Sexual equality, discrimination and harassment in medicine: it's time to act

More enlightened teaching would go a long way towards solving these problems

Among entrants to Australian medical schools, women slightly outnumber men. Of a total of 14 384 domestic medical students enrolled in medicine in 2014, (51.3%) were women.[1] By the time these women complete their training, significant gender imbalances will emerge in their fields of practice, with palliative medicine and sexual health being the only specialties with more women than men.

Redressing sexual inequalities in medicine will require more than increasing the numbers of women in male-dominated specialties; the changing roles of the sexes in society, learning styles, hospital-based training and the professional identities of women in a largely masculine medical hierarchy are all deeply relevant.

A 2015 United States study of women's perceptions of discrimination during surgical training and practice found that most observed or experienced gender-based discrimination during medical school (87%), residency (88%) and practice (91%).[2] These results suggest that bullying and discrimination are rife, and complaint mechanisms inadequate. Studies of women in North America show they experience greater levels of abuse than men, and that the high prevalence of harassment and discrimination has not diminished over time.[3-5] A 2014 systematic review and meta-analysis of harassment and discrimination in medical training showed that verbal harassment was the most common type of abuse and that physical abuse was the least common.[3] Abuse (verbal, physical, sexual, harassment, sex discrimination) affects performance and leads to stress and discomfort,[4-6] which in turn affects how supervisors and teachers view particular students. Women in all stages of medical training have been subjected to harassment and discrimination — beginning as early as medical school. No area is untouched.

Medical school

Medical students, eager to assume a professional identity, absorb the medical culture. Many argue that this is necessary for success, but enculturation can lead students to believing that progression in medicine requires them to accept the status quo.[5] Students quickly learn that conformity and complacency are crucial components of learning and professional advancement;[7] complaining is not an option. An Australian study pointed out that a reluctance to report bad behaviour might relate to the legalistic framework for managing complaints, particularly immediate notification of the complaint to the perpetrator and identification and subsequent vilification of the whistleblower.[8]

"Students quickly learn that conformity and complacency are crucial components of learning and professional advancement"

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In 2007, American medical students observed that unprofessional medical educators, who were protected by an established hierarchy of academic authority, did more to harm students' virtue, confidence and ethics than was acknowledged.[9] They said that students struggle to understand the disconnection between the explicit professional values they are taught and the implicit values of the hidden curriculum.[9] A 2012 US longitudinal study of third-year female medical students showed that gender would play a substantial role in their future careers, and that inappropriate gendered behaviour was inevitable in medical training generally.[3]

Trainees

Clinical training in hospitals involves working in a hierarchical team structure headed by a consultant, with the least experienced intern at the bottom. This crucial phase — a time when the dynamics of hierarchy and interpersonal relationships enhance or impair learning — can influence career choices.[4] Good supervisors can have positive influences on career choices; conversely, bad ones can quickly diminish aspirations. A 2005 US study of 4308 respondents (medical students, surgical residents, fellows and fully trained surgeons; 76% male) showed that men and women had similar reasons for choosing surgery, but for women, a significant factor was their positive clerkship (training) experience and availability of female role models.[10] Women were less likely to agree that their surgical training experiences were comparable to those of their male peers.[10] A 2012 Australian study of doctors' preferences for choice of specialty reported that life balance and capacity

to provide continuity of care with opportunities for academic or procedural work were highly influential.[11] This study did not break down its findings for men and women, but 61.5% of respondents were women. The study concluded that doctors prefer fewer hours of work, control of their working hours, low level on-call responsibilities, academic opportunities and significant procedural work.[11]

Surgery

In March this year, the Royal Australasian College of Surgeons established an Expert Advisory Panel to examine its culture after complaints of bullying and harassment of female surgical trainees reached the media. Surgery is popular among medical students, but their enthusiasm diminishes significantly for both sexes, particularly for women, by the time they need to decide on a specialty. Reasons include the heavy workload and a desire to have children.[12] Once they become surgeons, women are more positive about their career choice than female medical students contemplating such a career.[13] A 2014 literature review on gender-based differences in surgical training found that the lack of role models and gender awareness were responsible for the low numbers of women training in surgery. Women were unlikely to meet a female surgical role model during their training, and were more likely to experience gender-based discrimination during their surgical rotation ($P < 0.05$), leaving them with a perception that surgery was incompatible with a rewarding family life, happy marriage, or having children.[12]

Only 10% of surgeons in Australia (539/5507) are female. The Box shows a breakdown of Australian medical practitioners by specialty and sex. Less than 3% of female doctors are surgeons and less than 1% of all doctors are female surgeons. Among surgical specialties, women are most highly represented in paediatric surgery (29%) and least highly represented in orthopaedic surgery (3%) (Appendix).

Role strain, harassment, career penalties associated with maternity leave, and gender-based pay differentials are common challenges faced by women in many workplaces. However, in medicine generally, and in surgery in particular, there is an additional constraint. The main difference from medical school learning is that service provision is a significant component of the learning contract between the trainee and the employer. While trainees are required to focus on both learning and providing a service, the hospital is focused on patient care. A Canadian study describes sexual stereotyping that classifies females as being concerned about the welfare of others and being motivated by stronger needs for nurturance, in contrast with males who are classified as striving to master, dominate and control the self and the environment.[14] In hospitals, these attributes may lead women to prioritise patient safety ahead of their own learning needs.

US studies show that, while female medical students perform equally well on objective assessments, they consistently report less confidence in their abilities, and experience significantly more anxiety about their performance.[15] When making the transition to the workplace, female doctors, who are often more cautious, will worry about their inexperience, while many male doctors (with the same experience) will emphasise their skills and present as being ready for the clinical challenge. A supervisor responsible for patient care is likely to select the more confident trainee because of their work schedule and their assumptions (founded or unfounded) about trainees' competence. Hesitating and underconfident women miss out on opportunities because of their fear of not being good enough. This is particularly the case in procedural medicine.

All of this means that women gain experience at a slower rate than men; at the same time, the culture of "can do" prejudices them against specialties

Medical practitioners registered in Australia at 28 February 2015 by specialty, and proportions by sex

		Proportion	
Specialty	Total number	Female	Male
Addiction medicine	165	24%	76%
Anaesthesia	4 579	28%	72%
Dermatology	504	44%	56%
Emergency medicine	1 649	32%	68%
General practice	23 759	40%	60%
Intensive care medicine	808	16%	84%
Medical administration	329	32%	68%
Obstetrics and gynaecology	1 834	40%	60%
Occupational and environmental medicine	301	17%	83%
Ophthalmology	951	20%	80%
Paediatrics and child health	2 408	46%	54%
Pain medicine	251	22%	78%
Palliative medicine	293	55%	45%
Pathology	1 985	39%	61%
Physician	9 325	27%	73%
Psychiatry	3 385	38%	62%
Public health medicine	432	39%	61%
Radiation oncology	361	40%	60%
Radiology	2 255	24%	76%
Rehabilitation medicine	468	42%	58%
Sexual health medicine	116	55%	45%
Sport and exercise medicine	119	22%	78%
Surgery	5 507	10%	90%
Total	**61 784**	**33%**	**67%**

Source: Australian Health Practitioner Regulation Agency's Public Register of Medical Practitioners. ◆

such as surgery. Surgery, with its roots in the male apprenticeship model, may underappreciate female learning styles, which can lead supervisors to think female trainees lack commitment or are not cut out for the job, leading to women being belittled, excluded and bypassed on the basis of incorrect assumptions about skills and knowledge. A Finnish study found that male medical students were exposed to and performed surgical procedures significantly more often than female students.[16] This is where women may be at a disadvantage — their learning approaches and styles may not be as suited to the opportunistic supervision learning method used in hospitals that requires an assertive personality and a "can do" attitude that are not necessarily the best for patient care, but are best for progress in specialty training.

What can we do?

We need to heed the prevailing belief held by students that the medical culture is resolute. Governance structures for complaints about the behaviour of teachers should be transparent and accessible to medical students. Token attention to grievance processes without removing teachers who behave badly reinforces the belief that nothing can or should change. Targeted education is required, with accountable and transparent processes in place to ensure that zero tolerance of harassment and bullying is the norm.

Surgery is one area where the experience of women is well documented and consistently found wanting. If the surgical culture were reformed to accommodate gender differences in training, it may become a template for other areas of medicine. Recent research shows there is a generational shift among both men and women in relation to the balance between personal and professional lives, with participants saying that their priorities are radically different from those of their senior colleagues.[17] Given the increasing role played by women in medicine, it is time to reflect on the models underpinning specialty training and to look to methods shown to enhance learning for both sexes. Nurturing female surgeons to become clinical supervisors and encouraging female surgeons to teach and be involved in mentoring programs would help.

College policies and guidelines about harassment and discrimination alone will not change the culture — these must be accompanied by swift and strong action by college representatives when instances are brought to their attention. That men and women have inherently different characteristics and learning styles is now well established; the next step is to explicitly acknowledge these differences in the design of medical education. A failure to do this will maintain the status quo and perpetuate discrimination against women in medical training. Allowing a supervisor who is known to be sexist or discriminatory to teach brings into question the sincerity of a college in dealing with bad behaviour. Colleges need to have zero tolerance for harassment and discrimination.

Acknowledging the powerful influence of supervisors on learning outcomes for trainees is crucial. In addition to excellent knowledge in their disciplines, clinical supervisors need to have knowledge and skills in the areas of teaching methods, different learning styles, ethics, patient safety and sexual stereotyping. Being a senior doctor is not a qualification for teaching in itself, and the assumption that it is exposes medical education to the risk of nothing changing. Clinical supervisors need to be accredited. Accredited supervisors can reinforce the potential of all trainees rather than acting as a de-facto barrier to women's entry into male-dominated specialties.

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