Diagnosing the Culture of Medicine: Gender Discrimination Disorder

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INTRODUCTION

An article on gender discrimination in academic medicine that was recently published in the *Journal of the American Medical Association* has revealed a disturbing conclusion: 30 percent of female physicians report having experienced sexual harassment.[1] This discrepancy was first formally noted twenty years ago when 52 percent of women in academic medicine reported experiencing some form of harassment, which prompted the introduction of complaint mechanisms, anti-harassment policies, and professional ethics modules in medical curricula.[2] It was also thought that an increased female presence in medicine would, over time, reduce the magnitude of gender inequality. Despite efforts to improve gender balance and mitigate discrimination in the medical profession, harassment rates remain unacceptably high.

Gender discrimination is either overt or covert. Overt discrimination is comprised of inappropriate sexual advances and remarks based on an individual's gender whereas covert discrimination constitutes an "unconscious bias," which permits differential treatment with respect to opportunities and career prospects.[3] This gender bias is inculcated through the hidden curriculum—unspoken values and attitudes in medicine transmitted over the course of medical education—that can be as harmful as overt discrimination.[4] The subtle bias fostered by this hidden curriculum makes it difficult to report and eliminate because it does not explicitly violate institutional policies. This also explains why many women pursue pediatric and geriatric subspecialties, disciplines that require a traditionally feminine caretaker role, rather than surgery where they may encounter prejudice in an "old boy's club."[5]

ANALYSIS

The consequences of gender discrimination and, more broadly, the pervasive mistreatment of medical trainees due to gender, race, and age cannot be ignored. The verbal, physical, and sexual harassment that appear to be endemic to medicine are correlated with burnout and depression among practitioners.[6] This abuse is more serious than women being deterred from pursuing a male-dominated specialty or a female trainee being humiliated by an attending, because it affects both individual and public health. Mistreatment in the professional setting cannot be isolated from the public sphere because a practitioner's wellbeing has a direct impact on the wellness of their patients.

Sexual harassment can trigger dissatisfaction, low mood, and even suicidality in physicians, all of which can seriously compromise the quality of care received by their patients.[7] Moreover, discriminatory attitudes that become internalized over the course of medical education can introduce gender bias in diagnosis and threaten the respect between practitioners and patients. It is reasonable to assume that the conduct of mentors, whom trainees must mimic to develop their clinical skills, influences the attitudes of future physicians and thereby produces a transgenerational cycle of abuse. These long-term consequences make a

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compelling argument in support of institutional policies that seek to curb the incidence of harassment in academic medicine. Not only must physicians reduce gender discrimination in order to avoid legal action, but they ought to make this concerted effort because of their commitment to the ethical imperative of non-maleficence toward their patients *and* their peers.

The gender inequality encountered by female physicians is a product of our misogynistic society and the patriarchal hierarchy in medicine. Of course, sexual harassment is not unique to medicine and is prevalent in other settings.[8] However, the abuse inherent in medical culture is disconcerting because medicine is presumably held to a higher standard than most professions. If medicine is heralded as the bastion of compassion, empathy, and social justice, how can we reconcile the reality of widespread abuse in a profession that is supposed to set a moral precedent?

Upon learning of the high incidence of harassment in medicine, some practitioners defend their profession by insisting that colleagues and peers are too sensitive and are confusing attempts to build resilience as mistreatment. For instance, while randomly bombarding medical students with questions to test their knowledge has educational value, there is a clear distinction between trying to create "tougher" doctors and purposefully creating a toxic environment that facilitates the erosion of self-esteem through physical, verbal, and sexual abuse.[9] This culture of denial serves as a deterrent for individuals who have been directly affected by discrimination and wish to report a transgression. Indeed, many women are put off from reporting incidents in order to avoid being labeled as "hypersensitive" or "dramatic." Other victims of discrimination minimize their experiences and accept harassment as status quo.[10]

CONCLUSION

It cannot be said that strides in gender equity in both medicine and society have not been achieved. Nonetheless, a revised, multifaceted approach is needed to further mitigate instances of discrimination. Supportive counseling programs should be developed to help individuals affected by the abuse. In turn, these programs can facilitate conversations between faculty members as well as students. It is incumbent upon the medical profession to create a working environment where all members can feel safe. A sense of security and inclusivity will hopefully inspire victims to access complaint mechanisms. Reassuring complainants that punitive action will be reinforced and that they are not jeopardizing their career prospects is paramount. Ultimately, it is the duty of medical practitioners to remember the sympathy and understanding they pledged to offer their patients is also conducive to the wellbeing of their students and colleagues.

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[1] Reshma Jagsi et al., "Sexual Harassment and Discrimination Experiences of Academic Medical Faculty," *The Journal of the American Medical Association*315, no. 19 (May 2016): 2120, doi: 10.1001/jama.2016.2188.

[2] Henry K. Silver and Anita Duhl Glicken, "Medical Student Abuse: Incidence, Severity, and Significance,"*The Journal of the American Medical Association* 263, no. 4 (January 1990): 527, doi: 10.1001/jama.1990.03440040066030.

[3] Alexandra Sifferlin, "30% of Female Doctors Have Been Sexually Harassed," *Time*, May 17, 2016,http://time.com/4337372/30-of-female-doctors-have-been-sexually-harassed/.

[4] Sally C. Mahood, "Beware the Hidden Curriculum,"*Canadian Family Physician* 57, no. 9 (September 2011): 983, http://www.cfp.ca/content/57/9/983.full**.**

[5] Victoria Reed and Barbara Buddeberg-Discher, "Career obstacles for women in medicine: An overview,"*Medical Education* 35 (February 2001): 140, doi:10.1111/j.1365-2923.2001.00837.x.

[6] Liselotte N. Dyrbye et al., "Burnout and Suicidal Ideation among U.S. Medical Students," *Annals of Internal Medicine* 149, no. 5 (September 2008): 334, doi: 10.7326/0003-4819-149-5-200809020-00008.

[7] Erica Frank et al., "Experiences of belittlement and harassment and their correlates among medical students in the United States: longitudinal survey," *BMJ*333, no. 7570 (September 2006): 683, doi: 10.1136/bmj.38924.722037.7C.

[8] Adrianne N. Bruce et al., "Perceptions of gender-based discrimination during surgical training and practice," *Medical Education Online* 20 (February 2015), doi: http://dx.doi.org/10.3402/meo.v20.25923.

[9] Ajay Major, "To Bully and Be Bullied: Harassment and Mistreatment in Medical Education," *Virtual Mentor*16, no. 3 (March 2014): 157, http://journalofethics.ama-assn.org/2014/03/fred1-1403.html.

[10] Susan W. Hinze, "'Am I being over-sensitive?' Women's experience of sexual harassment during medical training," *Health (London)* 8, no. 1 (September 2004): 102, doi: 10.1177/1363459304038799.