

Perceptions of female medical students on gender equality gains at a local university

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Introduction

Gender bias has been entrenched in healthcare education, research and clinical practice.¹ In a review paper addressing gender bias in medicine, Wong stresses why this should receive attention when medical curricula are constructed. He highlights that gender inequities are still apparent in health, as much of the current medical knowledge is based on the 'male norm'. This bias within healthcare and the medical educational system has been reiterated by many within and outside of the profession. A recent study done in the United States² found that simply increasing the number of female students recruited for health education has not eliminated either gender bias present in the curriculum or the discrimination against women whilst participating in medical education.

In 2002 the World Health Organization adopted a gender policy committing itself to promoting gender equality and equity in health and to redressing health inequities that are a consequence of gender roles and unequal gender-relations in society.³ Key to achieving this goal is to make gender considerations an integral part of the pre-service training curricula of health professionals. Some of the major challenges of such initiatives include institutional resistance and difficulties in involving key faculty and, in particular, male colleagues in this process. In order to understand the integration needed, it is important to understand the working definitions of gender inequality and gender discrimination. *Gender inequality* refers to disparity between individuals due to gender. *Sexism*, also known as *gender discrimination* or *sex discrimination*, is the discrimination against a person (usually female) in opportunity or employment based on their sex.⁴

Up to the early 1980s a South African woman could not open a bank account without the permission of her husband or father. Only in the 1990s with the acceptance of the Bill of Rights did women receive formal recognition that they were viewed as equal citizens under Section 9 of the Constitution.⁵ Previous laws condoned prejudice in various ways: White women were not allowed to contribute to the working force in all business areas under the old common law. Black women were viewed as minors under previously applied customary laws and that excluded them from the right to own property or the rights to their children as legal guardians. Because of their *race and gender* black women were doubly discriminated against.⁶ The male-dominated history of the medical profession kept South African women from pursuing a medical career until early in the previous century. In 1947 Mary Susan Malahlele-Xakana became the first black woman to register as a medical doctor in South Africa.⁷ Since 1994, education policy-making in South Africa has focused on the transformation of education to improve access, quality, equity and redress for learners in line with the principles enshrined in the Constitution. A recent editorial in the *SAMJ*⁸ stated that although there has been a feminisation of the profession in recent years, equity remains elusive: women have not populated the specialisation fields or attained leadership positions in line with the current statistics on females in the profession.

The research field was a previously disadvantaged university, with mostly black students. The hope was that the data generated would reflect on and contrast the inequalities known to exist in wider society with the previous marginalisation of people-groups not only based on gender, but also on race. Building on previous international research, the aim of the study was to contribute to the understanding of women's experiences on gender discrimination and inequality while participating as learners in health education. The research question was whether the medical educational system could be perpetuating the inequalities or contributing to the restoration of the disparities known to exist.

Methodology

The study included all fourth-year female medical students at a university in South Africa. All female fourth-year medical students ($N=72$) who were willing to participate in the study were included. The cohort of students identified consisted primarily (92%) of students who were of African origin. A quantitative approach consisting of an observational, descriptive study design was applied. Data were collected by means of self-administered questionnaires. Each question consisted of a 'yes' or 'no' answer box, with the option to comment or elaborate on the answer. Face and content validity of the questions were accounted for by means of a literature review as well as review of the questionnaire by more than one peer as well as a bio-statistician.

Informed consent was obtained from all participants. Permission for the study was also granted and ethical clearance obtained from the Medunsa Research Ethics Committee and the School of Medicine. Consenting students completed the questionnaires after a series of four ethics lectures, of which the last two learning sessions focussed on equality, equity and vulnerable groups. After completion of the questionnaire, students were asked to put it in a box stationed at the front of the class. The statistical analysis was of a descriptive nature, where the responses in the different categories were summarised by frequency counts and percentages. The analysis of the open-ended questions was by means of describing and coding the data according to identified themes. Coding was done through an inductive, open process.

Results

Of the total number of questionnaires distributed, 48/72 fourth-year female medical students responded, yielding a response rate of 68%. Of the respondents, 32% reported having the perception that they were not taken seriously by their patients because they were female. In addition, 24% reported that they were not taken seriously by their male peers. However, it was reported by 94% that their learning facilitators took them seriously as women in the medical profession.

Short Report

Table I. Themes, categories and respondent responses

Theme	Category	Respondents' experience	Quote
Educational experience	Patient's response	Participants noted that patients would call them nurse or sister, while calling their male colleague doctor	<i>I would not make it in this profession because I am soft, emotionally weak and too sympathetic</i>
	Peer response	Participants responded that they were viewed as weak, inferior to men and not able to lead a group	
Hierarchy in medical training	Role models preference	The obstetrician preferred a male assistant	<i>I was asked to step down from assisting a caesarean section</i>
Responsibilities	Family responsibility	Women working in the department often had dual loyalties	<i>As women we could not equally share the burden of work expected from a registrar</i>
Sexual harassment	Power relationships	Comments and suggestions of a sexual nature	

Although a large majority (83%) of the respondent did not feel that they were discriminated against while in training, approximately 17% reported feeling discriminated against. In addition, 51% felt that 'there was a difference in how we are viewed as professional due to our gender'. The majority of the respondents (93%) felt that men and women are equals as healthcare professionals.

The author identified the four main themes from the open-ended responses, and this is presented in Table I.

Discussion

At the start of the millennium the World Health Organization adopted a gender policy that committed itself to promote gender equity and equality by implementing gender considerations into the curricula of health professionals' education.⁹ Although this was implemented into a programme at the above university, the gender bias is still evident. Policy alone cannot enforce change against the subtler tones of discrimination, but it should be lived by those in the medical profession on a continuous basis. Each professional contributes to a society that not only allows women equal opportunities, but views women as deserving of those opportunities. Curricular changes addressing gender inequality should be adopted on a broader curricular level to have significant impact and address the subtler tones of gender discrimination experienced in health education.

Conclusions

The findings indicate the necessity for additional support for women in medicine as well as addressing the gender role assumptions evident in the educational experience through curriculum reform.

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References

1. Wong YL. Gender Competencies in the medical curriculum: Addressing gender bias in medicine. *Asia-Pacific J Public Health* 2009;21:359. <http://aph.sagepub.com/content/21/4/359> (accessed May 2011).
2. Butler KM, Mason J. Does Gender Still Matter?: Women Physicians' Self-Reported Medical Education Experiences. *Student Summer Scholars*. 2010. Paper 45:1-2. <http://scholarworks.gvsu.edu/sss/45> (accessed May 2011).
3. The Constitutional Court of South Africa. <http://www.constitutionalcourt.org.za/text/rights/know/women.html> (accessed May 2010).
4. Oxford Dictionaries Online. <http://oxforddictionaries.com/definition/sex+discrimination> (accessed Sept 2011).
5. South African History Online. Biography: Mary Susan Malahle-Xakane. <http://www.sahistory.org.za/pages/people/bios/xakana-m.htm> (accessed Jan 2011).
6. World Health Organization. Integrating gender into the curricula for health professionals. Department of Gender, Women and Health (GWH). Meeting report: 4-6 December 2006:1.
7. Kleintjes S. Gender equity in South African education: 1994-2004: Conference proceedings. HSRC publication: L Christolm, J September. 2006:29.
8. Neayiyana DJ. Feminisation of the South African medical profession – not yet nirvana for gender equity. *S Afr Med J* 2011;101:5.
9. Science Museum. Women in medicine brought to life: Exploring the history of medicine. <http://www.sciencemuseum.org.uk/broughttolife/themes/practisingmedicine/women> (accessed Jan 2011).
10. World Health Organization. Integrating gender into the curricula for health professionals. Department of Gender, Women and Health (GWH). Meeting report: 4-6 December 2006.