INCREASING RIGOUR IN MEDICAL EDUCATION:

A SYMPOSIUM ON TEACHING ABOUT GENDER IN MEDICINE

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2002
Report to the Rural Undergraduate Support and Coordination (RUSC) Program on
The ‘Teaching about Gendered Medicine’ Symposium

Held on the 19th April 2001, Sydney, Australia.

Key words: gender analysis, medical education, women doctors, gendered medicine, gender and medicine, construction of knowledge
International participants including senior clinicians and academics, practitioners and students from 9 different countries gathered at the ‘Teaching about Gendered Medicine’ Symposium held in the 19th of April, 2001. The Symposium, funded by the Australian Department of Health and Ageing, Rural Undergraduate Support and Coordination (RUSC) Program, was a satellite meeting of the Medical Women’s International Association’s (MWIA) XXV International Congress, held in Sydney, Australia from the 19th-23rd of April, 2001.

The aim of the Symposium was to define the current status of Gender teaching in medical education from the perspective of the teachers and the taught, and in so doing to provide recommendations to the MWIA as to how to further develop the discipline of Gendered Medicine.

The Recommendations evolved through presentations, discussion and the sharing of experience. The essence of those Recommendations was that national governments, the World Health Organisation, non-government organisations and universities globally support and implement the introduction of teaching about Gendered Medicine into all undergraduate and post-graduate medical education. The Recommendations were presented to the MWIA and resulted in the development of two Resolutions from that Conference, that encourage greater equity, resources and leadership roles for medical women, and the inclusion of a gender perspective in health education and medical research.
EXECUTIVE SUMMARY

In association with the International Congress of the Medical Women’s International Association (MWIA), a one-day Satellite Symposium on Teaching about Gendered Medicine was held on Thursday 19th April 2001, Hilton Hotel, Sydney, Australia. The Symposium was funded by the Australian Department of Health and Ageing, Rural Undergraduate Support and Coordination (RUSC) Program as part of an integrated programme to encourage female doctors into rural medicine. It focussed on strategies for introducing curriculum to teach medical students about gender issues in relation to the medical curriculum, medical research, the medical profession, and the experience of women and men as doctors.

International participants attended, ranging from the ground breakers from privileged countries, to women from the developing world who have the courage to push for change in one of the most valued professions world wide. Expertise was in medical sciences, curriculum, gender issues and education. International participants included Dr Shelley Ross, incoming MWIA president from Canada; Professor Elisabeth Hultcrantz (Otori hnolaryngologist) and Associate Professor Carin Muhr (Neuroendocrinologist) came from Sweden; Professor Kumiko Eiguchi (Biochemist and Immunologist) from Argentina and Dr Astrid Buhren (Germany) and nine other members of the MWIA Executive. From Australia leading participants were Dr Deb Colville (surgeon), Professor Bryanne Barnett (psychiatrist), Associate Professor Dimity Pond (General Practice), Associate Professor Carolyn Quadrio, (Director of Mental Health Services) and Associate Professor Merilyn Liddell (Acting Head of General Practice) Monash University. The Symposium was developed and led by Ms Jo Wainer and Dr Lexia Bryant from the Monash University School of Rural Health.

The Symposium sought to:

1. Make Recommendations to the International Congress of the Medical Women’s International Association to support the introduction of teaching a Gender Perspective in all medical curricula internationally.
2. Begin to establish the discipline of Gendered Medicine.
3. Establish core content.
4. Develop some common language.
5. Validate and build on the work already done.

Recommendations were developed by Symposium participants and finalised by a Recommendations Committee, consisting of Associate Professor Carin Muhr (Sweden, surgeon), Dr Lexia Bryant (Monash, family practice), Professor Elisabeth Hultcrantz (Sweden, surgeon), Dr Deb Colville (Australia, surgeon), Ms Jo Wainer (Monash, social scientist). The Symposium recommended that:

1. National governments, the World Health Organisation, non-government organisations and universities support and implement the introduction of teaching about Gendered Medicine into all undergraduate and postgraduate health education.
2. Accreditation, evaluation and quality improvement in all medicine and health sciences courses will address the following issues:
   - knowledge domains including attitudinal and emotional ways of knowing
   - the provision of time for reflection
   - the provision of safe and respectful learning environments
   - the incorporation of ongoing constructive feedback
   - the facilitation of personalised relationships between teacher and student as a model for the doctor/patient relationship
3. Competence and leadership in medicine includes:
   - interpersonal skills
   - egalitarian engagement
   - intuitive understanding through knowledge domains including experience and empathy
• communication approaches which bring emotion into our consultations
• the life experiences of women and how these augment our profession

4. Implementation of these recommendations will include the following actions:
• medical women consciously mentor undergraduates and junior medical officers
• funding be provided to develop sustainable models of co-operative health care delivery, incorporating multidisciplinary teams
• funding be provided to develop programmes to support women as teachers and educators in medicine and health sciences
• funding be provided to develop programmes to support women as researchers in medicine and health sciences.

The Committee forwarded the Recommendations to the International Congress of the Medical Women's International Association to support the introduction of teaching a Gender Perspective in all medical curricula internationally. These Recommendations were amended to form the following Resolutions. These Resolutions were accepted by the General Assembly at the 25th MWIA International Congress in Sydney, Australia, April 2001

**MWIA Resolution 2**
MWIA urges affirmative action so that women, who represent half of the population, are given an equivalent share of appointed positions at all levels. MWIA calls on all member governments to introduce a gender perspective into all health policies, health budgets and provision of health care. This should extend further than sex differences in morbidity and mortality rates and includes those gendered behaviours damaging to health.
MWIA also urges all countries to recognize gender specificity in all medical research and education.

**MWIA Resolution 3**
MWIA encourages medical colleges, universities and other medical organizations to promote and support mentoring networks for junior medical women to encourage new female leadership.

The Aims of the Symposium were fully achieved: the Aim to establish core content for teaching about gender in medical curriculum was supported in two ways. The first was through the recommendations in relation to teaching process and content, the second was in the collection of gendered stories that can form the basis for curriculum.

This international discussion contributed to developing the common language and agreed definitions necessary for establishing a new discipline, validated and built on the work already done by doctors in many countries, and linked the work of academic doctors by providing a forum in which they could share and value their expertise.

The Symposium participants began to establish the discipline of Gendered Medicine and since then have taken part in the First International Program on Gender Perspective in Medicine, held in Sweden in August 2001, and the face-to-face meeting of the MWIA Executive in Bellagio, Italy in December, 2001. That meeting focussed on developing a manual to assist its members in introducing gender issues to all facets of medicine or 'Gender Mainstreaming'.

The Report concludes that ‘doctor’ is a performatively male social role that largely excludes ‘woman’. Suggested strategies for moving forward include a deconstruction of gender dynamics in all aspects of medicine to bring about a more equitable gender balance within the profession. The suggestion is made that the problem must be tackled not only at the personal, social and environmental levels but also at structural and institutional levels if it is to succeed. It is further suggested that this process may also reveal aspects of institutionalised medicine that have made it succeed for so long in its current form. Finally it is suggested that what is best about the current system must be preserved and married to a more inclusive approach.
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1. INTRODUCTION

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This teaching is already being implemented at universities in Australia, Sweden, The Netherlands, South Africa, the USA and Canada and forms part of the core curriculum of the Australian College of Rural and Remote Medicine. The Symposium explored the experience of this teaching, included contributions from other countries, and began to establish the discipline of ‘Gendered Medicine’.

1.1 RECOMMENDATIONS

Recommendations were developed by Symposium participants and finalised by a Recommendations Committee, consisting of Associate Professor Carin Muhr (Sweden, surgeon), Dr Lexia Bryant (Monash, family practice), Professor Elisabeth Hultcrantz (Sweden, surgeon), Dr Deb Colville (Australia, surgeon), Ms Jo Wainzer (Monash, social scientist). The Committee forwarded the Recommendations to the Medical Women’s International Association Congress

The Symposium recommended that:

1. National governments, the World Health Organisation, non-government organisations and universities support and implement the introduction of teaching about Gendered Medicine into all undergraduate and postgraduate health education.

2. Accreditation, evaluation and quality improvement in all medicine and health sciences courses will address the following issues:
   ▪ knowledge domains including attitudinal and emotional ways of knowing
   ▪ the provision of time for reflection
   ▪ the provision of safe and respectful learning environments
   ▪ the incorporation of ongoing constructive feedback
   ▪ the facilitation of personalised relationships between teacher and student as a model for the doctor/patient relationship

3. Competence and leadership in medicine includes:
   ▪ interpersonal skills
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   ▪ intuitive understanding through knowledge domains including experience and empathy
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4. Implementation of these recommendations will include the following actions:
   ▪ medical women consciously mentor undergraduates and junior medical officers
   ▪ funding be provided to develop sustainable models of co-operative health care delivery, incorporating multidisciplinary teams
   ▪ funding be provided to develop programmes to support women as teachers and educators in medicine and health sciences
   ▪ funding be provided to develop programmes to support women as researchers in medicine and health sciences.
1.2 AIMS OF SYMPOSIUM

1. To make Recommendations to the International Congress of the Medical Women’s International Association to support the introduction of teaching a Gender Perspective in all medical curricula internationally.
2. To begin to establish the discipline of Gendered Medicine.
3. To establish core content.
4. To develop some common language.
5. To validate and build on the work already done.

1.3 PARTICIPANTS

Forty five female doctors and medical students, and one male student attended. International participants attended, ranging from the ground breakers from privileged countries who challenge the dominant male culture, to women from the developing world who have the courage to want to change their culture to be one of hearing the voice of women in one of the most valued professions world wide. Expertise was in medicine, curriculum, gender issues and education. International participants included Dr Shelley Ross, incoming MWIA president from Canada; Professor Elisabeth Hultcrantz and Associate Professor Carin Muhr came from Sweden; Professor Kumiko Eiguchi from Argentina and Dr Astrid Buhren from Germany plus nine other members of the MWIA Executive. The sessions were recorded by medical students Ms Emem Ukor (audio), Ms Stephanie Weidlich (video), Ms Michelle Allen (notation).

1.4 BACKGROUND

This Symposium continued the development begun in 1997 of the skill base of academic rural doctors to teach and research about gender issues for rural doctors while introducing the topic to core medical curricula. The Symposium built on work already done during the RUSC Program, a Project of National Significance titled ‘Gender Issues in Rural Medical Practice’. Achievements so far include identification and training of rural doctors to teach the subject, recruiting female rural doctors as teaching staff, capacity building within academic units to research and teach about gender in medicine, and input to medical curriculum.

The Project has piloted and begun to implement curriculum change in six universities. It has been an outstanding success in bringing forward a difficult issue, identifying the champions in each university to take it forward, building networks, collecting the evidence, writing papers, presenting at conferences, and developing the momentum and infrastructure required to introduce a new topic into medical curricula.

1.4.1 Results So Far

Four of the 9 key targets of the RUSC Program have been addressed by this Project. They are:

1. Curriculum Design; contribution to Rural Curriculum at Monash, Newcastle, and Melbourne Universities reflecting unique features of rural health, and clinical skills and decision-making appropriate to rural practice. Contribution also to post-graduate curriculum developed by the Australian College of Rural and Remote Medicine.
2. Educational development for rural teachers has been initiated by the recruitment and training of rural doctors to teach the gender issues curriculum at Monash, Newcastle, Melbourne, and Adelaide Universities. National and international symposia, plus residential leadership training has been provided to rural medical academics from Monash, Melbourne, Newcastle, Queensland, Tasmania, Flinders, Adelaide and Western Australian Universities.
3. On-site support to rural teachers has been provided by full-time academics at Monash, Newcastle and Melbourne Universities.
4. Student assessment at Monash University now includes questions about gender issues for rural doctors, and several rural medical and academic staff now participate in the final year exams for students.

An unanticipated additional outcome has been the contribution of academic staff of the Gender Issues Project to research on workforce participation and strategies of female rural and remote doctors (Wainer, Bryant et al. 1999; Wainer, Carson et al. 2000; Wainer 2001; Wainer, Bryant et al. 2001; Wainer, Greacen et al. 2001). This research is now contributing to state and national policy and planning for the rural medical workforce.

1.4.2 Continuing Need

At the first national rural medical and health student meeting in Kalgoorlie in 1995 the students made three recommendations. They wanted the formation of the National Rural Health Network, regular student meetings, and the introduction of formal teaching about issues for women as rural doctors. Monash University School of Rural Health agreed to pick up this project, which became a Project of National Significance of the Rural Undergraduate Support and Coordination (RUSC) Program. The year 1999 was the first in which half the national medical student intake was female. We now have increasing evidence that women and men practice medicine and relate to their profession differently. The great majority of rural doctors are men (78%), and rural practice has been set up to reflect the way men practice, including the implicit assumption that the rural doctor has a wife. These models make it difficult for young women to see themselves as rural doctors and to imagine how to practice rural medicine and be in a family, or be a mother.

1.4.3 Teaching about Gendered Medicine

In 1997 Monash University piloted the teaching of a curriculum unit titled ‘Women in Rural General Practice’. A new objective was added to the Rural Curriculum,

To increase students’ understanding of issues that specifically relate to women doctors in rural areas including personal, professional and family issues.

The curriculum unit was introduced to the medical students in Year 2 and Year 6 as part of their compulsory rural terms. It was taught in part by female rural doctors in tutorials during the rural hospital rotation. These doctors act as role models for the female students, and as an authoritative female rural voice for the male students. The title of the curriculum has since been changed to ‘Gender Issues in Rural Medical Practice’ in order to accommodate the learning needs of the male students, and male doctors are part of the tutorial team.

In February 1999 the Project of National Significance - Gender Issues in Rural Medical Practice: Teaching Gender Seminar was held to consider the introduction of this curriculum to other medical schools (Wainer 1999). The seminar was attended by teaching staff from 9 of the then 10 medical schools, medical students, the presidents and council members of four medical colleges, and other senior doctors. The thirty people who attended the seminar unanimously passed a recommendation that:

Teaching about gender in medicine be included in the core curriculum of all medical schools.

The Universities participating in the Gender Issues in Rural Medical Practice project are Monash, Newcastle, Melbourne, Western Australia, Flinders and Adelaide. Newcastle, Melbourne and Western Australia have used the funding provided to employ female rural doctors to review, update and make gender-sensitive, the problems on which their Problem-Based Learning curriculum is based. The University of Melbourne is collecting data on the sex ratio of the rural medical teachers and has implemented regular seminars with students to consider gender issues during their rural rotations.
Monash University has established a Gender Working Party of the Five Year Curriculum Committee to oversee the integration of a Gender Perspective throughout the new curriculum.

1.4.4 International Presentations

Papers and workshops about Gendered Medicine have been presented at a series of international conferences in order to test the depth and scope of the issue and establish the credibility of the topic. These include:

Recommendation passed by the Conference for Undergraduate medical training:
‘...all medical schools recognise the importance of role models for their students by ensuring that students are taught by a fair proportion of female faculty, and in particular, by recruiting female rural doctors to teach.’

2. The 1998 WONCA Conference, Dublin
   • 3 papers
   • 1 workshop

3. The 1999 WONCA Rural Health Congress, Kuching
   • 2 workshops

4. The 2000 WONCA Rural Health Congress, Calgary
   • 1 keynote address
The Calgary Commitment to Women in Rural Family Medical Practice includes the recommendation that:
‘The many contributions of women to rural medical practice must be included in core medical curriculum’

5. The 2001 WONCA Conference, Durban
   • 1 workshop

6. The 2001 Medical Women’s International Association Congress, Sydney
   • 1 workshop
Resolutions passed at the Medical Women’s International Association Congress include the following:

‘Recommendation 2: MWIA calls on all member governments to introduce a gender perspective into all health policies, health budgets and provision of health care. MWIA also urges all countries to recognise gender specificity in all medical research and education.’

Two national residential workshops have been held to train leading rural and academic medical women in leadership, and provide opportunities for networking and strategic planning. Twenty female doctors have attended these including five women who were the presidents, vice-president or council members of their national medical colleges.

1.4.5 Website

The website for the Gender Issues Project is http://www.med.monash.edu.au/mrh/gendermed/ including an on-line discussion forum.

1.4.6 Students

The National Rural Health Network appointed a student to manage the Gender Portfolio in 1999, and included a series of workshops on gender at their National Conference in Wagga Wagga. Recommendations from that conference included three relating to teaching about gender issues:

1. Seek greater female participation in specialist training programs
2. Health curricula should include explicit discussion of gender issues in rural practice
3. Health curricula should provide a focus on experiences of women and men as rural health professionals.

The Australian Medical Students Association has published a pamphlet on gender issues for medical students titled “Careers, Choices and Change” asking the question: “Do men and women want different things from medical careers?” suggesting this is becoming increasingly important for the next generation of doctors.
2. CONTENT OF SYMPOSIUM

2.1 THE DISCUSSIONS

2.1.1 Introduction

Dr Lexia Bryant (Australia) introduced Dr Tamara Mackean (Australia). Dr Mackean is an academic and a lecturer in the Department of General Practice at Adelaide University. Dr Mackean is also an Indigenous Australian, and in this capacity she welcomed the international delegates to Australia. Dr Bryant then outlined the plan for the day’s proceedings. The programme commenced with a panel of students and teachers exploring their experience as learners and teachers of curriculum in Gendered Medicine. This was followed by discussion by all participants about their experience of teaching and learning about Gendered Medicine.

2.1.2 Defining ‘Gendered Medicine’

Professor Elizabeth Hultcrantz (Sweden) began with her understanding of the meaning of ‘Gendered Medicine’. She explained that to define the meaning of the term we need to answer several questions:

1. How does the gender of patients influence the treatment of their illnesses?
2. How does the gender of medical students influence their educational opportunities?
3. How is gender of the standard patient presented in textbooks?
4. What role does gender play in the relationships between female teacher/male student and vice versa and the relationship between female teacher/female student and male teacher/male students?
5. What role does gender play in the relationships between female doctor/male patient and vice versa and the relationship between female doctor/female patient and male teacher/male students?

Professor Hultcrantz pointed to the future need to think about the variety and differences in our responses to these relationships. She acknowledged that at a one day symposium they could not all be adequately addressed, but that this Symposium was a good place to begin.

One of the core aims of the Symposium was to share and discuss situational experience that the participants remembered as a success or failure in teaching with a gender issue at its core. Dr Lexia Bryant (Monash) lead the discussion by recounting a moment reported to her by a fifth year surgical student. This student was one of a group of six and:

"the male surgeon for that session instructed her to switch the operating light on and off, while the male students scrubbed to assist with the surgery."

That female student could not quite understand why she still felt humiliated and belittled by the experience. She had thought it was not worth mentioning.

One of the student participants of the Symposium commented that even now within her university there is a lack of female role models, but in an attempt to compensate for this her university hosted a meeting with female practitioners associated with the university which she found to be beneficial. This was reinforced by another participant.

The concern was raised that introducing teaching about gender issues into the specialities would meet with resistance. The feeling was, in order to be successful in making progress in bringing about change in the curriculum and the culture of medicine as it is now, that women would need to be united and supportive of each other as well as seeking support from well placed men within the Colleges. On this point it was noted that political support from the Commonwealth Government in Australia had been a vital step forward and more importantly that policy had been met with appropriate funding. Ms Jo Wainer (Monash)
pointed out that she had support from the Head of the School of Rural Health and the funding from the Commonwealth to back it up and that is how this Symposium came about.

Another participant commented that as a first year anatomy student she was tutored by a good looking male tutor who, in her eyes, clearly favoured female students who flirted with him and male students who ‘bonded’ with him at the pub. This tutor also openly stated that he could “get you a pass” if he wanted. When she complained about the inappropriateness of his behaviour to her male peers they couldn’t see what her problem was because, as she put it, “they were part of the majority”. She said that:

*It was “frustrating and kind of daunting to realise that my generation was involved in that cycle and nothing was going change”.*

At this point the issue of male defensiveness was raised in several ways. One participant noted that immediately you mention the word ‘gender’ men immediately ‘get the wrong idea’. Nobody wants to be seen as an oppressor and nobody wants to feel oppressed. The group acknowledged that trying to raising the issue of gender was at times perceived by men an attack on them. Another participant stated that:

*“Gendered Medicine should not be perceived as the same thing as women’s medicine”.*

Others agreed on the importance of ensuring that Gendered Medicine should raise both men’s and women’s awareness of each others’ issues in order to better understand each others’ perspective. Gender issues in medicine need to address gender issues for all in order to improve professional relationships and the profession in general.

Professor Kumiko Eiguchi (Argentina) described how she has started a Centre for Gender Studies in Argentina. Argentina is a strongly Catholic country and is conspicuous at United Nations conferences for being the one country to unswervingly vote in the manner sanctioned by the Vatican on women’s rights and reproductive health issues. The Vatican has traditionally found the concept of gender problematic and has forbidden its use. Overtly challenging the social order by opening a Centre for Gender Studies in Argentina takes great courage.

Whilst the experience of

*‘being labelled a “querulous paranoid feminist” for mentioning the gender inequalities in the medical profession’*

was shared by a number of participants, several could not name specific instances that they could recall that highlighted the nexus of gender and medicine. However, those participants did point out that they personally felt either resistance or disquiet in their surroundings and that senior men discouraged or pigeon-holed them early in their training. One participant commented that:

*“It’s not so much a glass-ceiling, it’s more an iron door”.*

These feelings or perceptions are perhaps the strongest indication of the need for thorough gender analysis of the medical environment along the lines highlighted by Professor Hultcrantz at the commencement of the session. A deconstruction of the social dynamics of these environments may lead to a greater understanding of the root causes of these perceptions and thus be suggestive of potential strategies to address them.

2.1.3 The Experience of Teaching and Learning

The conversation moved to a discussion of the actual environment of teaching commencing with the question “is the current system of imparting medical knowledge optimal?” It was acknowledged that good teaching is a specialised skill, acquired over time. The current system of clinicians or academics lecturing to large groups of students rested on the
assumption that mastery of your chosen field automatically implied you could teach it. The group acknowledged that students were highly critical of a lecturer’s performance; many admitting that they too had participated in the derision of lecturers purely because they were perceived to be nervous or clumsy in their presentation. It was noted that criticism was particularly harsh for women who lectured badly; but unlike male lecturers for whom poor performance was simply attributed to a lack of teaching skills, for women poor performance was attributed to a lack of competence because of gender.

Professor Hultcranz told about a moment after she had given a well-received lecture. She finished by asking the mixed sex audience how they felt about having a female professor in some of their courses. She did not want an answer she just wanted them to think about it. Later that day a female student came up to and said:

"Please don’t ask that question, we want to see you as the competent professor you are, not as a woman”.

There was a common perception that for young women to be successful doctors they were required to deny, mask or conceal their gender. This is an illustration of the conflict between the currently constructed role of doctor and the feminine social role. This is unsurprising considering that modern medicine has been created and practised largely by men. There have been few senior role models whose persona embodies the dual aspects of ‘competent and admirable doctor’ and ‘feminine or womanly’ making it difficult for young female doctors-in-the-making to feel secure or legitimate in their professional identity.

Some female students engage in the derision of ‘odd’ female senior colleagues in order to distance themselves from the ‘association by gender’. Not following the group in this activity may be perceived as being too political or ‘rocking the boat.’ Generally it was felt that female students do not want to ‘make a bad impression on the males around them’. As Professor Hultcranz put it:

"they want to be seen as doctors not women” as if the latter by definition excludes the former.

It becomes a ‘damned if you do, damned if you don’t’ scenario: women have to fit into the male ‘doctor’ role and yet strong and assertive women doctors can be criticised for not being ‘real women’. Female students have to search for an identity that is readily available to the male students and for women either of these options can draw criticism. Some medical schools have attempted to address the problem of the lack of female role models by holding group meetings with students and female doctors. All participants agreed that this was a positive start. One participant commented that in her experience only 50% of the female students ever came and that the meetings always created a lot of ‘turbulence’. The male students laughed at the young women for wanting to talk about their career aspirations and gender issues with senior women. She also added that maybe if the young men also had the opportunity to do so with a senior male they may feel more relaxed about discussing their aspirations and the impact that gender has on their studies and life generally. In doing so they may become better doctors.

The group reinforced that good role models were an important aspect of career development. They expressed a feeling that the bar was set much higher for women as teachers. If you perform well it’s because are a competent doctor, if you perform badly its because you are a woman. They felt that for them, having an off-day was unacceptable. This expectation of perfection was also apparent in the comments of one of the medical students present. She emphasised that to ‘survive medical school all students need to be very self-absorbed’, and in that sense she felt she had no time for compassion in the instance that a lecturer may ‘just be having a bad day’. She felt that she had to assert her ‘right not to be on top or the best every day’.

This relentless demand for perfection as opposed to a pursuit of excellence within medicine featured throughout the discussion. Its dehumanising effect was lamented by one of the
participants, its presence characterised by her teaching experience. She teaches medical students as well as nursing and social work students:

"The social work and nursing students will ask how you are and engage you on a personal level, the medical students disregard the person and move straight to the work, asking only about what work you have been doing or what papers or chapters you have been reading."

From this point one participant made the comment that perhaps as mentors she and her colleagues should be providing constructive criticism regardless of gender. She felt that her success in her field was attributable to confidence and a mentor had always provided her with constructive criticism. The process undertaken by Monash University in the Department of General Practice was explained. Students commencing their final year are given an opportunity have a confidential discussion with a member of staff (male or female) about any factors that they feel may have an impact on them personally throughout the year. All students, but particularly ones who have had problems, genuinely appreciate the opportunity to have this informal discussion.
2.2 PRESENTATIONS

2.2.1 The Importance of Participation

Dr Colville commenced this session with a presentation reminding participants of the significance of what they were doing. She spoke about the importance of the process of meeting and discussing changes to the way medicine is taught. She pointed out that by meeting and sharing experience and discussing medicine from a gender perspective the participants are creating a new culture of gender sensitive medicine.

Dr Deb Colville

We are here because we are all interested in making knowledge, in learning, and in teaching. Many of us have come a long way, and our time is precious too. We have come to learn more about gender and curriculum. In wanting to start to establish and develop the discipline of Gendered Medicine, I see us as coming here to look particularly at the ‘factory’ where doctors come to learn their own version of medical knowledge. We come and to think about our own part in this ‘factory’, imagine a better future, and learn how we might work in our own ways to change it. Gender and curriculum are very important issues.

In medical school, not only have we learnt a particular type of Gendered Medicine (a type that most of us agree has major gender problems that need to be rectified). Sadly, I believe that we as doctors have often been trained in ways that tend to close us off from acquiring new knowledge about gender and medicine in our own professional lives, regrettably, sometimes forever. I want to convince you that it is important to recognise the importance of generating the sorts of knowledge that we are ‘doing’ this very day. We are taking the steps to opening our minds to new possibilities. This is the very knowledge we are creating, holding within ourselves, and sharing today, and it is very important. It is important to our patients, to ourselves as women doctors, and to ourselves as people. We are doing this through engagement with other women.

So I want to highlight what I see as two ways of looking at gender and curriculum that we might otherwise overlook today. The two aspects are:

1. Documentation of curriculum, and participation in curriculum are two essentials of any curriculum.

2. Each element in any curriculum, documentation and participation alike, has a hidden (covert) curriculum, and a visible (overt) curriculum.

I will explain briefly how both of these important aspects of what we are doing today are gendered, in many ways.

Documentation and Participation:

Now all of us have grappled with, or are starting to engage with both these problems

1. How to write down parts of our curriculum, and
2. How to get the most out of a meeting or series of meetings of those interested in curriculum in our own area.

I will start by talking about curriculum documentation, such as these handbooks I have here about my ophthalmic curriculum. Next, I will discuss the idea that participation in workshops and meetings such as today’s; important gathering of women doctors from all over the world, is as much a form of curriculum development as are documents.

Firstly, regarding documentation, there are systematised ways to write, read and use the conventional types of documents that are called ‘curriculum documents’. These are the curriculum manuals, course handbooks, and subject guides that we use, as teachers, and as educators, generated for both students and teachers at our teaching hospitals and universities. Wenger (Wenger 1998) calls these ‘reifications’, but for our purpose today, documentation will do. The idea is that a living social and material system, that is, a
Curriculum, can be made into a ‘thing’, that is, reified. Reifications can travel, and can obviously serve different functions from ‘participation’ such as coming to this meeting.

While talking about documentation, identifying the traditional laundry list of items in a written curriculum document is relatively easy. The list includes: context; needs analysis; prior learning; student selection; student attributes; teaching and learning delivery; sequencing; ordering of topics into disciplines such as ophthalmology and microbiology. Also important is the ordering into themes and strands such as basic skills, professional practice and so on, and a list of how teaching and learning might happen, such as in a lecture, tutorial, workshop, or laboratory session. In surgery, for example we write down and document lists of suggestions about how best to do teaching in theatre, in outpatients and on ward rounds, as three important settings for teaching our registrars.

About participation; yes, it is said ‘meetings change hearts and minds’. So I come now to the idea that I want you to think about, that there are other ways to think of curriculum as well. One way of thinking of curriculum is that participation in a meeting is making knowledge. The meeting itself is a form of ‘curriculum’. No-one can deny that coming to a meeting such as we have today leads to us coming away holding new exciting knowledge about our own circumstances and our own teaching and clinical practices. Not so much ‘book knowledge’ but practical, feeling, serious knowledge that gives us hope and enthusiasm to approach and do teaching afresh. No detailed list of events can ever replace participation. As I said ‘Meetings change hearts and minds’. Indeed this is true for knowledge about medical education, about gender and about what is going on around us, and between us, in our profession. Through participation in this meeting we become part of a “community of practice”, with shared meanings, understandings and documents.

Finally, as Wenger says: Communities of practice are not self-contained entities. They develop in larger contexts: historical, social, cultural, institutional, with specific resources and constraints. Some of these conditions and requirements are explicitly articulated. Some are implicit but are no less binding. Yet even when the practice of a community is profoundly shaped by conditions outside the control of its members, as it always is in some respects, its day-to-day reality is nevertheless produced by participants within the resources and constraints of their situations. It is their response to their conditions, and therefore their enterprise (Wenger 1998).

Curriculum can be overt and covert, particularly with regard to gender. Gender-inclusive language is not the only covert aspect of curriculum that we can address. Other examples are choice of topics, marking down student assessment tasks where female students tend to speak less emphatically than men (and can be easily misconstrued as less knowledgeable). Often including themselves in the social context, rather than reporting medical knowledge from the stance of an impartial observer. There are many ways in which female medical students might be involved in a curriculum gendered to their disadvantage.

In surgery there are frequent examples of keen male students being included in theatre by scrubbing, where the female students are asked to ‘turn the theatre lights on and off’! These forms of indirect discrimination on the basis of sex stereotyping ought to be seen as such. There are myriad examples around us daily. These examples are covert to the extent that they are backgrounded in critiques of curriculum unless educators are especially alert.

As teachers of medical curricula, I suggest we ought to advocate for:

- The Canadian Document’s adoption(Appendix V), in principle and practice, by Australian medical schools, especially in regard to mainstreaming of gender issues in curriculum objectives, and in assessment of clinical competence.
- Core curriculum documents that include gender as an issue in medical problem solving, knowledge, practice and understandings of medical care
- Recognition that gender stereotypical representation of doctors and patients be altered, to take account of the multicultural, rather than a monocultural context of
Australian society. Such representations apply to all aspects of curricula, including curriculum documentation, and curriculum practices.

Here is a passage that I quote at length, as it seems to sum up one of the tensions involved in organising a workshop such as ours. Etienne Wenger (Wenger 1998) describes communities of practice, such as ours, in which we come together to make new meanings from our daily work in enacting gender-sensitive curriculum documents and practices. One dilemma presented in our workshop planning itself was the division of time and labour between narratives of daily practice, and narratives of ‘feminist’ theory, and of curriculum theory. Crucial however, was that we also put in a ‘very long lunch!’ Talking here of practice as participation, and of theory as ‘reification’, Wenger explores this dilemma as follows:

**The complementarity of participation and reification:**

Although seamlessly woven into our practices, the complementarity of participation and reification is something familiar. We use it as a matter of course in order to secure some continuity of meaning across time and space. Indeed, in their complementarity, participation and reification can make up for their respective shortcomings, so to speak. (p63)

If participation prevails- if most of what matters is left unreified – then there may not be enough material to anchor the specificities of coordination and to uncover diverging assumptions. This is always why lawyers always want everything in writing (p65).

If reification prevails - if everything is reified but with little opportunity for shared experience and interactive negotiation - then there may not be enough overlap in participation; to recover a co-ordinated, relevant, or generative meaning. This helps explain why putting everything in writing does not seem to solve all our problems (p65).

In cases of mismatches, it is necessary to analyse the situation in terms of the duality and to redress any imbalance. Merely adding more participation to participation or more reification to reification may not help much, because a form of participation or reification is by itself unlikely to correct its own shortcomings: not just another memo, not just another meeting (p65).

(Wenger 1998)

Following Dr Colville’s presentation Dr Lexia Bryant introduced the next session:

**2.2.2 Three 20 Minute Journeys-The Lost Art of the Way Women Learn**

Medical women live and work in cultures that have destroyed the concept of women as healers. Medical women worldwide have had to learn to live and work in roles that were constructed in their absence. Sometimes it is uncomfortable. To illustrate these points and to conceptualise how Gendered Medicine can be taught, the discussion was followed by presentations from three theorists who have helped create a language to express the concepts of gender issues in medicine. They were Ms Jo Wainer (Monash), Associate Professor Carin Muhr (Sweden) and Professor Elisabeth Hultcrantz (Sweden). Ms Wainer began with a paper describing the contributions and fate of the feminine and women who heal through history Ms Wainer is a social scientist and Senior Lecturer at the Monash University School of Rural Health. Her research interest is in women in the medical profession, and gendered medical knowledge and curriculum. The presentations appear here as they were given.

***2.2.2.1 Ms Jo Wainer***

I am going to start by briefly exploring the nature of the feminine, then touch on the mythological story of her defeat, and the actual story of the extermination of women healers. I will talk about the process of silencing women and ensuring our invisibility in the construction of knowledge, and touch on some of the consequences.

I will introduce two aspects of this multifaceted story. The first is the story of the defeat of the feminine in ancient mythology. The second is the development of science as a religion
that owed its ascendancy to its separation from instinct, intuition, nature and the feminine. This led to destruction of women healers during the Inquisition and their subsequent exclusion from the development of the body of knowledge of medicine, and continues to inform the experience of women in medicine. I am going to take us back to the dreamtime, to some of the myths that form our unconscious and continue to reside in the deep recesses of our knowing. So let me tell you the story, starting with an understanding of the feminine.

What does the she look like? Well, many things. According to Swiss psychotherapist and contemporary of Freud, Dr Carl Jung, this is one of them:

"The goddess, in my thinking, is the movement of the spiral. Like so many things in nature (plants, the seasons, the moon) the goddess moves in the darkness as much as in the light. She lives in the present and evaluates the moment. What is right today may be wrong tomorrow. She lives by the spirit, not by the law. She demands constant awareness and spontaneity.

She loves the potential in things; the possibilities in the growing plant, the growing child, the growing hopes and dreams. She trusts life: trusts change, trusts love and holds nothing static. She loves and lets go. She loves with her whole being, so that vulnerability becomes her greatest strength. What, for those who do not love her, is a contradiction, for those who do love her becomes paradox."

The feminine is represented in the moon, the earth, the physical and Mother Nature. Ancient mythology tells of the role of the goddess and of her incarnation, woman, in birthing the world and in birthing human life. This was a time, maybe 3000 years ago, of deeply earthed instinct, of the honouring of cycles, of Mother Earth, of harmony with nature. It was pre-scientific and non-rational and instinctual. In Indigenous peoples today these ways of knowing still exist, and like the feminine have been dispossessed and silenced. The presence of the feminine in defining the public domain, as priestesses and prophets, as warriors and leaders, was overthrown in a titanic battle and driven underground, for here are aspects of the feminine that are ungovernable and chaotic although, not without natural laws of their own.

The feminine has a dark side. The side which is kept in Pandora’s box and which is the impetus for the determined, structured, multilayered, unforgiving and relentless intention throughout the world to keep the feminine suppressed and in service. The untamed feminine looks like Lilith and Medusa.

Lilith is the dark aspect of the goddess so let me say a little about her. Lilith was Adam’s first wife, made like him from the earth, and they never found peace together. Adam tried to force Lilith to lie beneath him in the ‘missionary position’ favoured by male dominant societies. She disagreed with him in many matters and refused to lay beneath him in sexual intercourse, claiming they had been created equal. Instead Lilith sneered at Adam’s crude sexuality, cursed him and flew away to make her home by the Red Sea where she dwelt in a cave and engaged in unbridled promiscuity, consorted with lascivious demons and gave birth to hundreds of demonic babies.

When Lilith left, Adam was afraid and sacrificed the Unicorn to God. The Unicorn was Lilith’s totem and her link to the instinctual world; by killing it Adam sought to tame her. Lilith then took the Screech owl as her companion for it can move in the dark and is a creature of the moon. God sent angels to fetch Lilith back. The angels threatened her with the death of 100 of her children every day if she did not return but she cursed them and refused. So God created Eve, this time from Adam’s rib, as a more docile replacement Lilith has disappeared from the story told in the Bible but her daughters have continued to haunt men for thousands of years. The Greeks call them the daughters of Hecate, Christians call them succubi, or daughters of hell. These are lustful she-demons who visit boys and men in their sleep and ride them, causing nocturnal emissions and accompanying guilt and confusion.
Lilith is that quality in women that refuses to be bound in relationship. She wants not equality and sameness in the sense of identity or merging, but equal freedom to move, change, operate intuitively without compromise and be herself completely. She arouses great anxiety in both men and women and as a consequence has been ruthlessly suppressed.

In ancient times, in the place called Delphi, there sat the oracular priestess, the Pythia, who served the gods and prophesied the future. Her attendants were priestesses and she was guided by a python to draw her knowledge through trance and vision, from the bowels of mother earth. People came from all the civilised world to seek her guidance on matters of business, love and war, and to align themselves with the gods. She was overthrown by Apollo, who killed the python and placed priests as interpreters between Pythia and the people. Thus began the silencing of women, which continues until today.

The conquering of the feminine lodges deep in antiquity. In Joseph Campbell's terms:

"It is the conquest of a local matriarchal order by invading patriarchal nomads, and their reshaping of the local lore of the productive earth to their own ends. It is an example of the employment of a priestly device of mythological defamation, which has been in constant use...ever since."

This process turns the defeated people's gods into demons, and binds their rituals into new rituals for the new all-powerful god. It is a process that was implemented by Christianity in reconstructing the goddess into the servant Mary, and was repeated in Europe in the Middle Ages with the burning of the witches. Campbell says that the

"...battle was of two aspects of the human psyche at a critical moment of human history, when the light and rational, divisive functions, under the sign of the Heroic Male, overcame...the fascination of the dark mystery of the deeper levels of the soul."

Another part of the story of the demonisation of women lies with Athena and Medusa. In the European tradition they were the last of the female deities, the others having been systematically destroyed by the male gods. Let me tell you the story.

Medusa was the only mortal among the three Gorgon sisters, beautiful sea goddesses. Medusa lay with the sea god Poseidon in one of Athena's sanctuaries. In a fit of jealousy and rage, Athena transformed the sisters into ugly hags, and then assisted Perseus, the son of Zeus, to kill Medusa. Athena, after all, was the daughter of Zeus born from Zeus's head, fully armoured in adult form. She had no external mother or childhood. She is an intellectual construct, and she served her father well. She became a god of learning and of civilisation and of culture, and has an owl as her familiar, perhaps a secret sign that part of Lilith lies dormant within.

It may be that helping Poseidon strike down Medusa was necessary to allow Athena to survive the dark times until the feminine energy could rise again and the chains of silence and subordination could be broken. She agreed to be taken in and trained into the patriarchy and has at least survived when all the feminine forces that resisted were conquered or converted into service. Athena abets the slaying of Medusa partly from rage, perhaps, that Medusa was free to be completely female, and partly as cover to ensure her protection by the masculine forces that had taken over.

The Athena archetype holds a deep clue to the place of the feminine, and of women, in medicine. I suspect that many professional women, particularly doctors, have unconsciously followed Athena's lead in their determination to make a place for themselves in their beloved profession. Athena may be a model for how women have found a way to work in medicine in relative safety. It is a model that requires them to distance themselves from their femaleness, and other women.
Over time the feminine was defeated and withdrew and the gods took over yet for centuries women continued with their traditional role as the healers and physicians of their communities.

In mythology, dragons and serpents represent earth-based wisdom. You are invited to make the connection with the Caduceus. The patriarchal story is that heroic males, such as St George, have to kill dragons to keep them from swallowing maidens. Another interpretation is that, mythologically, being swallowed by a dragon, or python, is being initiated into the feminine mysteries. Medicine developed as part of the process to distinguish rational man from the non-rational feminine, to destroy and eliminate the chaotic and intuitive, as part of the evolutionary leap to science. And so we come to the second part of our story.

The Inquisition in Europe, which spilled over into the Americas, was focussed on rooting out women who were accused of being witches. It was at its most destructive and ruthless in the 16th and 17th centuries. I want to introduce it now because the burning of the witches continues to affect the unconscious of many of the women healers of today, haunted as they are by the shadow of the terror and death it cast over women who dared to heal.

The Inquisition was guided by a textbook, Malleus Maleficarum (Institoris and Sprenger 1951) first published in 1486 and second in sales only to the Bible. It describes how the Devil tempts men using succubi (remember the daughters of Lilith ?) and maintains that:

"All witchcraft comes from carnal lust, which in women is insatiable".

The acknowledged purpose of the authors was to execute as many witches as possible.

There were 3 core accusations against women that structured the witch burnings:

- women are sexual beings
- women were organised among the peasants
- women had magical powers to affect health

Writing in 1925, the Rev. Montague Summers (Summers 1994) expresses his loathing of women in the following terms:

"I have endeavoured to show the witch as she really was - an evil liver; a social pest and parasite; the devotee of a loathly and obscene creed; an adept at poisoning, blackmail, and other creeping crimes; a member of a powerful secret organisation inimical to Church and State; a blasphemer in word and deed; swaying the villagers by terror and superstition; a charlatan and a quack sometimes; a bawd; an abortionist; the dark counsellor of lewd court ladies and adulterous gallants; a minister to vice and inconceivable corruption; battenning upon the filth and foulest passions of the age." (Summers 1994)

At the level of the soul the torture and elimination of the witches was carried out systematically with the intent to break down and destroy strong women. In Mary Daly's terms:

"to dis-member and kill the Goddess, the divine spark of be-ing in women. The intent was to purify society of the existence and of the potential existence of such women" (Daly 1978)

It was focused on women who had rejected marriage (spinsters), or survived it (widows), what she calls the:

"indigestible’ elements - women whose physical, intellectual, economic, moral and spiritual independence and activity profoundly threatened the male monopoly in every sphere." (Daly 1978)
Estimates of the number of women killed between the fourteenth to the seventeenth century vary from hundreds of thousands to millions. In many villages only one or two women remained. An English witch-burner put it at the time:

"It were a thousand times better for the land if all Witches, but especially the blessing Witches, might suffer death."

William Perkins, a Cambridge preacher, declared that:

the 'good witch (was) a more horrible and detestable monster than the bad” so that “if death be due to any...then a thousand deaths of right belong to the good witch” (quoted from Daly 1978).

Malleus Maleficarum said that:

"If a woman dare to cure without having studied she is a witch and must die.”

(Institoris and Sprenger 1951)

One of the aspects which makes this story important for medical women today is that the nascent medical guilds were strongly implicated in the destruction of the witches. They were part of the trial process, and were explicitly empowered to identify whether a sickness was caused by witchcraft. So when women work as healers today, they have instinctive knowledge of how dangerous that can be. Many women are afraid to claim their full power for fear of being burnt, and an aspect of the feminine has, ever since, been contaminated by association with the masculine projection of the female-as-witch.

One outcome of the witch burnings is that the culture of medicine reflects the masculine experience and does not include or value the feminine. Another is that it can feel very dangerous to women, even today, to draw attention to their femaleness within medicine. After systematically destroying the women healers medicine was transferred from the fields into colleges, and women excluded from those colleges. It has taken until the 20th century for women to regain access to the study and practice of medicine. The intervening 300-400 years have produced an explosion of scientific knowledge about the human body that is the foundation of medicine as we know it. That foundation has been defined largely without the contribution of women.

Women have been absent from the production of scientific and medical knowledge, professional structures, values and leadership, and nearly invisible in the hierarchies of their own profession. For example you will have noticed that the slides I am using come from the Wellcome library; the largest collection of documents about the history of Western medicine. When I searched for women doctors, I found 12 in a database of more than 7000 images.

Five of 67 professors of medicine at both Monash and Sydney Universities are women. Even today women are scarcely present in the construction of the curriculum of their beloved profession. This means that in order to survive they often end up doing what Gloria Steinem has identified about university education;

...graduate with an A+ in self-denigration.

It is still a struggle to break the silence surrounding women and the practice of medicine. One of the reasons is that it is extremely difficult for women to talk about.

Medicine is a revered and privileged profession, with high status, prestige, community regard, and income. Women who become doctors benefit from the work men have done to create the profession and the revolution in the care and cure of human pain and illness that has resulted. They do not want to pull down the temple they have worked so hard to access, but women do want to be valued as full members of their profession, which most love and feel privileged to be part of. Many female doctors want to be valued for their femaleness as well as their doctoring, and there is the rub.
Medical women cannot speak about these issues for fear of being disloyal to their profession and being marginalised and excluded from the networks from which most power and influence flows.

- Women cannot speak for fear of offending men who have the power.
- The profession is hierarchical, authoritarian, and advancement is dependent on patronage, so it is risky to be seen to challenge the dynamics and structures.
- It is safer to identify with the strength/power than with the marginalised.
- There is the lure of being an insider.
- Fear of being seen as part of the group which science and medicine were developed to transcend.
- Cannot do it in isolation.
- Women disagree among themselves about what is going on, and medical women are more socially conservative and more likely to personalise difficulties than other women.
- Medical women and men are trained not to see.
- There is no vocabulary and the evidence base is only now being developed.
- The love of medicine and the deep satisfaction of being a doctor makes it seem churlish to bite the hand that feeds you.

In living out my commitment to the journey of the courageous feminine I have made a decision to never take part in criticising women, even if to do so would cement my place with powerful men, because in doing so I would be taking part in a system of silencing and denigrating women.

Associate Professor Carin Muhr (Sweden) then presented her address. Associate Professor Muhr holds her post in Neurology at the University of Uppsala in Sweden. She specialises in Neuroendocrinology. Her research background is in intracranial tumours, hormones and migraine. Associate Professor Muhr is a director of a five week course Women’s Health that has been running since 1996 and she also coordinates International Student Affairs in the medical faculty at her university. She is the Scientific Secretary of the Research Ethics Committee and in her own words "she tries to work with gender issues".

2.2.2.2 Associate Professor Carin Muhr

I’m very happy to be able to tell you a little about our work back in Uppsala. I already told you that Uppsala University was founded in 1477 and unfortunately some of those old thoughts are still in the walls and we struggle against them. I want to talk a little about goals. What kind of goals do we set, why do we fight in this area? Because it is a fight and a struggle. What methods can be used? We use some methods, many of you use other methods and achieve different results, but they are all interesting to discuss. What do we expect from this? We want equal rights for women and men. Currently there are differences but there should be no difference. I believe in mainstreaming gender issues. There is no single field where we can forget gender issues but we also need assertive actions to put them in all aspects of medicine. How you do that is very much dependant on the situation. Some countries have problems in some respects and we have problems in other respects. In medicine it is very fruitful to focus on the female patient because the female patient is the most common patient and they have to be handled not only by female doctors but also by male doctors. You can not get away from this fact so this is a good place to focus.

We have been working for a long time on the women’s health course and we have found this to be very fruitful. I want to show you a few vignettes from our Pedagogical Method Supplement. These are the instructions we work with in our Women’s Health Course. This is how we don’t want to behave in the situation I have used as an example. It shows a female patient meeting a male doctor and she feels very unique because the male doctor tells her he is ‘sorry, but there are no such symptoms’. In the area of heart disease this is a
problem because females do not present with the correct symptoms according to the
textbooks, which are based on male symptoms, so we do not get the correct diagnosis.

Coming now back to this problematic field of differences. It is really a difficult dilemma to
balance. We know there are differences, we have to stress the differences, but we do not
want the differences to be used against us. In history as far back as you can see women
have been put in a special category. Quite often people turn to gender blindness. They
assert that gender differences are not interesting meaning they feel they have no
importance and yet you learn when dealing with patients that there are many other factors
aside from biology. When you are in medicine you have to take all factors into account.
The problem is that it is difficult to separate biology from sociology, psychology, or culture
and I do not think we should really try because the separation is impossible. We know that
one affects the other and the other affects the first.

Let us use hormones as an example. We know that hormones will be affected by stress.
We know that depending on which hormonal level we are in, stress will affect us deeply. We
know also for example that stressed women working in hospitals have lower oestrogen
levels than non-stressed women. So even in that respect it will affect us and if the effect is
strong enough, fertility will be affected. We should emphasise the importance of taking all
aspects into consideration. When dealing with a female patient, to take into account not
only her clinical symptoms but also her life situation at the same time. This is what I will
continue to talk about.

Women have a high incidence of psychiatric illness in a male dominant culture. But in
females the lowest incidence of illness is when there is a good balance both of females and
males and it increases when there is a female dominance too. So inequalities lead to
illnesses. It's not only psychological suffering but other illnesses that result.

We need to come up with a strategy to try to move our issues forward. One way to do it is
to talk about human rights. As a strategy it is used very much within gynaecology within the
World Health Organisation when they try to push issues for women and children in
developing countries. If you look at it from a human rights perspective it is very difficult to
say that women should not have the same rights as men.

If we look at equal opportunities, of course we should have the same opportunities to
education as males. In Afghanistan that is not truly the case. Not only education we should
also have the same right to a career, but we do not have that; we do not have that in
Uppsala. We should have the same rights to knowledge. We should have the same rights
to knowledge about ourselves, our medical problems and about our medical illnesses.
Elisabeth and I have been working together within the Research Ethics Committee trying to
push for gender issues and you should see their reactions when we do not approve of
material only about males. It happens all the time so now in the titles they do not even tell
us it's male they just call the case 'human'. Just three weeks ago there was an application
about students and it happened to be that all these students were males and when we then
say this proves our point there are always reactions to it even today. We should get the
same pay, we do not in Uppsala. Again the University hospital females, senior doctors are
paid A$900 less every month than their male counterparts at the same level. That's a lot of
money!

I have a small anecdote from Iceland. The former president there was a female and an
eight year old boy was asked what he wanted to become and he said "well I would really
like to become a president but you know that's not possible because I'm a boy."

So what do we have to fight for? We have to fight to live already before birth. Nine
hundred and ninety nine out of one thousand abortions in China are made on girl foetuses.
We have to fight sexual abuse all over the world and we have to fight for education.

So coming back then to strategies that can be used. We have to unite. We have to form a
network. We have to identify the structures because this is really a structural issue. We
should not blame ourselves, because it’s a structural issue. We have to be prepared to fight and we have to realise that it is also an issue of power. One way to fight is to not always please; and especially to not please the male hierarchy. Of course when we do not do this they will not like it but we have to be prepared for the consequences. We also have to start a dialogue with those in the hierarchy but select the male partners carefully. We should choose our fight and not struggle with everyone because this is exhausting. This summer we will have European International Course on Gender Issues focused not only on women’s issues but also on men’s issues. That may be one way to start because then the men will have to come and join us, or risk being unrepresented when we discuss them. So the best option is to select the right partners for these kinds of activities. I think that doing this is a way to improve our lives and hopefully everyone’s life.

Professor Elisabeth Hultcrantz (Sweden) followed with her presentation. Professor Hultcrantz, received both her MD and PhD from Uppsala University in Sweden. She became Professor of Otorhinolaryngology at Uppsala University in 2000. In the same year she moved to a professorship at Linköping’s University (a younger university where Problem Based Learning is used) in Sweden.

In 1991, she was one of the founding members and one of two project leaders of a national network for women in academic medicine (MWA). The network has introduced the concept of gender into the undergraduate studies at all medical schools in Sweden. In 1994, the network was the recipient of the government’s first (and only!) ‘Equality Prize’. Another project for the network was a book published in 1998 based on students’ questions about women in the profession of physician: ‘MD, PhD and Woman.’ Professor Hultcrantz was chief editor (Hultcrantz 1998). This book is used as a textbook in the courses in gender aspects in the practice of medicine held at Swedish universities. Work on this book and other of her activities resulted in her receiving the ‘Member of the Year 2000 Award’ from the Swedish MWA.

2.2.2.3 Professor Elizabeth Hultcrantz

Learning about gender begins with the experience we get in our first family because all our life we create our gender identity. By the age of 3 your little boy or girl has had so many interpersonal contacts and has been exposed to pictures, and media and of course they also have a innate biology to carry on with. Gender identity is rather stable already at the age of 3. However it can still be modified throughout one’s life and that’s a big source of hope for us. When we teach about gender it is important to take in to account the individual’s development, ethnic background and family traditions. Talking about traits as male or female is dangerous because in that manner we can give the impression that gender is the same as the biological sex and not something that is changeable.

"You are not born as a girl, you become one."

This is a classical quotation from Simone de Beauvoire (de Beauvoire 1949). The dilemma is discussed in many books and one of them is by Martha Minnow. The book is called "Making the Difference" because she says:

"If your focus lay on the differences between the sexes in order to change the gender power about us, there is a risk that you instead increase the problem." (Minnow 1990)

Teaching young people especially when you yourself are not young is a difficult task. Before you can talk about gender you have to let your audience define their opinion about what gender is and how they look at what is male and female. The male role is usually much more rigid than the female. Probably because the values the different roles have. Being a tomboy has been OK, at least for younger girls and the medical students have probably been recruited from that group. For a boy to be girlish is still regarded as something you do not want to be and in many contexts still “boys don't cry".
Medical students in Sweden regard men and women as very equal. Both boys and girls hope that they will have the same rights and possibilities in their career and they assume that they would share a domestic world with a promise to be on equal terms. Most of them have grown up in families where both parents have worked outside the home or at least, in our generation, usually the mother has worked part-time. If you try to show them using statistical data on salaries and positions that there is still an imbalance not only in society in general, but also in hospitals and in medical faculties, they do not believe you. They reply that ‘this is a situation for you who are older’ and ‘we would never accept that’ and ‘everything will be changed soon in the future’. You can easily understand this reaction because nobody wants to be either an oppressor or oppressed. They are looking forward to becoming doctors in a fair society.

Teaching about female and male patients is not as threatening. After the World Congress on Women in Beijing 1995 many governments acquired a new interest in women's health. An official government study in Sweden in 1996 gave many results that were unexpected for the laymen but have been confirmed also in other countries. Some examples of the results:

- women use the health care system more often than men
- they seem to be sicker but
- they live 6 years longer than men
- women get less expensive older medicines, older drugs
- they get less rehabilitation and
- they get less surgery especially transplantations and heart surgery
- women have more difficulties in getting compensation for work related injuries (the insurance company will instead explain the woman's complaint as caused by her domestic work situation)

You may recognise this fact but I think it is important that you do the same type of investigations in your own countries, to see if it's really so. These data can easily be discussed in a mixed student group, even as a political matter. It represents a lack of democracy. From a general point of justice both men and women should find justice in the health care system and if you can point out these differences as hard data it is something you really can discuss. Then you can discuss, if you want to go deeper into it, why the women seem to have a less privileged position in the healthcare system. You have to look at women's subordinate position in society in general and use feminist theory about the distribution of power. Otherwise you will end up in a 'blame-the-victim' situation to explain women's situation; women are such-and-such that is why the situation is like that. That is very dangerous; you have to look at the structure and not at the individual.

Another published study about how women's health is taught came from my own university in Linköping. In 1997 the medical textbooks used in the Medical Faculty for undergraduate studies were analysed from a gender perspective. Some of the results were:

- very few authors were women
- the standard patient was still a man
- illustrations are mostly men
- normal values for lab tests are still from a 70kg man
- the diseases where women patients are more common are less thoroughly covered in the book than diseases where men are over represented.

Their profession usually describes men, which is rarely the case for women. For example in dermatology women are mostly described as housewives with an identity to be beautiful which is described as the main program for them when they get any type of skin diseases. The textbook used in gynaecology for the past 20 years in Sweden had a very old fashion view of women: the cause of premenstrual tension, lack of interest of sex, and many other problems are more or less described by the women's wish to pursue her career. We still read this textbook, so how does it influence students of both sexes to be exposed from the beginning and all through their studies to this type of sex-stereotype discrimination?
Beginning to teach about gender in medicine can be done in different ways. Optimal, of course, would be to introduce a gender prospective in all subjects and textbooks, but that is usually not possible. Elective courses that students voluntarily choose are a good way to start. These courses will have an impact on more than just the students who attend. The teachers in other courses suddenly get new questions asked by the students and as a consequence, within the faculty, the discussion about if and why a change in general medicine curriculum is necessary would never stop. If you have the course as part of the ordinary curriculum you may risk protests and objections amongst students who feel threatened by the concept that they are a barrier to gender equality. One single student can cause a lot of fuss and can be difficult to neutralise.

At the university of Uppsala, Sweden we have an elective course in women's health, which will be held this spring for the tenth time. The course is built on “key lectures” and group discussions based on Supplementary Instruction (SI). The students also write a paper on a topic they choose with a focus on gender perspective, a paper they have to defend in a general discussion. That is also very good training for them.

Another way to introduce gender into curriculum is through seminars where students can work with cases; so-called ‘Gender Collisions’

These Gender Collisions cases should be discussed to start with in same sex groups. Then you gather these groups together and the students present their solutions to these Gender Collisions. The male and the female students usually come to different opinions about what the solution is. At that point the male students usually try to convince the females that their opinions are right and the females’ are wrong. As a tutor of these seminars you have the obligation to make sure that the students go from the seminars knowing that there is no right or wrong that there are only different ways to look at the same problem. This is something they have to live with and in this way you can get male students interested in how females think. Usually women discussing how the boys think but the opposite is not true; these male medical students are really very interested in knowing how females think because they know that the majority of their patients in almost all fields will be women. And of course they are good guys they want to know how women think, so read this Gender Collision now and see if you could discuss this for two hours, that's what we usually do.

I would like to show you one of these Gender Collisions now.

Anna and Kyle are doing their internships at the Internal Medicine clinic in X town. They are both have a very detailed schedule for their intern tasks: Thursdays says 1-3pm out patients 3-5pm library studies. During the first month they work every patient takes so much time that they are not finished with their out patients until five o’clock. After that, one Thursday Kyle is finished at three o’clock and he hurry's happily to the library. The next morning Kyle notices that Anna is cross and he cannot understand why. The next Thursday Anna is finished at three o’clock. She notices that Kyle still has many patients left and that he will not be able to finish even by five o’clock. Instead of going to the library as she would like she takes come of Kyle’s patients without asking him first. At four-thirty Kyle notices what has happened and he rushes into Anna’s room. Instead of being grateful he is very upset. Anna doesn't understand at all.

Is this a Gender Collision you could be able to discuss do you think? OK then I think you are so smart so I can give you the second Gender Collision at the same time because this is more difficult:

Anna and Kyle are working in the Department of Surgery. Every other day each of them is supposed to do the pm round in the ward at 3:30 after they are finished with surgery. It is always difficult to be on time because of long operations. One time Kyle comes at 4:15 while the nurse is distributing the medicines and the food is being served. He said cheerfully, “Hi nurses! Now we have to hurry up with the round because I’m going to pick up my baby at nursery school at five o’clock.” The
nurses join in unwillingly but Kyle tries to be extra nice and after a while that was very good again. The next day Anna is also late coming in at 4:15. She apologised for being late tells the nurses that she is in a hurry. The answer she gets is, “Can’t you see that we have other things to do right now? You’ll have to wait until we are ready they do the round at 4:15.” Anna is cross, especially as she too has to pick up a child. The situation is repeated several times and Anna becomes more and more depressed because she notices that Kyle never seems to have any problem getting things the way he wants them while she cannot. Kyle uses flirting as a method to get what he wants. Anna who very much enjoys doing surgery is now looking forward to the day she can quit. She is very worried however that the same problem will occur at the next department.

Professor Hultcrantz asked the participants:
"Is this a problem you think that you could discuss as a student, as a resident, as a doctor?"

Participant answered:
"Yeah I have had students who have started to cry when they have read this so it is very important that they can discuss these problems in safe groups as we talked about in my group here earlier. Somewhere they can really talk about the feelings they have because most of us who have experienced situations like that we are just swallowed up with shame. We haven't discussed it and we have no one to talk about it with, especially not the nurses."

The presentation continued...
The third Gender Collision is a Swedish one so you will read that in the paper because that has to do with something in the family. Persons who are familiar with a student group’s background and the way they think should of course write the Gender Collisions locally. It’s nothing you can distribute centrally and the cases have to be changed over time too, with increasing equality in society. The collisions maybe subtle but will always exist! Similar Collisions can of course be with different combinations of female doctors/male patient and male doctor/female patient. Use situations that you know about and that have made you feel uncomfortable in your experience. As teachers you can take that situation and try to analyse it and write a case and then use it for students to discuss. That is a very good way to do it. In faculties where Problem Based Learning is used the gender aspects can be part of the cases used in the ordinary curriculum. A couple of universities in the Netherlands have done that since before 1998. In the Netherlands there has been a Professorship in Women's Health since 1996.

It is important that you have male students involved and some men teachers even in the curricula where the courses are electives, otherwise the faculty members who are predominantly men will object and be reluctant to support the course. It is equally important that you have a pre-discussion within the course which means the different problems can very well be discussed in single sex groups before the general discussion. The girls are otherwise quite reluctant to say what they think since they do not want to hurt the feelings of the males if these are in a minority. It is also very easy for one single man to take over a discussion and thus silence the girls. Group discussion using the Supplementary Instruction method is an excellent method for learning. What is good for girls is usually also good for boys but the opposite is not always true.

I have recently moved to a new university, Linköping, where Problem Based Learning has been used since it was established 15 years ago. Nowadays I have students who are very accustomed to working in groups. The week before I left Sweden I applied together with a local network of female doctors in senior positions, to get a gender seminar every semester from semester 6 to 10 into the curriculum and use these Gender Collisions as a basis for discussion. We also want to distribute the book ‘MD, PhD and Woman’ among the students at the beginning of semester 6 when they start their clinical rotation. The National Network for Women in Academic Medicine wrote this book based on student’s questions about aspects of the medical profession. By spreading the book we hope also to get in contact with the students who are not especially interested to begin with. Eight of the 22 authors of
that book are working in the faculty and the students will meet them as they pass through the different clinics.

So I will end this presentation by showing you some of the illustrations out of 'MD, PhD and Woman' drawn by a congenial old colleague May Strandberg. She's not only an artist; 20 years ago she did very good research on women doctors and suicide. Most pictures are self-explanatory:

Do you have to be on-call again tonight, Mom?

Please, doctor! Can't I just get a little estrogen to help with my hot flashes?

I don't know, my dear. Research has shown that it's dangerous for your heart! A large prospective study was done on men in Japan a few years ago.
In the book we also talk about what it’s like to be a woman doctor combined with a family. The same question can of course be said about how it is to be a male doctor combined with a family so we can use the different chapters of this book as a ground for discussion and that’s what we want.

Turning to the topic of women and research and women in science, it was said in Sweden that the reason why women didn’t get so many grants and so much money was that they had some dull topics for their research, that it was not interesting. I don’t think that’s true; it depends where you put your interest.

Using Gender Collisions is something I could recommend to be a way to open the eyes both for students and for doctors to gender issues because these gender issues are equally experienced in the homes. So it’s something that happens all the time when we are in relationships with other people of the opposite sex or of the same sex too. If you put your own problems in the cases and you discuss the case you neutralise the emotional impact of the discussion. You don’t discuss your own problem you discuss “a case.” That makes it much easier to talk about.
2.3 SMALL GROUP WORK

This session, facilitated by Ms Jo Wainer, is the session in which the Recommendations from the Symposium were developed. Ms Wainer put forward three Concepts for groups to work on. They were:

1. The Impact of Gender on learning/teaching styles
2. What women bring to the discipline of medicine
3. Redefine Competence to include women’s strengths

Participants were asked to decide which Concept they would like to concentrate on and then to join with each other in groups of no more than six people to work on each point. One person in each group was appointed record taker and the notes were made on transparencies. Two to three small groups therefore worked on each of the three Concepts. Discussion within the groups lasted for an hour and a half and at the end of this period a ‘report back session’ was conducted. Here all the ideas contributed amongst the groups were discussed and redrafted by Dr Lexia Bryant and Associate Professor Merilyn Liddell (Monash). The output of these small group discussions contains unique content and is the product of the huge range of experience, and intellect and feeling of the participants as they evolved into the final Recommendations (see 1.1 Recommendations).

The Following information presents the draft Recommendations and presents the recorded notes from which they were drawn for each of the Concepts

**2.3.1 Concept 1 – The Impact of Gender on learning/teaching styles**

**2.3.1.1 Outcomes of Discussion of Concept 1**

We recommend that accreditation evaluation and quality improvement in all medicine and health sciences courses address the following issues:

- Learning Environments(LE) should facilitate personal relationships between teacher and student
- LE will provide an atmosphere of respect and safety
- LE should provide time for reflection
- LE should address attitudinal and emotional as well as knowledge domains
- LE should incorporate ongoing, constructive feedback

We say, “yes” to

- Teaching/Learning which creates relationships between
  - Teacher
  - Student
  - An environment of respect and safety
  - Time for reflection
  - Ongoing evaluation of the teaching of these issues
External Processes

2.3.1.2 Small Groups Work for Concept 1

- tend to maternal style brought into teaching
  - Personal care
  - Smaller groups
  - Attitudinal and emotional level
- passion for what you do if you are female
- single mentoring – teaching one-on-one
  - Feedback
    - Being pushed to higher level
- Small teamwork
  - worthwhile role within
    - “x anonymous”
    - only a couple of teachers have learnt my name
    - only one actually working contact (female)
- mentor rather than content
- “do not learn with ritual humiliation”
  - Very prone in clinical teaching and postgraduate
  - Ridicule as teaching tool
- positive teaching
  - Power structures
  - Students are very vulnerable
- “What is “right” is already gendered”
- validated above, put on final exams
- female ability to make relationships and to interact with patient
- patient doctor relation subject
  - Video and analyse
- practicalities
  - “supplemented instruction” with student tutor 2 semesters ahead
    - i.e. safer environment
    - more personalised
- confidence issues
  - Not just students but also females in academic applications
  - Female tendency to be more self contained – focus on weaknesses rather than strengths
    - Assumption you are not as good as the guy next door
- structural vs confidence
- confidence is a gendered construct
  - mother vs academic
  - females as teachers utilising other strengths and aspects
- fitting into given system
  - Vs
    - Independence

Ability to develop relationship
2.3.2 Concept 2 - What women bring to the discipline of medicine

2.3.2.1 Outcomes of Discussion of Concept 2

We recommend that the strengths that women bring to the discipline of medicine be affirmed.

We recommend that medical women consciously mentor undergraduates and junior medical officers.

2.3.2.2 Small Groups Work for Concept 2

STRENGTHS

- intuition balanced with knowledge
- communication approaches (bringing emotions to our consultations)
- acknowledging our different life experiences and how these augment our profession

We recommend that medical schools commit to valuing the strengths and experiences of Women in Medicine:

- honesty
- teamwork
- encouraging new norms of practice
- deconstructing the hierarchy

2.3.3 Concept 3 - Redefine Competence to include women’s strengths

2.3.3.1 Outcomes of Discussions for Concept 3

Definitions in competence and leadership must incorporate attributes that highlight women’s strengths, including:

- capacity for interpersonal skills
- capacity for egalitarian engagement
- ability to summarise knowledge and experience
- empathy

This definition is for women in medicine

Competence = capacity to fulfil tasks
+ to do this well

define science?

Seek funding for

1. To develop models of/trailing of models of General Practice/Family Practice incorporating multi-disciplinary teams. (Women work co-operatively in teams).

2. Dedicated programs to provide education, experience, salary and support to encourage and develop skills in women in both teaching and in research. (increasing cohort of women undergraduates and postgraduates need women teachers).

2.3.3.2 Small Groups Work for Concept 3

Strengths of Women / Competence

- Awareness
- Confidence
- Integration of personal and professional bringing the whole person to the clinical context
- Delegation
- Teamwork – including multidiscipline
- Capacity for empathy
- Intuitive and able to identify and deal with issues
- More caring
- Sees the work gets done

Broader life experience e.g. from raising a family
- Networks and personal connections – web
- Holistic
- Not competitive
- Relational perspective
- Empathetic
- Communicate emotions as part of the therapeutic alliance

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Performance Quality</th>
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<tr>
<td>Redefine intuitive, gossip, anecdote, instinct as strengths</td>
<td></td>
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<td>Social</td>
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<td>Delegatory</td>
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Right brain activity is as cognitive as left brain
- Parent / mentor, teacher
- Is there a difference in the way men and women function?
  Yes, demonstrable.
- Intuitive, empathic, expressive, nurturing, good at promoting others.
- This is not included in structures.
- Those who dominate the field exhibit masculine style.
- Social competence
- Emotional intelligence
- Capacity for empathy
- Interpersonal communication skills
- Capacity for egalitarian engagement
- Ability to work with intuition and emotion

COMPETENCE
Why is competence an important issue?
- Critical for women to gain respect amongst male and female colleagues gaining a reputation for excellence – technical competence is the starting point.
- Women are able to take up positions of influence in learning establishments to effect change.
- Funding structures have worked against women – eg fee for service.

How is competence gauged currently?
- Patient satisfaction
- Money earned
- Number of patients seen
- Research funding
- Appointments/chair of dept/professor

What do women bring to/add to medicine? Strengths of women.
- Look at outcomes in very different ways (bureaucrat $, men - how many won/lost, women look for an individual's improvement in life/quality change e.g. in General Practice men gauge competence in number of patients seen, money earned, clearing the waiting room.
- Co-operation with other workers in allied medical roles/work in team
- Can do research which measures different outcomes – qualitative research – redefine what is research
- Networking with others in collaborative way
- In tune with own and others’ feelings
- Nurturing side-maternal aspect
- Lateral thinking
- Work in a different style
- Women earn less money – cost the government less

Strengths
- Mental health interests and skills and strengths
- Alternative ways of measuring/gauging competence
- Measuring 'health' of community rather than 'illness' or numbers of sick people – relative changes in health in community.
- Through the rural GP move and funding in Australia – this has opened up opportunities for a number of women to take up academic practice
- Funding is coming from rural source but the topics relate to women working in urban locations as well.

Recommendations:
- Models of GP/Family Practice incorporating multi-disciplinary teams, funding from government to develop trialing/piloting such models
- Dedicated government funding to encourage and develop women in teaching and research – financial support, education, experience, support. Positive discrimination/affirmative action.
- Making pools of money available from the government.

The recommendations that were agreed to by Symposium participants were developed from the feedback from the small groups. The agreed content was then adapted into international language by the Recommendations Committee comprising Dr Deb Colville, Dr Lexia Bryant and Ms Jo Wainer (Australia) and Professors Elisabeth Hultcrantz and Carin Muhr (Sweden) and submitted to the Recommendations Committee of the MWIA Congress.
2.4 CONTRIBUTIONS

Upon registration for the Symposium, the participants were asked ‘to bring your own story in any format you feel comfortable with.’ The following are some of the written contributions that the participants brought with them. They appear here unedited and de-identified; only the contributor’s profession is mentioned.

2.4.1 General Practitioner

As a reasonably educated, moderately observant human being, it surprises me that it took me till my late 30’s to realise men and women are different. It wasn’t until after my 3rd child (and 1st son) was born that I realised that there were inherent differences that had little to do with socialisation.

In retrospect the consequences of this in my medical career became apparent as an intern when survival depended on "taking it like a man’. I did it quite well – my male colleagues even called me “mate!” I enjoyed the camaraderie, but the internal tensions did not surface until my years in full time general practice. Increasingly I discovered that though I worked the same hours, did the same overtime, I did way more PAP smears, ran through the tissue box on the desk much faster and earned far less. I actually thought it was a discipline problem. If only I had the discipline to restrict my patients to the regulation 1.6 problems per consult and turn a deaf ear to their distress signals, I could be a successful GP.

Six years out of uni I was exhausted, depressed and demoralised. I survived by making some major career changes, but it’s taken much longer to reassess the sense of failure and the feeling of always “fighting in someone else’s armour.”

Twenty-three years after graduating I still enjoy medicine. I love the variety, the detective work, the intellectual challenge, the vast array of individuals I meet in the course of my work, the effort and integrity most people put into their lives. But I really hate the insinuations that I’m not pulling my weight and the financial inequities.

It will be fascinating to watch the feminisation of general practice, but I fear that it will only decrease the respect and funding for it.

2.4.2 Medical Student

In my experience as a pre-clinical medical student, my gender has very rarely been an issue. I went to an all-girls high school, and to be honest I am only gradually becoming aware that there are real differences in the way males and females learn and behave. In my course the vast majority of teaching is delivered by lecture, and as one of many my gender certainly is not an issue for the lecturer. Of the good lecturers who excite and inspire me, I find myself saying “I could be you” or “I want to do that” about both male and female speakers, but it is valuable that a few have been women. In tutorials and exams, where the numbers are smaller I am more aware of my sex. There have been tutors who try to be ‘one of the boys’ or who encourage or do not sufficiently suppress inappropriate behaviour or comments in surface anatomy clinical examinations classes, but other female students have been there to validate my feelings and suggest other less threatening environments to practise these skills.

Memorable experiences include a disturbingly ‘friendly’ anatomy professor, the well-intentioned suggestion by another student that we should wear a tight shirt to our oral exams, and being the only female student present on the day we dissected male external genitalia, and being forced to do it alone while the boys watched as they (even the demonstrator) could not stomach doing it themselves. I know very little about life after lecture theatres, but I imagine this experience of being a faceless, genderless bum on a seat will end, and my gender, appearance and presentation will be noticeable and important in a hospital. I could also hazard a guess that this may occasionally work against me. I do not want to believe that the profession I have chosen (and that has chosen me) does not accept me and I hope the experiences I hear of from other women are relics of the past. It remains a mystery and a challenge for me how I will manage both family and career, but I possibly naively hope that my future husband may struggle with similar issues. If worst comes to worst there’s always my mother, she did not do such a bad job raising me.
2.4.3 Medical Student

In preparation for this conference I was asked to consider a time in my medical education where gender has been important. To understand my experience of the course, I should explain that I have recently returned to Medicine after a year off. During this year I travelled in Africa, Europe and Asia and completed Medical Electives in South Africa, Tanzania, Thursday Island and Darwin. I am studying final year at the University of Melbourne, a traditionally conservative and orthodox Medical School.

The most positive experiences I have had during my medical education have been the extra-curricular elective placements that I have undertaken by choice, as well as my Fifth Year placements in Obstetrics and Gynaecology and Paediatrics. During the majority of the rest of the time, I haven’t enjoyed the clinical environment. I have never experienced any overt single episodes, but rather they have been quite insidious and poorly defined.

It has been during my final two years of Medicine where I have most acutely felt the Masculine nature of the medical course. I have recently completed my Specialist Medicine rotation, which I found very disheartening. Three out of the 16 tutors that I have ongoing contact with are female, so to say that it has been male dominated is an understatement. However, I think there is more to it than a lack of women. It’s the whole environment, which I think is one of male dominance and male style. It’s very important to me to be able to get to know my teachers a little, for them to become mentors as well as instructors. There simply hasn’t been room for this. Of all of my tutors over a ten-week period, a handful have actually learnt my name, and only one has ever inquired into my interests, within and outside of Medicine. It is only this tutor, a female, who also felt the need to spend time with us as people, not just as students. The elation my group of six female students felt after she sat talking with us for an hour after a tutorial was great – it was the highlight of the term. We walked around for days with smiles on our faces.

I’m still not certain that all I’m experiencing is due to gender, but do believe that the environment of the Tertiary Teaching Hospital is very hostile, anonymous and male dominated. I can not help but think that if it were more feminised, I would feel more comfortable and supported. This nebulous lack of female influences hasn’t impeded my ability to succeed, but it has definitely hampered my ability to enjoy the experience. It has also left me feeling like I need to leave the tertiary hospital setting for my internship, to find a smaller and more personal place to work. Likewise, it has had a great influence on current career interests.

It’s very important to me to have contact with strong role models and mentors. I passed through fourth year feeling very lost within the hospital system, not really enjoying it, and not really identifying with many of the staff which I had contact with. In my fifth year the highlight was my Obstetric and Gynaecology Term. During this rotation there was an organised mentor program in place. I found this scheme incredibly useful. For the first time in our clinical teaching, I had close and ongoing contact with a single Doctor. My Mentor was male, and he played an incredible role in directing my teaching. He did this not by teaching me the theory I needed to know, but rather by inspiring me to learn about areas touched on in clinical encounters with patients. My mentor gave me positive feedback continuously, but also expected the highest of standards. I thrived in this supportive, yet stimulating environment. Finally, I found myself in an environment where my individuality mattered to those teaching me. My mentor was interested in me as a person – it was nourishing.

During my fifth year, it became apparent to me that I needed to be surrounded by medical women, to talk with them and to learn about their experience. I needed some career counselling, and wanted to get to know some of the woman I had come across in a relaxed environment outside of the hospital. To this end, I organised a dinner, which was attended by 10 students and 4 female doctors from various specialties (GP, Neurology, Obs and Gynae and Surgery). The feedback from everyone was very positive. The women Doctors impressed upon us the need to create a supportive network of colleagues, both male and
female. They were more than happy to share their experiences with us and enjoyed having a supportive audience. The women Students were delighted to be surrounded by successful and happy mentors, who we could easily identify with and learn from. It was a very insightful experience. It also made me realise that sometimes you have to take control and create situations that fill in the void of our medical courses. And, in actual fact, the people who have had the strongest influence on me have been mentors I have found outside of the teaching program, here in Melbourne and in sites where I have done elective placements.

2.4.4 General Practitioner

When I was a medical student (from 1969 to 1974) we had very few women teachers. I can only remember 3 amongst the 100 or so teachers who were women. They all seemed so formidable, as I think they would have to be to work in medical academia at that time. We were taught about medicine with great emphasis on objectivity and professional distance. We were taught entirely in the hospital system where the patients were divorced from a social context, and were not people with families and homes.

I wondered where those feminine qualities of caring and nurturing belonged and when I tried to model myself on our teachers it always felt wrong. When I graduated, I chose to work in general practice because I thought it would be a place where I could work as a woman, with people within families and communities.

Over the years I have realised that the feminine qualities of nurturing, caring and connectedness that we as women bring are absolutely at the centre of the practice of medicine.

I am really lucky to now be working in general practice in rural New South Wales. On the wall in my consulting room I have a beautiful pastel drawing, which my mother drew of me holding my daughter when she was 3. To me it speaks not only of the love between my mother, my daughter and myself but also of the mother qualities which we as women give our patients.

We are getting an extra doctor in the practice soon, so I will have to share a room with another doctor in the practice. We have agreed that I will share with another female GP. We both love sewing and embroidery. At the moment she is working on a lovely cross-stitch piece, which will have handprints of her children on it. I am working on a crazy patchwork piece called “Healing hearts” which symbolises the healing which comes from within us. We will both hang our work in our shared consulting room when we finish it.

It is wonderful to work in a place where our qualities as women doctors are not only valued but celebrated.

When I was a little kid I wanted to be a teacher or a nurse, both of which I have a great deal of respect for as professions, but they’re not my vocation and I couldn’t have boxed myself into the mould and remained sane for the rest of my life. I looked around at the women in my life and I saw good, solid, intelligent women who had had 2 choices in life, nursing or teaching and made their choice accordingly, never considering the endless possibilities of professions that were available to them. When my older sister was 6 my father asked her what she wanted to do in life and she replied that she wanted to go to teachers college and be a teacher, my dad asked her about going to university and her response was that it was too hard and she’d gladly stick with teachers college. My sister is now studying medicine at the University of Sydney and the rest is history.

Looking back it sounds as though I come from an oppressive household that frowns on tertiary education for females, confiscates and burns any copies of The Female Eunuch hidden under the bed and directs its daughters to the nearest kitchen sink and apron but that image couldn’t be further from the truth. I had parents who encouraged me to do whatever I could and give whatever it was possible to give to the world but the close female role models and society’s influence as a whole shaped my view on life and my role in it astoundingly. This trivial story doesn’t mean much until you hear that I’m speaking of the
1980s and then you speak to girls of the 2000s and they utter the same self-doubt about their life and future and that’s got to change.

I do not assume that the women in medicine conference nor the women's work shops that are beginning to grow throughout medical schools across Australia will change the lives of little girls today, but I do believe that they have the potential to change the life of females in medical school today. The way you see your future is indisputably shaped by the role models that you see around you. The males in our field make up a greater proportion of the specialists and as a direct consequence make up a greater proportion of our lecturers and our tutors. Each time a confident and competent female takes the floor females throughout the lecture theatre either consciously or subconsciously consider themselves in that role. So far as I can remember in my medical student career I have female role models in paediatrics, endocrinology, anaesthetics, gastroenterology, academia and many fine role models in general practice. But I am aware that there are other specialties and I do not want to extrapolate in my own mind and assume that other specialities are family hostile, female hostile or women simply do not perform well in them, but that is the underlying message that I and my female peers receive. Our perception of female specialisation has to change, the ratio of female medical students has shifted over the past two decades to now being dominated by women, medicine is no longer seen as family hostile, female hostile and a field in which women simply do not excel. I want our ideas of specialisation for women to change and I think that with greater rates of female specialisation the profession will change, so that women do not have to be pseudo-men in order to survive but a profession which nurtures and gains from the attributes that many women possess.

My idealism has been tarnished sufficiently so that I’m not prepared to commit to changing the outlook of female children across Australia as a result of my attending the conference, but I can commit to changing the perceptions of females in Newcastle medical school so that they do not assume that their 23rd chromosome removes from them any hope of specialising.

I joined the Medical Women’s International Association to try to change the situation for female physicians. One of the tasks for the MWIA is to develop the role of the female physician so that it will integrate with the sexual identity and the professional role, basically allowing a relaxed natural professional role where one can be oneself.

2.4.5 Doctor and Medical Educator

When teaching 1st year students medical interviewing, we ran through all the usual questions: nature of the pain site, radiation, precipitating and relieving factors and so on. Having just read a book on patient-centred medicine, I asked the students to also ask the question: “What does this pain mean to you?”

The first patient was a young woman who had been in hospital for 10 weeks with abdominal pain, as yet undiagnosed. She was an expert on answering all the “usual” (scientific) questions. When asked what the pain meant to her, she started crying and told us how she was afraid of dying, how she was a single mum, how her 10 year old son was having nightmares about her.

Is this a “feminine” approach to questioning? It is certainly not the sort of question I have ever seen put by a male doctor. Was it helpful? - I think the students were blown away and we all gained insight into the extent of this woman’s suffering and her desperate feminine needs (completely unmet by the system to date).

I think this open ended question “what does this pain mean to you” encapsulates for me much of what an approach to medicine that is informed by the feminine, that is willing to ask open questions, that is willing to tolerate a story, however long that takes to tell, that respects the “other’s” view.

It is difficult to overestimate the importance of mentors and role models in medicine; in particular role models who show or value women as competent, achieving human beings,
who value their particular strengths as well as their abilities to learn non-generic medical skills, and who respect their unique life experience.

2.4.6 General Practitioner

The first time I recall being aware of gender issues in medicine was during my first 3 months of working in General Practice which was located in a small rural town. The town had undergone some change and had become a largely ‘welfare class’ town with lots of disadvantaged people. There were few resources available to the people in the town.

There was only one general practice made up of 6 male GPs all in their late 30’s early 40’s. I was really keen and determined to do my very best. I found myself seeing a lot of women patients, a lot of people with complex, complicated health problems and mental illnesses.

In retrospect, the work I was doing was really hard and challenging. I was seeing about 8-10 patients per session. I think I was managing difficult problems very well. I didn’t get any positive feedback or recognition from my GP Supervisor and all I remember him saying to me was that “you will never be able to survive if you continue seeing so few patients”. My confidence was really knocked and by the end of the 6 months in the practice, I really questioned my abilities, skills and my future in medicine and general practice.

I felt that because the other male GPs didn’t value women’s health and weren’t able to make much money from handling women’s health problems, they simply chose to ignore it.

When I was trying to address their deficiencies, even then they didn’t understand what I was doing and didn’t support me. I was being judged by their values.

2.4.7 Academic and Medical Educator

I am frantically writing this on my flight to Sydney to attend the Gender in Medicine Symposium prior to the Medical Women’s Conference and I find myself sandwiched between two gentlemen whom have both appropriated the arm rests. Sound familiar? Is this gender or is it personality? Am I ready to rumble for the arm rests or is that just a little childish (or boyish)?

Everyday I am reminded of the fact that I am woman and not man. If I were a man I would have been Doogie Howser! Enough of the sarcastic preamble, we have examples a plenty for the general sexist attitude of our society, however covert they may be. As a female doctor, gender issues are not what they were 10, 20, 50 or 100 years ago but, unfortunately, they still exist.

We all have multitudes of stories about fighting for theatre time with our muscular male colleagues as the orthopaedic consultants assume that you wouldn’t be interested; or being referred to, along with your female colleagues, as the “girls”; or being groped in the registrar’s office by your superiors; or simply being ignored…….

It takes strong women to stand up to these innuendoes, the disrespect and occasional blatant harassment. Fortunately, not all our male colleagues are prone to the Y chromosome effect. I have found some of my most ardent supporters in my male superiors and colleagues. The challenge is instilling the attitude of equality into our peers and, importantly, into our up and coming doctors, male and female alike.

In my experience (limited though it may be), I have found the majority of men to be unaware of the impact of their seemingly non-sexist comments and behaviours. For example, a male colleague introduces another male colleague as “doctor” and a female colleague by her first name. Sexist or forgetful? Who is responsible for addressing these sexist/forgetful comments? If you stand up for yourself as a junior medical officer, do you jeopardise your career, earn respect or get a reputation as a hard-nosed bitch?
I believe it is primarily the responsibility of families to teach respect regardless of gender and that ethos needs to be embraced in our educational institutions, not least of which are the tertiary institutions. Medicine, particularly, has an important role in fostering these ideals, as they not only influence relations between doctors but also relations between doctors and patients.

So, where to from here? Thankfully we have wonderful societies that encourage women in their medical careers and these networks continually need strengthening and evolution as gender issues arise and change. It is also imperative that appropriate gender teaching and learning is incorporated into medical curricula. As an influential group, the Medical Women’s International Association is one of the key stakeholders in such a course of action. The recommendations resulting from this symposium should ideally be given due consideration by curriculum committees and suitable programs developed.

2.4.8 Surgeon and Academic

'Hilton Balm'

Before the satellite workshop, I didn't write the 'one page' contribution that we were invited to bring along to our satellite workshop on "Creating and Teaching the Discipline of Gendered Medicine". But I have decided to write down some of my reflections today as my contribution to that part of our workshop. 'Hilton balm' is my title for this short piece.

The word balm sounds like bomb - and the phrase 'Hilton Balm' is based on "the Hilton bomb" - an historical event, an explosion that many of us recall occurred at the same Sydney Hotel Hilton at which we held our meetings this week, although the explosion happened more than a decade ago.

The satellite and main conference events were held at the Sydney Hilton hotel on Thursday 19th April to Monday 23rd. Further events were held in Melbourne yesterday, Tuesday 24th April. For me this last few days has involved focussing on learning ways to work as women together to create, further, and teach, the discipline that we are calling 'Gendered Medicine'. We held our day-long satellite workshop on Thursday. We co-convened a number of sessions-for me the three were: Women in Surgery, Women in Medicine, and, almost as if to link these two, Mentoring.

Satellite symposium and workshop summaries for all four events were produced by women present at each session, and we were also able to write recommendations from each to go forward into the political arena, a contextual link with the history of a resolutions process by women doctors globally since MWIA's establishment in 1916, the date I recall from the MWIA banner and talks.

At the conference were women doctors 'representing' all the women doctors in at least 42 countries. By the time we came to the final business meeting of MWIA on Monday lunchtime, the debate that occurred in the business meeting about the 'private is political' implications of including the very word 'empowerment' within the very statutes of our own organisation of MWIA made lots of symbolic sense.

'Global' then local. At Monash and Melbourne, with international and Australian guests, we met and talked yesterday, asking how we might further this work in our own universities and colleges, and to explore how we might transfer the 'heady' feelings back to change our workplaces, medical classrooms, and homelife. Concentrating on our roles as women doctors who educate, 'Gendered Medicine' - yes, it's already deeply embedded in both our 'lived' and our written curricula, but we can see now that this is the case, and we do not often like the shape it has in mind for us as women doctors. So let's work to explore how we will get it right for us as women doctors, while at the same time knowing full well that we are all 'different'.

We blended engaging, participating, dancing, policy making, writing, connecting, taking photographs, having fun, allowing grief, and feeling very moved by one another. I think the best thing I have learnt is that, while acknowledging the seriousness of the predicament in
which I and other women doctors find ourselves, we can create safe spaces from which we will emerge to ‘do Gender Curriculum differently’. I want to say thank you to the many many women who helped me ‘grow and connect’ this last few days and months through our participation in the MWIA planning and the events in Sydney and Melbourne. Through the months of drafting, digital communication, dramas, drinks, and discussions, I didn’t anticipate the ‘dreamy’ feeling I have now.

Does anyone else want to write their ‘after’ story?

2.4.9 Academic and Medical Educator

A group of female academics from my faculty had met to discuss the possibility of getting a gender perspective into the new curriculum at an academic advisory committee meeting. We did this, very publicly, and about 15 women attended. My sense was that we all knew there was some work to be done to improve things, and have not had the skills or the time to pursue it. We may also have felt that this was difficult work. Identification with a challenge to the dominant culture can result in one being branded as unreliable, ‘not one of the boys’, and not OK to be included in the inner circle.

We decided to play it by ear a bit; to wait and see, to take action to have women included if it became appropriate, and to back each other up if it became necessary. When we met in plenary session I was surprised to find that I had been included as one of only 3 female chairs of working groups. That was a very public statement by the organisers that it was OK for me to be there because I am an experienced chairperson. At the next plenary session a male academic spoke and exclusively referred to the consultant as ‘he’ which I felt precluded the possibility of women being consultants. I had not planned to make myself visible in any way, but I was unable to let that pass because if we do not disallow exclusion at every point, then we end up by colluding with it. So I publicly asked that as a group we make a commitment to gender inclusive language. The male academic chairing the session was not amused.

This was a bit of a problem for a number of reasons:

a) I was challenging the process of silencing the women. This process is powerful and insidious and has us as bamboozled as rabbits in a spotlight. One doctor said she just dropped into total fear when I spoke.

b) This was a process set up by the Dean and carried out by three male professors. Challenging their world view was not appreciated.

c) My comment was spontaneous and not well crafted, so that it came across as more confrontational than I would have liked.

My memory is that the room became completely silent, the Chair said "your comments are noted" and then we moved on. But the effect was to ripple outwards. The first manifestation was that only 3 - 4 of the original 15 women in our group were prepared to be seen with me from then on. So women who had wanted to work together became unable to do so because I was no longer safe to be seen with.

2.4.10 Academic Doctor

I had to attend a meeting with academic colleagues to discuss the teaching of gender issues in the medical curriculum. There are only three of us at the meeting.

We will discuss a new program, which will replace others. I have been nervous tense all morning, typing, photocopying, arranging, stapling, clipping papers. The papers seem so flimsy, so inadequate. Unable to show my years of work and what it means to me.

The room is bare walled, empty apart from a table and randomly arranged chairs. To start there is chit-chat. ‘...this table is odd.’ ‘...it looks like some sort of massage table’.
Then the business starts. Her words are smooth, professional, rehearsed. I disagree with her. ‘We should not disregard a program that is working well.’ My voice is taut, and sharp. He says ‘Now don’t get emotional.’ His voice is stern and angry.

I am silenced. I sit, my head down, doodling, desperately trying to control the well of tears with the movements of my hand and pen, forming round curves, the shapes of flowers on paper. I can feel the hot tears gathering in my eyes and running down my cheeks. I have stopped drawing now, the tears are dripping from my chin.

They keep talking. Her posture is deliberate, tolerating no distractions. She has turned away, so all I see is her back, her profile, held hard with concentration away from me. She keeps talking, with him occasionally agreeing with her.

He passes me a box of tissues, but still she looks away. Her organised flow of words continues, her voice controlled, her tone even and firm like a fixed smile. The tears are streaming now. I try to hold them back, so instead they come in bursts. My mind is overwhelmed by pain, memories of past hurts, sense of dread of losses still to come, and useless efforts to stop the tears.

Now and then I grasp bits of what she is saying ..’I think...we should...four models...maybe even a fifth, her one...must work as a team...I chair ...of course...I support...equity...must not talk outside...until there is agreement’

Sometimes she pauses to get agreement. He asks me questions. She looks momentarily in my direction. Can’t they see that I can’t discuss anything just now- I have no coherent words- all I can do is nod or shrug. I am trying to control the tears with swallows that keep turning into gulps. I can hear myself. The gulps sound like sobs.

They have come to a question for which a nod or shrug won’t do.

I am reaching down deep to find some strength. How can I manage to answer with coherent words? I finally manage to speak coherently. He takes the answer as a criticism. He says ‘Let’s cut the emotion’, his voice stern and angry again.

I am trying to find that very last fibre of strength. Can I find the words to give the correct answer, this time. At last I do. Then the tears take over again. They are finishing the meeting now going over what they’ve said and agreed. Somewhere in there I can hear him say ‘I know this is distressing.’

They are arranging another meeting, asking me to attend. ‘I’m busy on that day. I’ll find someone else.’ I am garbling. Then the tears start to pour out again. She stands up walking in his direction ready to leave. ‘I need to talk to you about this other paper’ she says to him, ‘We haven’t finished the work we were doing on it’. Her voice is business like, sure and satisfied with importance. He looks at me and says ‘Does your supervisor know how distressed you are?’ ‘I don’t want to talk about it’ I shake my head. O God I wish they would go away. ‘You want be alone’ she says. She is actually looking in my direction now. All I can see of her is a blur I nod. They go.

At last they are gone. I am alone, really alone. But less alone, less abandoned, less ashamed than when they were here. People walk past the room. They don’t look in my direction. I am alone. I feel like I am glued to the chair and now they are gone the tears become loud sobs. There is someone outside the window. I am alone now. Alone but not alone, the pain, the tears are still here.

I sit immobilised by the pain and tears. I sit alone. How long has it been now? How will I get out of here? I need to walk out the door, up the stairs, out the front entrance, across the road, and down the steps to the car park. How can I walk out there like this? I only have to control the tears for about five minutes. Then I can go. I’ll hold my breath. I’ll
concentrate. I start to weep again. I hold my breath. I concentrate. This time I manage it. There is a sink in the room. I hadn't noticed it before. I splash cold water over my face. Now I will go, now while I have stopped crying.

I hurry out the door, up the stairs, out the front entrance, across the road, and down the steps to the car park. At last I am safe in the car. The weeping starts again. I am driving now, my vision blurred with tears. I drive automatically, round the roundabout, down the hill, to the left, past the big roundabout, past the traffic lights, to the next roundabout to the right and into the car park.

I stop and start to sob again. How can I walk up to office now? I feel immobilised again. I don't think I can open the car door and walk up the hill from the car park to the office. My mobile phone is ringing. Please someone help me. 'It's Jasmine'. 'Where are you?' 'Five minutes from your work' 'I'm really upset. I'm in the car park. Can you come here to me?'

At last she is here. She gets into the car. She doesn't need to say anything. She sits next to me and puts her arms around me. The tears are more of a release now, a comfort, not a shame or embarrassment. At last I am not alone.
2.5 CLOSING

The days proceedings were closed by Dr Lexia Bryant (Monash) and Dr Tamara Mackean(Australia):

Dr Bryant:
I think every Australian is precious, as is every human. There are some who for some of us are a bit more precious and an Aboriginal medical practitioner in Australia is a rarity and we can't value it enough. More than that it brings another voice to this work that we are doing and this is the first time in my experience we've had one of our Aboriginal colleagues input these gender meetings. I've been exposed nationally and internationally to other cultures today, most cultures from around the world, so thank you for being here. We are going to ask Tamara to comment and close this day for us with the support of her colleagues behind her.

Dr Mackean:
I must say I am humbled by Lexia’s comments about being a precious person. I am me, I’m just me and what I do with my life is viewed positively by my Aboriginal community, by my medical community, by my family as good that I’m happy. I would like to close the day the way it began by sharing an experience of mine with you. It’s not scientific. It’s not evidence based. It’s just a personal story about how I was 16 years old and I had my first opportunity to go bush, go walkabout. I was very lucky to go to the Warburton community which is in the central desert area of Western Australia. I was taken in to this community by the Aboriginal women there and I was able to partake of a traditional lifestyle. I gathered food with them. I partook in a corroboree with them. I danced with them, in traditional dress if that’s what you could call it -shorts and painting your chest is dressed! To me that is my traditional way and I had a moment of immense spiritual knowledge and affirmation of my aboriginality and my femininity. I want to share that with you all to inspire you, to encourage you to take these next steps forward in our work. I’d also like to say this is just a start it’s not the end and so to all of you, welcome.
3. CONCLUSIONS

The Aims of the Symposium were achieved. The Recommendations from the Symposium were presented to the International Congress of the Medical Women's International Association. The Recommendations were amended to form the following Resolutions. The Following Resolutions were accepted by the General Assembly at the 25th MWIA International Congress in Sydney, Australia, April 2001

**MWIA Resolution 2**

MWIA urges affirmative action so that women, who represent half of the population, are given an equivalent share of appointed positions at all levels. MWIA calls on all member governments to introduce a gender perspective into all health policies, health budgets and provision of health care. This should extend further than sex differences in morbidity and mortality rates and includes those gendered behaviours damaging to health. MWIA also urges all countries to recognize gender specificity in all medical research and education.

**MWIA Resolution 3**

MWIA encourages medical colleges, universities and other medical organizations to promote and support mentoring networks for junior medical women to encourage new female leadership.

The Symposium participants began to establish the discipline of Gendered Medicine and since then some have taken part in the First International Program on Gender Perspective in Medicine, held in Sweden in August 2001, and the face-to-face meeting of the MWIA Executive in Bellagio, Italy in December, 2001. That meeting focussed on developing a manual to assist its members in introducing gender issues to all facets of medicine or ‘Gender Mainstreaming’.

The Aim to establish core content for teaching about gender in medical curriculum was supported in two ways. The first was through the recommendations in relation to teaching process and content, the second was in the collection of gendered stories that can form the basis for curriculum.

This international discussion contributed to developing the common language and agreed definitions necessary for establishing a new discipline, validated and built on the work already done by doctors in many countries, and linked the work and the academic doctors by providing a forum in which they could share and value their expertise.

**What do we need to progress?**

Women make up half of the world’s people and yet as we heard during the course of this Symposium, in medical texts world-wide the standard patient is still a man, illustrations are mostly men, normal values for lab tests are still from a 70kg man, the diseases more common in women are less thoroughly covered in the book than diseases where men are over represented… and the list goes on. It therefore seems timely that we desist with this ‘gender tribalism’ and engage in a real dialogue about the obvious: men and women are different. We need to find the answer to the question: ‘how does this impact on medicine in all aspects?"

Medicine as a profession and as a body of knowledge has developed in the absence of women. The role of doctor has therefore developed as a distinctly masculine one. Despite the increasing participation of women the role has changed very little. In the countries represented at this Symposium young women account for around half of all medical students and yet young women say they don’t want to ‘see’ themselves as ‘women’ but as ‘doctor’; an acknowledgement of the obvious, that ‘doctor’ is a performatve social role that excludes ‘woman’. Aside from the enormous amount of medical information provided during the course of undergraduate training both male and female students are subjected to a system
that subordinates them, makes them compete with each other for the favour of their superiors and deliberately excludes the feminine. This process inhibits the exercise of much of the creative intelligence they may posses.

That such a profession as medicine, which prides itself on its relentless pursuit of the knowable truth, should under-report half of its domain is unscientific. Purely from a human rights perspective, it is no longer acceptable to persist in this approach to the discipline.

What is required is a deconstruction of gender dynamics in all aspects of medicine. In order to develop a thorough strategy to bring about a more equitable gender balance within the profession the problem must be tackled not only at the personal, social and environmental levels but also at structural and institutional levels. This process will also reveal what aspects of institutionalised medicine have made it succeed for so long in its current form.

What is best about the current system must be maintained and married to a more inclusive approach.

It is time to begin a dialogue that commences with the telling of the other half of the story, to bring us closer to the balance worthy of the profession.
## APPENDIX I - LIST OF PARTICIPANTS

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Institution/Department</th>
<th>Country</th>
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<tbody>
<tr>
<td>Ms Allen</td>
<td>Medical Student</td>
<td>University Of Tasmania</td>
<td>AUSTRALIA</td>
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<tr>
<td>Dr Baird</td>
<td>Senior Lecturer</td>
<td>Flinders University</td>
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<tr>
<td>Dr Barnard</td>
<td>Senior Lecturer</td>
<td>University Of Western Australia</td>
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<tr>
<td>Prof Barnett</td>
<td>Professor Of Psychiatry</td>
<td>University Of New South Wales</td>
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<td>Dr Birks</td>
<td>GP</td>
<td>School Of Rural Health</td>
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<tr>
<td>Dr Blennow</td>
<td>Chief Psychiatrist</td>
<td>Psychiatric Clinic</td>
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<tr>
<td>Dr Braude</td>
<td>Physician In Private Practice</td>
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<td>Dr Chalmers</td>
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<td>Ms Coffey</td>
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<td>Adelaide University</td>
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<td>Dr Coles</td>
<td>General Practitioner</td>
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<td>Dr Colville</td>
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<td>Dr Cooper</td>
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<td>Dr Dabson</td>
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<td>Dr Eiguchi</td>
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<td>ARGENTINA</td>
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<td>Dr Fourcroy</td>
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<td>Dr Hultcrantz</td>
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<tr>
<td>Prof Quadrio</td>
<td>Director Mental Health Services</td>
<td>Corrections Health Service</td>
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<tr>
<td>Dr Ratko</td>
<td>Republican Sanitary Inspector President-Elect</td>
<td>Min of Health&amp; Soc.Prot.n Rep of Srpska</td>
<td>REP SRPSKA</td>
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<tr>
<td>Dr Ross</td>
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<td>M W I A</td>
<td>CANADA</td>
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<tr>
<td>Dr Slobodan</td>
<td>Chief Of Dept. ISI MMA</td>
<td>Military Medical Academy – Belgrade</td>
<td>SERBIA</td>
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<tr>
<td>Ms Spinaze</td>
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<tr>
<td>Dr Strasser</td>
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<td>Dr Tolhurst</td>
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<td>Ms Ukor</td>
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<td>Ms Wainer</td>
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<td>Monash Uni School Of Rural Health</td>
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</tr>
<tr>
<td>Miss Weidlich</td>
<td>Dep.Chair, Nat. Rural Health Network</td>
<td>Newcastle University</td>
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</table>
APPENDIX II - BIOGRAPHIES OF PRESENTERS

Professor Elisabeth Hultcranz, MD, Ph.D. (Sweden)
Professor of Otorhinolaryngology, Linkoping University, Sweden. Her research interest is in blood circulation in the inner ear and diseases related to it. She has a special interest in sleep apnoea and other breathing disturbances, especially in children. She has published more than 60 papers and book chapters.

*In 1991, she was one of the founding members of a national network for women in academic medicine. The network has introduced the concept of gender into the undergraduate studies at all medical schools in Sweden. In 1994, the network was the recipient of the government’s first “Equality Prize.”*

Another project for the network was a book published in 1998 based on students’ questions about women in the profession of physician: *MD, Ph.D. and Woman*. Dr. Hultcrantz was chief editor. This book is used as a textbook in the courses in gender aspects in the practice of medicine held at Swedish universities. Work on this book and other of her activities resulted in the award: “the member of the year 2000” from the Swedish Medical Women’s Association.

In 1995, the government announced the availability of grants to support the development of courses in Women’s Health. In collaborations with Carin Muhr, Associate Professor of Neurology and a member of the network, Dr. Hultcrantz initiated the course as an elective within the undergraduate program for medical students. It has been very well received by the students taking it, but it has also been a provocation for many others. About 25% of the students are men. The introduction of this course was appreciated also among nurses and others working in the medical field.

Associate Professor Carin Muhr (Sweden)
Carin holds her post in Neurology at the University of Uppsala in Sweden. She specialises in Neuroendocrinology. Her research background is in intracranial tumours, hormones and migraine. She is a director of a five week course Women’s Health that has been running since 1996 and she also coordinates International Student Affairs in the medical faculty at her university. She is the Scientific Secretary of the Research Ethics Committee.

Dr Lexia Bryant, MBBS, D.Obs, Dip.FT, FACRRM, FRACGP (Monash)
Lexia is Senior Lecturer at the School of Rural Health and immediate past-president of the Australian College of Rural and Remote Medicine (ACRRM). She chaired the working party that developed the policy on Women in Rural Practice for ACRRM.

She is leading the contribution of the School to the development of the new curriculum at Monash. This builds on her experience as the first director of the Victorian Advanced Training for General Practice (VATGP) program, a Monash University based Special Skills and Advanced Rural Skills Training Programme with more than 65 positions and 44 registrars.

Lexia is a member of the Board of the Rural Workforce Agency of Victoria, and chairs the Scientific Committee for the World Organisation of Family Doctors (WONCA) International Rural Health Conference being held in 2002 in Melbourne.

Lexia has presented papers and workshops at national and international conferences on women as rural doctors, including the WONCA Conference in Durban in 1998, and the WONCA Rural Conference in Kuching in 1999.

She is on the management team for the Gender Issues in Rural Practice project at the School of Rural Health, and the research project on Sustainable Practice for Female Rural General Practitioners.

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She co-chaired the Satellite Symposium on Developing and Teaching about Gendered Medicine, as well as the sessions on Women in Medicine and Mentoring that were part of the Scientific Programme of the Medical Women's International Association International Congress.

Ms Jo Wainer, MA, ASIA (Monash)

Jo is a medical sociologist working in rural health. She is a senior lecturer at Monash University School of Rural Health with an international reputation in gender analysis and medicine. She was an advisor to the Secretary General of the UN Fourth World Conference on Women in New York, and attended that conference in Beijing (1995) as a member of Secretary General's staff, as well as the 'Prepcom' in New York. The following year she was the Non-Government Organisation representative on the Australian Delegation to the UN Commission on the Status of Women in New York. She attended the UN International Conference on Population and Development and the parallel NGO Forum in Cairo in 1994 as a journalist for the Australian Broadcasting Corporation. At the 1997 meeting of the Western Pacific Region of the World Health Organisation in Sydney, Australia she was a representative of an international NGO.

Jo was a contributing editor for the World Organisation of Family Doctors (WONCA) policy on Rural Health and Rural Practice (1999). In 2000 she was an invited Keynote speaker on Women as Rural Doctors at the 4th WONCA World Rural Health Conference in Calgary, Canada.

Jo organised the Satellite Symposium on Developing and Teaching about Gendered Medicine in April 2001 in Sydney, attached to the Medical Women’s International Association World Congress, and she was jointly responsible for the session in the main conference on Women in Medicine.

Jo is responsible for the Gender Issues in Rural Medical Practice project at the School of Rural Health, and national and state-based research projects on women as rural doctors.

Dr Deb Colville MBBS FRACO FRACS, Grad Dip Epidemiol, Master Public Health, Grad Cert Voc Ed Training (Clinical Instruction) (Australia)

Deb is an ophthalmic surgeon, a council member of the Royal Australasian College of Surgeons and was elected to the Royal Australian and New Zealand College of Ophthalmologists Federal Qualifications and Education Committee 1995. She chairs the Women in Surgery Committee, Royal Australasian College of Surgeons and is currently Director of Vocational Training Program, Royal Australian and New Zealand College of Ophthalmologists. She is Director of Medical Curriculum Development, Royal Victorian Eye and Ear Hospital, Melbourne and was Director of Ophthalmology Austin Repatriation Medical Centre 1992-1994. She is Senior Lecturer, Centre Eye Research Australia, Melbourne University Department of Ophthalmology and Problem-based Learning Tutor, University of Melbourne. She has studied for the Grad Dip Epidemiology and Master of Public Health, University of Melbourne from 1993 onwards. Supervisor Advanced Study Unit, Austin Repatriation Clinical School: ‘Gender and Surgery’ 1992 onwards.

She completed a Graduate Certificate in Vocational Education and Training (Clinical Instruction) in 1996, at the Hawthorn campus of the University of Melbourne Faculty of Education. She was elected Federal Councillor for the RACONZ in 1999, and re-elected in 2000. She commenced a Post-graduate Diploma in Education in 1997, conversing to Masters candidature in 1997. Deb has co-convened the Intercollegiate Women’s Committee since 1998. Her research interests are in genetic ophthalmology of renal-eye conditions (Austin Repatriation Hospital), public health ophthalmology including diagnostic test and new technology evaluation (Public Health NHMRC funding), and latterly, qualitative research into the training and development of ophthalmologists, particularly discourses in professional identity formation, including gender issues.
### APPENDIX III – TIMETABLE OF SYMPOSIUM

Creating and Teaching the Discipline of Gendered Medicine

**9.15 – 4.45pm with lunch break 12.30 – 2.00**

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Speaker/ Participants</th>
<th>Leader</th>
<th>Outcome</th>
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<tbody>
<tr>
<td>9.15</td>
<td>Welcome / Set scene introduction to day</td>
<td>D Colville</td>
<td></td>
<td>Hand over</td>
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<tr>
<td>9.30-10.15</td>
<td>PLENARY – Student/ Teacher Panel</td>
<td>Gill Paulsen, Emem Ukor, Stephanie Weidlich, Anne Coffey, Deb Colville, Kaye Birks, Jo Wainer, Elisabeth Hultcrantz</td>
<td>L Bryant</td>
<td>Recommendation s- Practical implications &amp; need for this work. Hand over</td>
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<tr>
<td>10.15- 11.15</td>
<td>PLENARY – &quot;Tell the Stories of Teaching Learning Experiences&quot;</td>
<td>Everyone</td>
<td>E Hultcrantz</td>
<td>Recommendation s- Practical teaching/learning</td>
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<tr>
<td>11.15</td>
<td>Morning Tea</td>
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<tr>
<td>11.30-12.30</td>
<td>Small Group Work, + table on Preferred Curriculum</td>
<td>Facilitators from delegates</td>
<td>J Wainer</td>
<td>Recommendation s- Practical teaching/learning</td>
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<tr>
<td>12.30-2.00</td>
<td>Lunch Video comments from participants</td>
<td>Lunch</td>
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<tr>
<td>2.00 – 2.20</td>
<td>Curriculum audit</td>
<td>Everyone</td>
<td>D Colville</td>
<td>Document existing curriculum</td>
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<tr>
<td>2.20- 3.45</td>
<td>&quot;Three 20 Minute Journeys “ Presentations, Discussions &amp; Questions</td>
<td>Carin Muhr, Jo Wainer, Elisabeth Hultcrantz</td>
<td>L Bryant</td>
<td>Recommendation s- Theoretical foundations, understanding why this work is essential.</td>
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<td>3.45 – 4.00</td>
<td>Afternoon tea</td>
<td></td>
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<tr>
<td>4.00-4.30</td>
<td>Finalise recommendations</td>
<td>L Bryant</td>
<td></td>
<td>Final recommendations</td>
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<tr>
<td>4.30-4.45</td>
<td>Final Ceremony</td>
<td>All delegates</td>
<td>J Wainer</td>
<td>A way to carry this work to the next step</td>
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</table>

Video of participants comments may be extended after the closing ceremony.
APPENDIX IV - PROGRAMME OF SYMPOSIUM

CREATING AND TEACHING THE DISCIPLINE
OF GENDERED MEDICINE

AIM OF THIS ONE DAY CONFERENCE:
1. To make recommendations to the International Congress of the Medical Women’s International Association (MWIA) to support the introduction of teaching about gender Issues in all Medical Curricula internationally
2. To begin to establish the discipline of Gendered Medicine
3. To develop some common language
4. To validate and build on the work already done

AUDIENCE ANALYSIS:
An international audience ranging from the “ground breakers from the privileged countries” who are challenging the dominant male culture, to women from the developing world who do not have a voice but have the courage to want to change their culture to be one of hearing the voice of women in one of the most valued professions world wide. Expertise will be in medicine, curriculum, gender issues, education.

PROGRAMME:

9.15 Introduction: Dr Deb Colville (Australia)
Deb to welcome delegates and set the scene emphasising the need for this work, then outline the plan of the day. That we will commence with the practical experiences of teachers and students as women in medicine, move to the stories of the experts in teaching and learning about the new discipline of teaching gendered medicine. After lunch we will take you on a journey from the theorists who have helped us create a language to express our needs to address gender issues and understand our history in the art of medicine. Introduce the concept for the day that the task for the participants is to assume that this is an “accepted”, “important discipline” in the medical curriculum in their university and visualise how they might teach this discipline in the culture of their university.

9.30-10.15 Student / Teacher Panel: Dr Lexia Bryant (Monash)
In this session a panel consisting of teachers and students of “gender issues in the medical undergraduate curriculum” tell the story of their experience of teaching this discipline. This will be a facilitated discussion exploring the experience of teaching this subject in a medical undergraduate curriculum. Story telling by the teachers and students, the difficulties and the empowering which resulted from the teaching. It is possible that the issues raised here will be:-
- Teachable moments
- Lost opportunities
- What happened when the session did not work
- How to explain why we are doing this – theory
- A gender curriculum

Recommendations: students, teachers and delegates are encouraged to come to this session prepared to contribute a written recommendation to the conference. From this session the expectation is that the recommendations are practical and from your experience.

10.15-11.15 “Tell the stories from experienced teachers/learners”: Professor Elisabeth Hultcrantz (Sweden)
Preparation to delegates, bring your story in any format that you feel comfortable with, written, drawing, poem, chart etc. with the intention that this work is collated and published for use as part of curriculum materia.
This session is designed to make explicit the way women doctors and students from all cultures are contributing to the teaching and learning of the discipline of Gendered Medicine, even though they may not have recognised what they are doing. Individual contributions will be honoured and valued, and the beginnings of a common vocabulary will be commenced. The next step is having this validated by our profession.

The scene has been set for the women to tell the stories of their teaching and role modelling. It is important that the recorder documents these stories.

This is the only outcome needed from this session. If the freedom is created to produce this wisdom nothing more needs to be done in this session.

Recommendations: students, teachers and delegates are encouraged to come to this session prepared to contribute a written recommendation to the conference. From this session the expectation is that the recommendations are practical and from your experience.

Note the conflict here, we need the practical recommendations from all delegates yet we have defined that recommendations are not required from this session. This dilemma needs resolution. Alternatives - Either no recommendations and hear the stories or recommendations are handed in a written form

Break for Morning tea – invitation from the chair of previous session
Where are we at after morning tea - The gauntlet has been thrown to you, the delegates, at this stage, there is excitement and fear. We all "know" this is important work but we are fearful of what it means when we go back to our universities.

11.30-12.30 Small Group Work leading to the Morning’s Recommendations: Ms Jo Wainer (Monash)
The conference will be presented with the recommendations from the work of the morning and refinement of these recommendations is the task of this session. These recommendations will be related to the practical implementation of teaching a gendered medical discipline. There will be a round table discussion facilitated by Deb Colville of the Preferred Curriculum, teaching and learning strategies.

Lunch:

2.00- 2.20 Curriculum Audit – Dr Deb Colville (Australia)
Teaching about gender is being done in a number of countries and a number of Australian Universities. This is an opportunity to all delegates to write down on an A4 sheet supplied by us the teaching they are doing, or know about. Discussion will be encouraged during this writing time.

2.20 – 3.45 “Three 20 Minute Journeys-The Lost Art of the Way Women Learn”: Carin Muhr, Jo Wainer, Elizabeth Hultcrantz. – Facilitator Dr Lexia Bryant (Monash)

Medical women live and work in cultures that have destroyed the concept of women as healers and medical women world-wide have had to learn to live and work in a male dominated day-to-day culture and work culture. It is uncomfortable.

This session will introduce the valuing of the feminine way of knowing and the feminine way of learning. It will introduce the language that is comfortable for women to use. This will be a learned discussion of the education theories of the way women learn that “fits” for them. Left brain right brain or whatever is the latest theory of understanding this difference. This is the equivalent of a “keynote address” from an international expert. Twenty five minutes has been allowed for discussion.
The Chair of this session has the awesome responsibility of taking these learned keynote addresses to the hearts of the women delegates. This must be “set-up” in the introduction and completed in a short “spontaneous” summary and perhaps a request for one vignette from the audience that illustrates an understanding of a practical teaching/learning event that makes sense, in retrospect, with the input of the wisdom in this session. For example: normalising of this teaching “but I do this every day” when I am teaching”

**Recommendations:** These three invited international speakers have the responsibility to make one recommendation each for “consideration” by all delegates. These recommendations will be related to the theoretical wisdom of teaching a Gendered Medical discipline.

**4.00 - 4.30 Finalise Recommendations: Dr Lexia Bryant (Monash)**

**4.30 – 4.45 Closing ceremony developed by Ms Jo Wainer (Monash) and Dr Lexia Bryant (Monash)**

At the end of the day delegates may continue to record their comments on video, for use as teaching material.

**NOTE: Recommendations from this symposium will be submitted to the Medical Women’s International Association by Dr Deb Colville (Australia) and Dr Lexia Bryant (Monash).**

Behind the scenes recorders of the conference have accumulated all recommendations from the plenary session, workshop, delegate individual submissions and these will be presented to the conference delegates.
Part I: EVALUATING WOMEN’S HEALTH AND GENDER

Current medical curriculum in Canada combines the compartmentalization of specialties such as cardiology or obstetrics with a life phases approach that recognizes the unique manifestations of illness in different age groups (e.g. pediatrics, geriatrics). Recent understanding of the broader determinants of health such as gender, socio-economic status, or ethnicity has begun to permeate medical teaching, although specific educational objectives and evaluation in these areas are in their infancy.

The Gender Issues Committee of the Council of Ontario Faculties of Medicine received funding from the Women's Health Council of the Ontario Ministry of Health to:

1. collect and review existing goals and objectives for medical education in women's health and gender equity,
2. develop strategies for testing these objectives in licensure and certification examinations, and
3. meet with The Medical Council of Canada, The College of Family Physicians of Canada, and The Royal College of Physicians and Surgeons to implement these objectives and strategies.

Defining Women’s Health

Women's health involves women's emotional, social, cultural, spiritual and physical well-being, and is determined by the social, political, and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences and women's own beliefs about, and experiences of, health. Every woman should be provided with the opportunity to achieve, sustain, and maintain health as defined by that woman herself, to her full potential. (1)

This definition was adopted by Health Canada, and the Canadian delegation to the U.N. Women's Conference in Beijing.

Reviewing Goals and Objectives

Women's health is determined by the biology of being female and the social context of gender. Educational objectives defining necessary knowledge of biology permeate the objectives of system or specialty teaching at medical schools. Objectives that address attitudes relevant to women's health and gender are less apparent in medical curricula. Failure to emphasize the role that attitudes about women play in influencing health care limits both the assimilation, and use of appropriate knowledge and skills. A review of the goals and objectives of Ontario's medical schools and a relatively fruitless search of the literature, done in 1993-4 prompted the Women's Health Interschool Curriculum Committee (whose work is now carried on by the Gender Issues Committee of COFM) to create a template of goals for women's health education in medical schools. (1). These primarily address attitudes and behaviours that foster gender equity in medical care. Although this
work has been widely cited, no medical school has specifically incorporated these principles into their curricula or examinations. As a result standardized assessment tools have been developed to evaluate students' knowledge and skills but the assessment of attitudes, if undertaken at all, has generally remained secondary. The implication, which students readily grasp, is that knowledge and skills matter, while attitudes and behaviours don't. On the other hand, organizations that administer tests of medical students and residents nationally, such as the Medical Council of Canada and the College of Family Physicians of Canada, include, within their objectives, some which generally address the context of health and illness and which, with modification, would speak to the issues of concern. Using these objectives and information from medical, educational, and sociological literatures and educators the following objectives were developed.

GOALS AND OBJECTIVES IN WOMEN'S HEALTH AND GENDER ISSUES

What follows is not a comprehensive list of all objectives relevant to the content of women’s health, but rather those objectives which are central to the context of women’s health and to the goal of fostering gender equality in medical care and research.

1. to recognize that health involves emotional, social, cultural, spiritual and physical well-being, and is determined by an individual's social, political, and economic context as well as by biology.
2. to explain the breadth and depth of research in women’s health as well as the limitations of medical knowledge in this area
3. to evaluate the effect of personal biases and limitations resulting from socialization, gender and racial stereotypes, etc.
4. to recognize the existence of power differentials in relationships, particularly the relationship between doctor and patient and to:
   - explain the sources of power imbalances
   - suggest ways to minimize the effect of the imbalance between doctor and patient
   - describe the variety of manifestations and consequences of power differentials
   - identify ways that gender, race, class, culture, ethnicity, ability/disability, age and sexual orientation can affect these differentials
   - behave in ways that enhance empowerment of the patient and minimize the hierarchical nature of that relationship
5. to use gender sensitive language and behaviour to minimize the negative impact of gender stereotypes and to foster respect for the equality, individuality, and value of all people

More specific objectives of relevance to specific disease entities include being able to answer the following:

1. Are the symptoms of a particular disease the same for women and men? (E.g. chest pain, depression)
2. Are the findings for a particular disease the same for men and women? (e.g. chest pain, depression)
3. Is the etiology of a particular disease the same for women and men? (E.g. substance abuse)
4. Are there differences in the appropriate investigation of particular findings between men and women (e.g. headache, abdominal pain, chest pain, back pain)
5. Is treatment of a disease the same for men and women? (E.g. dosage, treatment during pregnancy or lactation, timing of treatment and menstrual cycle)
6. Are risk factors for a particular disease the same for women and men? (E.g. lung cancer, angina)
7. What are the symptoms, signs, and treatment of a particular disease when the patient is pregnant?
8. How does a relative lack of control over one’s home or workplace impact on health, and the treatment of illness for women and for men?
9. Do wealth and health interact differently for men and women?
10. What are the social determinants of a particular disease?

More specific objectives regarding gender based analysis of research evidence include being able to answer the following:

1. Is there gender bias inherent in the hypothesis of a study?
2. Is the inclusion or exclusion of women as participants in a study appropriate?
3. Does data analysis properly acknowledges similar and different responses by sex?
4. Can findings from studies that exclude particular groups such as women, children, particular races, etc. be generalized and applied to those groups?

More specific objectives regarding language include being able to answer the following:

1. How does language used by the physician either reinforce or minimize gender stereotypes?
2. How should the physician respond to patient communication patterns that reflect gender or racial stereotypes?
3. When is gender neutral language appropriate? When is it inappropriate?
4. How can the physician use language to minimize the power imbalance between doctor and patient?

TESTING THE OBJECTIVES

The following examples are starting points for discussion. They will be modified by input and expertise of those more skilled at evaluation techniques and more familiar with the core content to be examined. To be relevant to the needs of each organization involved in national testing of students and residents for licensure (Medical Council of Canada, College of Family Physicians of Canada, Royal College of Physicians and Surgeons) they require some “customization”.

1. Can the candidate take a comprehensive women's health history? (Ref 4, p103 - taking a "women's health history")
2. Following a clinical scenario in an OSCE the candidate should be asked how his or her approach to the patient would be altered if that patient were of the opposite sex.
3. Candidates should be asked to critique research results that show gender bias - e.g. failure to analyse by sex, extrapolation of results on testing of men to apply to women.
4. After presenting the candidate with the abstract of a study including men only, ask the student to apply the findings to a the case of a woman with the illness studied.
5. Candidates could be asked to identify differences in etiology, pathogenesis, clinical presentation, and treatment of disease between men and women.
6. After viewing a brief video illustrating control of a patient by the physician, lack of respect, etc., the candidate could be asked to pick out problems or comment on the observed interaction.
7. Candidates could be asked to identify sources and effects of power imbalances in doctor patient relationship.
8. In any clinical encounter one of the behaviours to be evaluated could be whether students demonstrate power sharing with the patient (e.g. - a hormone replacement therapy scenario could be used to assess whether the student works with the patient to minimize power imbalances, or instead, advises specific treatment).
9. The SAMP format could be used to assess awareness of violence as cause of a patient's presenting symptoms and signs.
10. One aspect of boundary issues could be evaluated during an OSCE, using a simulated patient of the same sex as the candidate, by having the patient ask the candidate for a date.

11. Further test boundary issues in a clinical OSCE, by creating a scenario which requires the candidate to ask a patient to undress, to describe appropriate disrobing and draping, and to explain why the patient should be allowed to undress alone.

Part I: Summary

In Ontario, current objectives for medical education do not adequately acknowledge the context of women's health and gender. Such issues as the effects of powerlessness or violence on health, or the impact of sex role stereotypes on well being, may be serendipitously addressed by the small number of medical educators who focus on women's health, however more systematic and generalized teaching would be advantageous. The adoption of explicit learning objectives addressing attitudes, behaviours, and context by licencing bodies and medical schools, and evaluation of those objectives, will increase graduating physicians’ understanding of the determinants of women’s health. Using existing literature and consultation with key informants this project has identified important educational objectives and developed strategies for their evaluation. By collaborating with the three licencing organizations in Canada (the Medical Council of Canada, the College of Family Physicians of Canada, and the Royal College of Physicians and Surgeons of Canada) this work has been, or will be integrated into licencing examinations.

* * * * * * * * * * * *

We would like to thank the Women’s Health Council of the Ontario Ministry of Health for proposing and funding this project, and Mary Kay Whitaker and Marg Harrington of COFM for all their assistance. Members of the GIC-COFM who participated include Maria Bacchus, Angela Cheung, May Cohen, Bertha Garcia, Rose Goldstein, Moira Kapral, Barbara Lent, Susan Phillips, Beverly Richardson, Miriam Rossi, Margaret Skimba, Donna Stewart, and Ron Wigle.

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REFERENCES


Appendix I - Definitions

sex: biological characteristics including anatomy and physiology, that distinguish males and females

gender: socially constructed meanings attached to sex differences and to the roles of, and relationships between men and women

women’s health: involves women's emotional, social, cultural, spiritual and physical well-being, and is determined by the social, political, and economic context of women's lives as well as by biology. This broad definition recognizes the validity of women's life experiences
and women's own beliefs about, and experiences of, health. Every woman should be provided with the opportunity to achieve, sustain, and maintain health as defined by that woman herself, to her full potential.

**gender equity:** being fair to men and women - this may require treating men and women differently to compensate for historic disadvantages, to level the playing field, and to create equal outcomes for men and women.

**gender equality:** men and women share equal status in society.

**women-centred analysis:** focuses on females, acknowledges the above definition of women's health, and that men and women are different although neither is “the norm.”

**gender-based analysis:** examines both individual situations of women and men and their relationships, acknowledges that health is determined by biology and gender, and seeks to understand the effects of gender and gender bias on health.

**GENDER BIASES**

1. **Androcentricity:** the adoption of a male perspective.
   - exclusion or under-representation of women resulting in overgeneralization
   - taking males as the norm
   - accepting or justifying male dominance
   - victim blaming
   - paradoxical gynocentricity by excluding men from consideration in areas that tend to be identified as female

2. **Gender Insensitivity:** being gender blind or neutral, ie ignoring sex or gender when they are significant.
   - decontextualization involves ignoring that similar inputs may have different outcomes for men and women
   - assumed gender homogeneity occurs when analysis fails to identify sex differences in outcomes
   - householdism means inappropriately using the household or family rather than the individual as the smallest unit of analysis

3. **Double Standards:** evaluating the same e.g., traits or behaviours differently in each sex.
   - sexual dichotomism exaggerates differences by treating the sexes as if they have no overlapping characteristics
   - reification of gender stereotypes involves treating a gender stereotype as if it were part of human nature rather than socially imposed
REFERENCES


