Perspective

Breaking the mould: Redefining gender in medical education in India

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Abstract

The role of gender as a social determinant of health is widely studied and accepted in global and national contexts alike. A key area of concern has been the inadequate and inaccurate representation of gender in contemporary medicine. Collective reviews of popular undergraduate medical textbooks in India have deemed the content as, at best, gender-blind and, at worst, gender-biased. Yet, large-scale change towards engendering medical education is still awaited. This article attempts to rationalize the need for gender-sensitivity in medical education, particularly highlighting the bane of an improper understanding of gender. It elaborates the merits of integrating gender in medical education, as seen through an initiative in medical colleges of Maharashtra. Finally, the article submits that gender-integration is an important first step among many which can guide an intersectional approach to practising medicine in India, and encourage ground-level change, as the country strives to achieve universal health coverage.

Keywords: Gender; India; Medical education; Sex; Social determinants of health; Transgender.

Introduction

Every third-year undergraduate medical student in India attends a course on Forensic Medicine and Toxicology (FMT). FMT deals with the application of medical knowledge to the processes of law, and professionals from both fields assist the court in arriving at the 'truth'.[1] However, while appearing to be neutral in such scenarios, both the law and FMT have been critiqued for reflecting society's gender biases and pre-existing notions when searching for the 'truth'.

Take sex verification tests. In this FMT lesson, students are trained to recognise the physiological and biological markers used for the classification of people into a 'male' or 'female' binary, so they can successfully 'verify' those who fall out of it.[2] In another lecture, they learn about 'virginity testing' where the presence of a

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hymen is predominantly considered to be proof of virginity and, by extension, a rape survivor's chastity and morality, assuming that any woman who is sexually active must have engaged in consensual sex.[3] The problem with both these tests is that they lack scientific bases and are biased against women and girls. Moreover, a systematic review found that hymen examination does not accurately or reliably predict virginity status and on the contrary, could cause physical, psychological, and social harms to the examinee.[4]

These are two among several examples which raise concerns about gender-insensitive and gender-biased content in medical education (ME) in India.[5-7] This article attempts to shed light on the role of undergraduate ME in shaping these biases and how they can be addressed in the existing curriculum to improve health.

A Foundational Fallacy

The medical curriculum largely posits 'sex' as the anatomical and genotypical distinction between the binaries of male and female. This classification of human bodies does not accommodate variations in anatomy, such as persons with difference in sex development (DSD). Persons with DSD were previously considered to be 'inter-sex' or 'between the sexes'.[8] The binary classification also fails to recognise the power relations between men, women, and transgender persons that affect their health status and access to health services. Transgender people are those whose gender identity is different from the gender they were thought to be at birth. "Trans" is often used as shorthand for transgender.[9] 'Sex' is often conflated with 'gender', a social construction of the performative roles of people based on their biological sex. This social construction pervades the experience of physical illness and is a determinant of the health care offered by doctors.

For instance, the perception of anginal symptoms is an important survival mechanism in patients with acute coronary syndrome (ACS), alerting to the need for urgent medical care.[10] Descriptions of pain and associated symptoms among men and women may vary, demonstrating sex differences in the pathophysiology of ACS and gender variations in reporting. While chest pain has been found to be the most common symptom in both men and women, absence of chest pain or discomfort as a symptom of ACS was more common among women.[10] So, failure to accommodate this difference when teaching differential diagnoses, taking the human male as the norm, puts women at risk of non-recognition of a serious heart ailment. This illustrates that the presentation of women's health concerns does not always differ because of their 'biological make-up' but, instead, is a manifestation of gender-based variations.

Gender – a Social Determinant of Health

Gender, as envisioned by feminist scholars, alludes to systems of hegemonic power hierarchies built upon social, demographic, and commercial differences.[11] In feminist language, gender is a deep-seated social determinant of health (SDH) and well-being, problematised by its conceptualisation as a binary of men and women. The binary is exclusionary of transgender communities and gender non-conforming persons and is a barrier to their access to health care, even after the Supreme Court of India identified a third gender. For this reason, gender-transformative theory advocates a bottom-up approach to change the structural understanding of health issues, as seen through a non-binary lens of gender, by working with communities on the ground.

Exemplary of this approach is an initiative to integrate Gender in Medical Education (GME) in government medical colleges of Maharashtra. Implemented by Centre for Enquiry into Health and Allied Themes (CEHAT), in collaboration with the

Directorate of Medical Education and Research (DMER) and Maharashtra University of Health Sciences (MUHS), GME worked closely with medical educators from seven colleges across Maharashtra and trained them to identify gaps in their disciplines from a gender-lens.[12] It culminated in the development of modules for five disciplines (Medicine, Community Medicine, FMT, Obstetrics and Gynecology, and Psychiatry) consisting of 83 gender-integrated medical lectures and three additional lectures on gender implications for women's health.

The modules incrementally address gender-biased text and teaching in ME and offer an alternative method of imparting the same curriculum as prescribed by the DMER and MUHS. In a formative lecture on sex and gender, it distinguishes the two and moves to expanding biological sex from its current binary definition to include persons with DSD – congenital conditions in which the development of chromosomal, gonadal or anatomical sex is atypical, and could comprise a wide set of metabolic and anatomic variants that often can result in atypical genital appearance.[8] This may lead to emotional and psychological distress if not sensitively addressed by health care providers. The binary understanding of gender is also challenged to draw attention to the health concerns of transgender persons. Treatment areas like non-communicable diseases and contraceptive needs, which are seldom practised from a gender lens, are unpacked to identify areas of difference between men, women, and transgender persons.

Conclusion: An Intersectional Approach to Medicine

The purpose of redefining gender in ME is to facilitate the mitigation of health inequity which arises due to gender inequality. But there is also interaction between gender and other social power hierarchies that accompany class, caste, religion, ethnicity, disability, and sexual orientation. Health inequity is experienced on a gradient and will not be comparable between different groups of people, such as a poor, upper-caste man and a Dalit, homosexual woman. Traditionally, ME in India does not foray into understanding sexuality, a reality which is evident from doctors' discussion on safe sexual practices with only married women. The inclusion of intersectional factors in ME is needed, beyond its current effort to position medical humanities through AETCOM (attitude, ethics and communication). Although a progressive step, AETCOM needs to acknowledge the diversity among patients and how their lived realities affect their health.[13] A concerted effort is required to integrate gender and its interactions with other determinants at a national level to mould how doctors view health problems, thereby promoting community well-being and furthering universal health coverage.

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