is no room for complacency if we hope to create a society in which sexism in no longer a force. Much remains to be done. It is disheartening that Phillips and Ferguson found that both male and female medical students still equate adulthood more closely with maleness. This suggests that sexism has not been eliminated. We need to continue to examine the "facts" we hold true about men and women and their outlooks, preferences and behaviours. By questioning our assumptions and being open to new information we can help eliminate sexism in medicine.

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