Chapter 3

Representation of Gender Equality From the Perspective of the Medical Trainee and its Ripple Effect: Highlighting Gender Inequality in Medical Student Experiences

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ABSTRACT

It comes as no surprise that to tackle gender inequality in the future of the medical profession, the experiences of those who will become it must first be reviewed. Gender inequality is rife throughout all aspects of medical student life; from the classroom to clinical placements, from other healthcare professionals and public alike, for both male and female students. This chapter will discuss these, review literature, and share experiences. Consequently, this has an impact on their career choices, attrition, and mental health. By improving experiences and encouraging diversity, the hope is to reduce the negative effects discussed within the chapter, and break the cycle of inequality.

INTRODUCTION

The desire for gender equality in the medical profession has never been more transparent and public as currently. It comes as no surprise that to tackle the future of the medical professions, we must first review the experiences of those who will become it.

From the perspective of a medical trainee, gender inequality affects the day-to-day experience and training, varying treatment from both healthcare professionals and the public and differing advice from seniors, colleagues and the wider community. Consequently, it has an impact on career choices, attrition and mental health.

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The chapter will review the changes in medical student intake; describe medical student experiences both in the classroom and on placement, followed by the consequences of these experiences. Although gender issues are acknowledged on an international stage, there is limited information as to the rationale behind why they occur, particularly in relation to medical trainees and students. Furthermore, in aid of making change, this chapter will try not only to identify areas of gender inequality but attempt to suggest strategical methods in which we can implement change.

With the primary goal of identifying and challenging gender inequality within medical school, the hope is to tackle the problem at the core as a preventative measure breaking the cycle, instead of a reactive stance.

As with most aspects of gender inequality, typically the limelight demonstrates that inequality is greater amongst women. However, there are areas in which gender inequality is more evident in men and the aim is to highlight these as equally important as those affecting women.

A Long Journey: Acceptance of Women in Medicine

Welcoming women into medicine has been a slow and at times a frowned upon process. From being considered witches and being burned at the stake, to now being Presidents of medical societies; women have come a long way. (Arrizabalaga, Abellana, Viñas, Merino & Ascaso, 2014; “Women in medicine”, n.d.)

Women’s way into formal medicine was through nursing, with others like Margaret Buckley masquerading as a male doctor for 46 years. The first ever woman to gain official entry into medicine was Elizabeth Blackwell (USA) in 1849 (“Women in medicine”, n.d.). Since then the proportion of women entering medicine continues to rise. In 1996 more women were being accepted into medical school than men within Australia, the United Kingdom (UK) and the United States of America (USA) (Reynold, 2018). Female physicians now form 26% of the UK workforce compared to 6% in 1950 (“Timeline of women in medicine”, 2018) but there is clear disparity between percentage entering medical school (>50%) and those working (26%).

Research consistently tells us that gender stereotypes and childhood aspirations emerge early in childhood and continue throughout adolescence (Legewie & DiPrete, 2014). Although encouraging that both genders are permitted to study medicine, entry into medical school is not the only obstacle they face. It is of equal important that deliverers of medical education and training address the gender inequalities within medical school itself.

It is clear from reviewing history that gender stereotypes have drastically changed over time. From the right to vote in 1918 and the women in the workforce post World War II, society began to understand women too can contribute to more than just the home. Physical ability continued to be questioned and famously in 1967, Katherine Switzer became the first woman to officially complete the full Boston marathon, not without an element of ‘race drama’. Freedom to be independent was demonstrated in 2018 by Saudi women being allowed to drive, previously prevented by Saudi Arabian law. This stated that women should always have a male guardian and therefore would never need to drive. This change in law became necessary as the female workforce increased who needed to be able to drive independently.

Medicine is a widely acknowledged vocation which involves intellect, physical stamina and independence to make decisions. Women, with these skills, have a proven track record in leadership roles within the political arena across the world. These changes above as well as many more have demonstrated women’s capabilities and have generated momentum for change towards women as leaders in healthcare.