Gender in Medical Education: Perceptions of Medical Educators

Study conducted among medical educators of seven medical colleges in Maharashtra

Priya John
Amruta Bavadekar
Ameerah Hasnain
Asilata Karandikar

Cehat
Centre for Enquiry into Health and Allied Themes

Gender in Medical Education: Perceptions of Medical Educators

Study conducted among medical educators of seven medical colleges in Maharashtra

Priya John
Amruta Bavadekar
Ameerah Hasnain
Asilata Karandikar

Cehat
Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

Published in 2015

For additional copies of this report, please contact:

Centre for Enquiry into Health and Allied Themes (CEHAT)
Survey No. 2804 & 2805
Aaram Society Road
Vakola, Santacruz (E)
Mumbai - 400055.
Tel: (91) (22) 26673154, 26673571
Fax: (91) (22) 26673156
Email: cehat@vsnl.com
Website: www.cehat.org

Citation: John, Priya; Bavadekar, Amruta; Hasnain, Ameerah and Karandikar, Asilata. (2015). Gender in Medical Education: Perceptions of Medical Educators. Mumbai: CEHAT.

ISBN: 978-81-89042-69-1

This publication does not have any copyright. Any part of this publication can be reproduced but not for commercial purposes. All credits need to be acknowledged and if reproduced should inform the publisher.

Cover design by: Pramila Naik

Printed at :
Satam Udyog
Parel, Mumbai-400 012.

Table of Contents

Abbreviations

CBHI	Central Bureau of Health Intelligence
CuT	Copper T
DMER	Directorate of Medical Education and Research
FMT	Forensic Medicine and Toxicology
GMC	Government Medical College
GME	Gender in Medical Education
Hb	Haemoglobin
IPD	Inpatient Department
IPV	Intimate Partner Violence
IUCD	Intrauterine Contraceptive Device
MBBS	Bachelor of Medicine and Surgery
MCI	Medical Council of India
MLC	Medico-legal case
MoHFW	Ministry of Health and Family Welfare
MoME	Ministry of Medical Education
MUHS	Maharashtra University of Health Sciences
ObGyn	Obstetrics and Gynaecology
OPD	Outpatient Department
PG	Post-graduate
PSM	Preventive and Social Medicine
ROME	Reorientation of Medical Education
SDH	Social Determinants of Health
UG	Under-graduate
UNFPA	United Nations Population Fund
WHO	World Health Organisation

List of Tables

List of Boxes

Preface

We are happy to publish the report "Gender in Medical education: Perceptions of Medical Educators" based on a study conducted across seven medical colleges in the state of Maharashtra. This study was undertaken as part of a pioneering project being implemented by CEHAT in collaboration with the DMER, MUHS and the UNFPA for integrating gender sensitive training modules in the under graduate curriculum of the MBBS.

The study explored the perceptions of medical educators regarding the relevance of gender in medical education, their perceptions regarding patients and gender sensitivity in teaching and practice on issues such as abortion, sex selection and violence against women. What emerged is the lack of understanding about relevance of gender in medical teaching, gender stereotyping of women in general and patients in particular and misconceptions about access to abortion. We hope that the report will be useful for those working in the field of women's health and rights, public health and policy.

As part of the training component of the project, twenty medical educators across seven medical colleges have participated in an intensive training on gender in medical education. CEHAT is currently in the process of developing gender sensitive training modules for the entire UG curriculum on five disciplines viz Obstetrics and Gynaeacology, Forensic Medicine, Medicine, Psychiatry and Community Medicine in collaboration with these trained educators and experts in the field. This builds on an earlier initiative of the Achutha Menon Centre for Health Science Studies (AMCHSS) on gender sensitisation of medical education, that undertook gender sensitisation of medical educators and published gender review of medical textbooks.

Padma Bhate-Deosthali
Coordinator, CEHAT

Acknowledgements

We'd like to acknowledge the contribution of several individuals and agencies in the preparation of this report. At the outset, we are grateful to DMER for facilitating the entire research process. We thank the Deans and senior administrative officers of the participating medical colleges for their support during the research.We thank UNFPA for their support in carrying out this study.

We are grateful to Rashi Vidyasagar, Prarthi Sharma, Sumeet Pokharankar and Dhruv Kulshethra for their role in the data collection. We thank Suchitra Wagle, Sangeeta Rege and Padma Deosthali for conducting the training of the research team in interviewing skills.

We are especially grateful to the Programme Development Committee members - Dr. Padmini Swaminathan, Renu Khanna and Sangeeta Rege for reviewing the project and the report at various stages.

We also extend our gratitude to Dr. Sundari Ravindran for reviewing the preliminary findings of the project.

This report was possible due to the unwavering support and guidance of our colleague, Padma Deosthali.

We thank Dr. Padma Prakash for editing the document. We are grateful to Jasmin Chembiparambil for coordinating the publication process.

Last but not the least, we thank all the research participants for participating in the study.

Executive Summary

Over the last few decades, systematic critiques of medicine and public health curricula in India have highlighted many lapses in the inclusion of social determinants of health in medical education. Health is often predicated on social structures with prescriptive gender identities and associated power relations. Needless to say, gender is a pivotal determinant of health. In India, medical education, comprising training and curriculum, is often divorced from gender theory and perspective. There has, therefore, been a call for a re-orientation of medical education in India to include gender in the instruction and training of medical students.

It is in this context that the Integrating Gender in Medical Education project (GME) has been conceptualised and implemented. The Centre for Enquiry into Health and Allied Themes (CEHAT), with the support of United Nations Population Fund (UNFPA), Directorate of Medical Education and Research (DMER) and Maharashtra University of Health Sciences (MUHS), has undertaken a project on integrating gender in medical education in Maharashtra. As a part of the GME project, a situation analysis was undertaken in the year 2014. The main purpose of the situation analysis was to capture the perceptions of medical educators about patients, medical profession, curriculum, pedagogy, etc. Issues of violence against women, abortion rights, sex selection/ determination etc., gender issues that CEHAT has long worked on, were prioritised in the situation analysis study.

Most respondents of the study were of the opinion that the content of the textbooks had not changed significantly over the years. Largely, the changes observed were the inclusion of [a] new technologies, [b] new legislations, and [c] new diseases. According to many medical educators, social determinants of health fall exclusively within the ambit of the PSM discipline. With regard to gender as a social determinant of health, nearly all respondents stated that there is limited discussion on gender in medical textbooks. The articulations of the respondents regarding gender were centred on issues related to anatomical difference, diseases and/or violence. There were a number of respondents who stated that the concept of gender was not included in the medical curriculum and further, there is no need to include the concept as it is irrelevant in medical education.

Gender was understood by the respondents as [a] a demographic category; [b] health issues of women; [c] increased violence against women; [d] increased presence of women in the workforce

and/or [e] gendered nature of medical institutions. The understanding was at best limited and at worst harmful.

PSM educators identified more nutrition-related problems among women than in men who, according to them, came with complaints related to lifestyle or communicable diseases. Medicine, ObGyn and PSM educators identified anaemia as a common condition among women. Psychiatry educators claimed that women displayed 'hysterical symptoms' and 'housewives' in particular experienced 'Intentional Hysterical Episodes'. A number of the educators held fairly stereotypical views of men and women who seek their care. In the presentation of complaints, many of the educators were of the opinion that women are not as straightforward as men. Women tend to seek medical attention for minor health complaints whereas men came in with 'significant complaints'.

Views of doctors regarding survivors of violence and their dilemmas give a glimpse of the prejudices and misconceptions operative within doctor-patient interactions in sexual or domestic violence cases. An allegation should be proven in court for a conviction of the accused. Some educators were of the opinion that the accused need not be put on trial or in custody. This view is blind to the survivor's vulnerability to subsequent threat and harassment at the hands of the accused if he is not detained.

Several ad hoc and informal conditions were applied in the provision of MTP at the health facilities. This was especially the case for abortions sought in the second trimester. The conditions for provision of MTP varied from case to case, depending on the stage of pregnancy, family size, number of daughters etc. Doctors claimed that in the case of unmarried major women seeking abortion, the consent of guardians is sought and a medico-legal case is registered. Based on the responses, clearly it was the doctor's discretion [a] to provide the MTP services or not and [b] if the service was to be provided then under which condition of the MTP Act to provide the service.

In conclusion, the study findings point to the need for a nuanced understanding of gender among medical educators and students. The introduction of gender could pave the way for an opening up of medicine to delve deeper into how signifiers such as class, caste, gender etc. have a bearing on health. The medical curriculum and training must undergo fundamental changes to integrate gender so as to ensure the creation of a gender-sensitive and socially-relevant medical force in the country.

I. Introduction : Gender in medicine

Over the last few decades, systematic critiques of medicine and public health curricula in India have highlighted many lapses in the inclusion of social determinants of health in medical education (Qadeer and Nayar, 2011). In 1993, a study of recently graduated medical students in Mumbai confirmed that the orientation of medical students to social dimensions of health was poor (Rangan and Uplekar, 1993). The authors identified the quality and content of training imparted as being one of the main factors for this situation (ibid, p. 63). In India, the Reorientation of Medical Education (ROME) scheme was launched in 1977 to re-examine the medical education system to balance the prevalent biomedical paradigm with an orientation to comprehensive health informed by training not only in hospitals but also in communities (Planning Commission 1985; Chauhan, Purty and Singh, 2013). Later, in 1991 the concept of ROME was adapted by the WHO for the South-East Asia Region with a renewed focus on [a] creation of 'socially relevant and responsive' medical doctors, [b] revisiting medical education to improve 'quality and quantity of medical graduates produced' and [c] education of doctors to 'include ethical, social, technical, scientific and managerial abilities' (WHO 1991, p. 6).

Health is often predicated on social structures with prescriptive gender identities and associated power relations. Needless to say, gender is a pivotal determinant of health. Gender hierarchies and differences are understood to create differences between men and women in terms of their 'exposure to risk factors, household level investment in nutrition, care and education, access to and use of health services, experience in healthcare settings and social impacts of ill-health' (WHO, 2015). There is compelling evidence to support how health is experienced differently by men and women owing to 'sex-specific vulnerabilities' and 'gendered vulnerabilities' (Snow 2007, p. 9-10). The interaction of gender with health is seen in the variation in access to health systems and services for men, women and intersexed persons/transgenders. Several studies have thrown light on the lower access to health care among women and on the bias against women in treatment and care in health facilities (Iyer, Sen, George, 2007; Iyer 2007; George 2007 cited in Sen, Ostlin, George, 2007). Within the household and outside, deeply-entrenched gender inequities often take the shape of intimate partner violence (IPV) and sexual violence. Violence against women is a crucial variable that must be factored in the intersection of gender and health.

The evidence available on the linkages between gender and health begs for a re-examination of health through a gender lens in order to identify the impact of gendered realities of discrimination and vulnerability. Further, in order to create 'socially relevant and responsive doctors', it is pivotal to integrate gender in the understanding of health held within the medical community.

One way to ensure this integration is through the medical education system. In India, medical education, comprising training and curriculum, is often divorced from gender theory and perspective (Subha Sri, 2010). It has been documented that women experiencing reproductive health problems were better able to cope if health professionals counselled their male partners to regulate their sexual activity so as not to inflict unwanted sex on them (Khanna et. al., 2002). However, doctors and nurses are not equipped to deal with cases of sexual violence or IPV (ibid.). Such lack of orientation skews patient-health professional relationships and further accentuates gender vulnerabilities and disadvantages. In light of this evidence, there has been a call for a re-orientation of medical education in India to include gender in the instruction and training of medical students (Narayan, 2002; Subha Sri, 2010).

In April 2005 an issue of the Review of Women Studies of the Economic and Political Weekly was devoted to reviews of medical textbooks that were commonly used in Indian medical colleges from a gender perspective. Textbooks used for community medicine, psychiatry, obstetrics and gynaecology (ObGyn), forensic medicine and toxicology (FMT), paediatrics, preventive and social medicine (PSM) and surgery were reviewed. The gender analysis revealed across the board that medical textbooks used in the MBBS curriculum were at best, gender blind and at worst, gender biased (Gaitonde, 2005; Khanna, 2005; Prakash, 2005; Iyengar, 2005; Bhate and Shrikala, 2005; Patel, 2005; Agnes, 2005). Social differences and biases stemming from signifiers such as gender, caste, class etc. were inadequately explored in community medicine textbooks (Gaitonde, 2005). Also, women's health was often problematically conflated with demography and population control issues in certain textbooks (Bhate and Acharya, 2005). One of the reviewers highlighted that the ObGyn textbooks were silent on the role of gender hierarchies and power relations in reproductive health of women (Iyengar, 2005). In psychiatry, the need to explore social realities to better understand mental health concerns was entirely absent in the subject textbooks (Patel, 2005; Davar, 2005). Gender biases were also clearly identified in the sections on sexual offences, wife murder and bride burning in the FMT textbooks by the reviewer (Agnes, 2005).

The WHO clearly acknowledges the imperative of systematic integration of gender in medical education specifically, in the 'pre-service training curricula' of students (2007, p. 1). Based on a review of 'gender in medical education' (GME) initiatives undertaken mostly in Australia and North America the WHO identifies [a] 'development and implementation of the course', [b] 'curriculum development', [c] 'capacity building of faculty' and [d] 'advocacy for policy change pertaining to the curricula of health professionals' as key components of such projects (ibid., p. 4). An international consultative meeting of leaders of medical education organised by WHO arrived at a consensus that gender and human rights perspectives should be integrated in all disciplines of medical education and such training should be continued throughout the professional life commencing with the undergraduate course (ibid. p. 26).

It is in this context that the Integrating Gender in Medical Education project (GME) has been conceptualised and implemented. The Centre for Enquiry into Health and Allied Themes (CEHAT), with the support of United Nations Population Fund (UNFPA), Directorate of Medical Education and Research (DMER) and Maharashtra University of Health Sciences (MUHS), has undertaken a project on integrating gender in medical education in Maharashtra. The GME project is operational in seven medical colleges in Maharashtra and aims to sensitise medical students and health professionals to gender inequity and its interaction with health (Table 1). The participating medical colleges have been nominated by the DMER and MUHS. A meeting of the Deans of the nominated colleges was organised by the DMER in order to share the project idea and to formalise their commitment to the GME project. Specifically, the GME project has sought to achieve gender sensitisation and awareness among medical educators and students on public health issues such as sex selection, abortion and violence against women by integrating gender perspectives in the MBBS curriculum.

Table 1: List of seven participating medical colleges under GME project

S. No.	Medical Colleges
1	Government Medical College, Nagpur
2	Shri Bhausaheb Hire Government Medical College, Dhule
3	Rajarshi Chhatrapati Shahu Maharaj Government Medical College, Kolhapur
4	Government Medical College, Miraj
5	Government Medical College, Aurangabad
6	Swami Ramanand Teerth Government Medical College, Ambejogai
7	Mahatma Gandhi Mission Medical College, Navi Mumbai

The main strategies of the project are:

- Build capacity of medical faculty on gender perspectives and women's health issues through a training of trainers' (ToT) programme.
- Facilitate teaching of gender perspectives to MBBS students by trained medical faculty.
- Advocate for policy inclusion of modules integrating gender perspectives in MBBS curriculum by assessing impact of this programme.

GME Situation Analysis: Rationale and Research Objectives

As a part of the GME project, a situation analysis was undertaken in the year 2014. The situation analysis was conducted after the first ToT was completed in 2014. Many participant-medical educators of the first ToT could not continue with the GME trainings as they were contractual employees about to complete their tenure in the medical colleges. At this juncture, with this new development, the project team decided to collect information about the participant medical colleges

to be better acquainted with the medical education system in Maharashtra. It became necessary to understand the current conditions under which teaching and practice is undertaken in each college. The situation analysis was conceptualised to gather data about the college level infrastructure, strength of students, staff, capacity-building initiatives, research conducted, challenges and others. The main purpose of the situation analysis was to gather the perceptions of medical educators about patients, medical profession, curriculum, pedagogy, etc. Issues of violence against women, abortion rights, sex selection/determination etc., gender issues that CEHAT has long worked on, were prioritised in the situation analysis study. The research objectives, thus, were:

- To capture perceptions of medical educators regarding the relevance of gender in medical education.
- To capture perceptions of medical educators regarding patients and doctors from a gender perspective.
- To explore the conditions under which teaching and practice is undertaken in medical colleges.
- To explore why gender sensitivity is imperative in medical education and practice, and to that end, elicit information on specific practices pertaining to women's health.

Methodology

The situation analysis was a qualitative study aiming to understand the status of medical education in Maharashtra. Informed by feminist theory, the study attempted to capture the extent to which gender hierarchies and biases are operative in medical education and to some extent, in medical practice.

Data collection - In-depth interview method

The situation analysis was carried out through a series of in-depth interviews with medical educators, social service superintendents, librarians, students and administrative representatives. For the purpose of this report, we would take into account only the interviews conducted with the medical educators.

Interview guides were used to conduct the interviews (Annexure 1, 2 & 3). The guides consisted of questions on the content of teaching on social determinants of health, especially gender, in undergraduate medical education. The questions were related to the current understanding of the issues of gender in medicine among teachers, and whether these were considered relevant to medical teaching and practice. There were department-specific questions on protocols and practices followed for responding to sexual and domestic violence. There were also questions on protocols followed for abortion and concerns around sex determination/selection for relevant

departments. Lastly, there were questions related to pedagogical practices and research activities.

Purposive sampling

The study adopted purposive sampling and sought to have at least two faculty members from each department, including one project participant[1] and one non-participant.

The response to the study was affected by the following factors. Some participants had left the medical college since the commencement of the project (3), while some others refused to participate in the GME project (5). Also, in some departments medical educators were not deputed for the project (10). Of the targeted 70 interviews, 10 interviews could not be conducted owing to unavailability of faculty members at the time of visit - which was often the case due to short-staffing in the department (10), or, refusal to participate in the study (2). In Government Medical College Aurangabad, there were two additional interviews: one in PSM and one in FMT (Table 2).

Study Respondents

A total of 60 faculty members were interviewed for the purpose of the study. The break-up of faculty members as per medical college and departments is given in the table below.

Table 2: Department and medical college-wise study respondents

Depar-tment	GMC Ambe-jogai	GMC Auran-gabad	GMC Dhule	GMC Kolh-apur	GMC Miraj	GMC Nagpur	MGM Navi Mumbai	Sub-Total
FMT	2	3	2	1	2	2	1	13
Medicine	2	2	2	1	2	2	0	11
ObGyn	2	2	1	2	2	2	2	13
PSM	2	3	2	2	2	2	2	15
Psychiatry	-	-	1	2	1	2	2	8
Sub-total	8	10	8	8	9	10	7	-
Total	**60 medical educators**							

Source: Study data

There were 23 female respondents out of the total 60. There were no women faculty members in any of the FMT departments in the seven medical colleges at the time of study. The department-wise break up is given in table 3.

[1] Project participants were those medical educators who underwent the first GME Training of Trainers focussing on the integration of gender in medical education.

Table 3: Department-wise number of male and female respondents

Department	Female respondents	Male respondents
ObGyn	5	8
Medicine	4	7
FMT	0	13
PSM	10	5
Psychiatry	4	4

Source: Study data

Data analysis

Qualitative data analysis was done with the help of QDA software package Atlas.ti 6.2. To begin with, all transcripts were read and key themes underlying the responses were identified. Subsequently the transcripts were re-read thoroughly to prepare codes based on the questions asked in the interviews and the research objectives. The set of codes were discussed within the research team and finalised. The codes were entered in the software along with the transcripts. In this way, query reports were generated for each code. Finally, the analysis was carried out by putting together the codes under different themes.

Structure of the report

As stated earlier, this is a report of the interviews conducted with the medical educators regarding their perceptions of the medical education system in Maharashtra and the relevance of gender in medical education. In the subsequent sections, the findings of the study are presented. After an overview of medical education in Maharashtra, the findings are organised as perceptions of educators regarding [a] the current medical curriculum; [b] pedagogy used; [c] interactions with patients; [d] gender and the medical profession and [e] conclusion. The report ends with a conclusion that summarises the findings and highlights the need for integration of gender in medical education as envisaged in the GME project.

II. Medical Education in Maharashtra: An Overview

The Ministry of Health and Family Welfare (MoHFW) is responsible for medical education in the country. In Maharashtra, there is also a Ministry of Medical Education (MoME) (Figure 1). The Department of Medical Education and Drugs comes under the MoME and MoHFW in Maharashtra. The DMER is the nodal agency for medical education in the state.

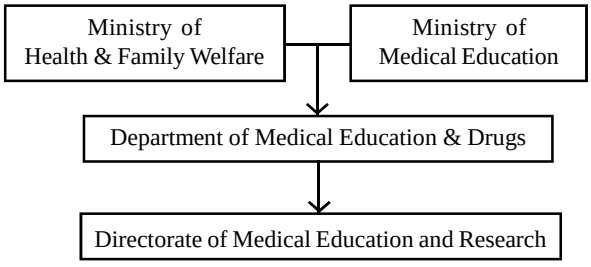

Figure 1 : Administrative structure for medical education in Maharashtra

As of 2013, Maharashtra had a total of 44 medical colleges, with an admission capacity of 5,945 per year in the MBBS course (Bachelor of Medicine and Surgery) (CBHI 2013). Most medical colleges in the state are located in urban centres. 25 of the total 44 medical colleges are trust-owned, privately managed institutions (ibid.). The remaining 19 government medical colleges are located in 15 districts of the state (Annexure 4). There are two government medical colleges in Pune and Nagpur while there are four in Mumbai.

Prior to 1998, the state had regional universities under which all medical colleges of that region were covered. The syllabus for the MBBS course was also decided by the respective universities and hence, was different across the state. Since the MUHS was set up in 1998, all government and private medical colleges in the state bear affiliation to this umbrella university.

The Medical Council of India (MCI) under the Union Ministry of Health and Family Welfare, stipulates the rules for medical school curriculum structure and content, and regulates all aspects of the medical curriculum and teaching. The undergraduate medical degree which provides basic training in clinical medicine is structured as shown in table 4.

Table 4: Basic medical curriculum

Phase	Type	Duration	Subjects
First	Preclinical	12 months	Anatomy, Physiology and Biochemistry
Second	Paraclinical	18 months	Pharmacology, Pathology, Microbiology and Forensic Medicine and Toxicology
Third	Clinical	24 months	Ophthalmology, Otorhinolaryngology, Community Medicine, General Medicine, Paediatrics, Surgery, Orthopaedic Surgery, Psychiatry and Obstetrics & Gynaecology
Compulsory Rotating Internship		12 months	
Total duration: 5.5 years			

Source: MUHS website

Teaching is carried out through traditional didactic methods of classroom lectures and case discussions during clinical postings. The assessment of students comprises both external and internal assessments. Examinations are conducted uniformly for all medical colleges under the MUHS. As per the MBBS syllabus and guidelines, the student assessments consist of oral tests along with written examination with multiple-choice and essay questions and practicals. In medical colleges across Maharashtra, research is an essential component of postgraduate training. Additionally, there are departmental research projects on a variety of topics conducted by staff members (DMER, 2015).

The student strength in the study colleges in the MBBS course was between 100-200 students in each phase (Table 5). Miraj, Kolhapur and Dhule did not offer any PG courses. Diploma courses were available only in Aurangabad GMC. Interestingly, in Maharashtra, PG courses in Psychiatry are offered in only five of the 19 government medical colleges (Times of India, 2015). Only colleges located in Mumbai and Pune offer PG courses in Psychiatry. This means that only a small number of medical students located in urban centres such as Mumbai and Pune specialise in Psychiatry in Maharashtra.

For infrastructure and facilities details of the study colleges refer to Annexure 5.

Table 5: Student strength in study colleges

Medical college	MBBS			PG		PG Diploma		
	Phase 1	Phase 2	Phase 3	Phase 1	Phase 2	Phase 3	Phase 1	Phase 2
GMC Aurangabad	150	150	150	62	62	62	22	22
GMC Miraj	150	100	100	-	-	-	-	-
GMC Kolhapur	150	210	162	-	-	-	-	-
GMC Dhule	100	DNP	DNP	-	-	-	-	-
GMC Ambejogai	100	50/100	50	33	40	44	-	-
GMC Nagpur	200	200	200	124	124	124	DNP	DNP
MGM Navi Mumbai	150	150	100	92	92	92	-	-

Source: Study data
DNP – data not provided

In all the government medical colleges, there was considerable shortfall of faculty members in the five departments (Table 6). The percentage of vacancies was higher in the FMT and Psychiatry departments. In Kolhapur, 75 percent positions for faculty in the FMT department were not filled.

Table 6: Percentage of shortfall of faculty in study medical colleges

Subjects	Medical Colleges						
	GMC Ambejogai	GMC Aurangabad	GMC Dhule	GMC Kolhapur	GMC Miraj	GMC Nagpur	MGM Navi Mumbai
ObGyn	15.3	33	10	10	14.2	4.7	NA
Medicine	0	40	33	11	46.2	7.6	NA
FMT	25	25	25	75	60	18.18	NA
PSM	14.2	0	33.3	40	33.3	5.8	NA
Psychiatry	66.6	66.6	33	25	50	25	NA

Source: Study data

III. State of medical curriculum

This section presents the responses of the medical educators related to the change in medical curriculum and syllabus. The respondents of the study were asked to share their views on changes in the curriculum and topics related to social determinants of health with a special focus on gender.

Changes in curriculum and examination pattern

The study respondents completed their MBBS course between the years 1974-2009 (Table 7). Most respondents were of the opinion that the content of the textbooks had not changed significantly over the years. Respondents noted few changes between the current textbooks and those that they had studied as students (Table 7). Largely, the changes observed were the inclusion of [a] new technologies e.g. sonography and stem cell therapy, [b] new legislations e.g. the Protection of Children from Sexual Offences (POCSO) or the Criminal Law Amendment Act, [c]' new diseases' e.g. HIV/AIDS while removing those that have been eradicated and [d] in the FMT practical schedule teaching only foetus age estimation without delving into the cause of death, sex determination or conducting an autopsy.

Table 7: Year of completion of MBBS course of study respondents

Year of completion	Number of study respondents*
1974-76	3
1980-89	11
1990-1999	21
2000-2009	23

Source: Study data

* Data available for 58 respondents

With regard to the inclusion of legislations, the FMT medical educators highlighted that there is a lack of updation of legislations or amendments made to laws in the textbooks (Box 1). If this is correct, then, the information provided to students regarding legislations could be inaccurate and even harmful when applied in medical practice.

Box 1: Responses of educators regarding lack of updation of legislations

The same text books are referred to even now…Some of the content is contradictory to the law itself. There is no updation of laws related to the age at marriage and the legal age for sexual intercourse. In the books, sexual intercourse by a man with his wife or any other woman who is under the age of 16 years is considered unlawful. But, this is a contradiction as the legal age of marriage for girls is eighteen years and for boys is twenty one years. (FMT, Assistant Professor, Male)

Although there is introduction of laws like the sexual assault law in medical textbooks, there is no updation related to amendments of the law. (FMT, Assistant Professor, Male)

All the respondents pointed out that there has been a change in the examination pattern with the introduction of multiple-choice questions in the assessments. Some respondents approved of the new examination pattern as it was seen as leading to an increase in the specificity of medical knowledge among students. On the other hand, there were respondents who considered it a hindrance in the actual skill development of medical students. Multiple choice questions were considered inadequate in assessing the level of skill development in a student.

Social determinants of health in curriculum

The responses related to social determinants of health (SDH) were rather varied. Respondents variously associated SDH with making village visits, rural and urban postings, vaccination programmes, teaching related to family planning methods, hygiene and sanitation, occupational health hazards, biomedical waste management etc. The gist of the multitude of responses, however, was that SDH are largely the concern of the PSM department where it is adequately addressed. More than half of the respondents understood SDH to be covered only in PSM (Table 8). Strikingly, one respondent, an FMT educator, claimed that SDH such as poverty, gender, caste, rural/urban location or religion do not have any effect on the health of an individual. The table indicates that in the medical curriculum SDH are currently included to some extent in PSM. According to many medical educators, SDH fall exclusively within the ambit of the PSM discipline.

Table 8: Number of respondents stating SDH is part of only PSM

Departments	Numbers who stated SDH part of PSM	Total number of respondents
FMT	6	13
Medicine	9	11
ObGyn	6	13
PSM	6	15
Psychiatry	4	8

Source: Study data

Some respondents contended that SDH is covered and relevant in other departments as well (Box 2). Both the psychiatry educators quoted below claimed that SDH was taught in all disciplines.

Box 2: Responses of educators related to SDH in medical curriculum

SDH are covered under PSM and ObGyn as both the streams belong to preventive medicine. Currently SDH are more focused around sex determination issues. Earlier, the teaching around SDH was more related to diseases common among males and females, the reasons for it, problems related to poverty, diseases common among rural women, causes, treatments, how these diseases can be prevented by improving the socio economic status etc. (ObGyn, Assistant Professor, Male)

Social issues are very much important in psychiatry, as psychiatry cannot be practised without paying attention to social issues. This is so because psychiatrists as doctors need to sympathise with patients and be sensitive towards them. Social factors such as poverty have an effect on the health of an individual. Hence, social factors are covered in each and every discipline of medicine such as surgery, physiology, pathology etc. (Psychiatry, Assistant Professor, Male)

PSM and psychiatry mostly deal with social determinants of health. Other subjects also focus on it, but their approach is more about symptomology, treatment. PSM and psychiatry look into the entire biopsychosocial model. (Psychiatry, Assistant Professor, Female)

We also found that respondents did not teach SDH as these determinants were understood to be irrelevant to the discipline (Box 3). These respondents claimed that their discipline had no use of SDH or the determinants had no practical application.

Box 3: Responses related to irrelevance of SDH in certain medical disciplines

Social determinants of health like gender and poverty do not have any relevance in FMT department, as doctors from this department deal with 'cases' or 'dead bodies', so there is no question of gender discrimination…However, I have observed that people from lower socio economic status are exposed to sexual offences more than people belonging to middle or upper socio economic status. (FMT, Assistant Professor, Male)

SDH do not have a practical application, but it somewhere affects the treatment in an indirect way. It helps in offering better service to patients…All these aspects were covered in PSM itself, as medicine focuses more on clinical services. (Medicine, Assistant Professor, Male)

MBBS students are trained to be doctors, so all the teachings are in relation to disease and disorders…MBBS curriculum does not go from poverty to disease. The teaching is centred on disease and it covers all relevant factors…In medicine epidemiological factors are covered, of which social factors are also a part. However, these are not dealt with in depth as there is not much relevance of it. (Medicine, Assistant Professor, Male)

If social determinants of health like caste are taught to students then, doctors as medical professionals are creating casteism, which actually should be eradicated from the society. (FMT, Associate Professor, Male)

Significantly, the first FMT educator's statement on greater exposure of poorer segments to sexual offences highlights precisely the kind of class bias and misconceptions among doctors that can be addressed through better integration of SDH in medical education. Similarly, the second FMT educator's contention related to caste points to an absence of a curiosity regarding a social reality in order to better define the phenomenon and deal with its ramifications. In the medical profession, the integration of social theory would aid in addressing discrimination and bias stemming from such circumvention of issues and concerns. A number of teachers from the PSM department who were interviewed for the study shared the ways in which SDH is covered in the discipline-specific curriculum and its training (Box 4). SDH are especially emphasised in the current curriculum as more weightage is given to these topics, according to the respondents.

Box 4: Responses of PSM educators regarding SDH in the curriculum

The students are given family cases to handle at urban health centres. They are instructed to study the role of social factors like poverty, illiteracy, gender bias, ignorance of health etc. among patients. (PSM, Professor, Female)

We had concepts of sociology, family type, social context of health and disease. Though all these sociology related topics were part of the subject, not much weightage was given during examination. Now, enough weightage is given to all these issues. (PSM, Associate Professor, Male)

Now the undergraduate students have one chapter called social sciences, in which all the social determinants are covered. It includes social aspects of disease, doctor patient relationship, doctor - sister relationship, medical officer as a leader and what all qualities a medical officer should have to be a good leader. It also has a discussion around socio economic factors like poverty, gender, age, type of family, urban/rural area of residence, availability of health care facility in the vicinity, education level, occupation etc. All these topics are discussed in theory as well as in every case presentation. (PSM, Assistant Professor, Male)

SDH are taught only for 'short note' type questions that are asked in examinations…every disease is discussed in the form of Agent-Host-Environment triad, which is known as the epidemiological triad, so there is a mention of social factors while discussing major diseases, when agent and host factors are deliberated. (PSM, Associate Professor, Female)

Gender as a social determinant of health in curriculum

With regard to Gender as an SDH, nearly all respondents stated that there is limited discussion on gender in the medical textbooks. The responses related to this theme show that gender as a social determinant of health was variously understood by the respondents to mean any one or a combination of the following:

- Biological differences between men and women
- Sex-specific diseases
- Violence against women

The articulations of the respondents regarding gender were centred on these issues related to anatomy, diseases or violence. Although the above-mentioned issues are rightly associated by the respondents with the notion of gender, the deeper theoretical underpinnings of gender are missing from the discussion. There were few important references to social structures and systems that perpetuate sexism and misogyny (Box 5).

Box 5: Responses regarding gendered social system and structures

But it (gender bias) is obvious everywhere…one need not go into details; gender bias is always there. (PSM, Assistant Professor, Female)

Not much stress was given on gender as a SDH. There were some references to how male members are given first preference in food and also owing to male dominance in the society vasectomy are performed in much lesser numbers as compared to tubectomy, which is costlier and time consuming. (PSM, Associate Professor, Female)

Gender bias is there, we teach this gender bias only as far as abortion is concerned in our subject…We explain why female foeticide occurs…this we teach them but other gender bias will come when they are working in the male dominant society, as the decision making is mainly done by males. (ObGyn, Professor, Male)

The statement of the first PSM educator is revealing as the educator is clearly aware of the pervasive nature of a gendered social system but sees no merit in digging any further to discuss or consider gender bias. This is reminiscent of the contention in the previous section on caste and how its discussions could lead to casteism (see Box 3). A different approach to the phenomenon is proposed by the PSM educator here in which gender bias is simply taken for granted and a detailed discussion is rendered unnecessary.

There were also a number of respondents who stated that the concept of gender was not included in the medical curriculum and further, there is no need to include the concept as it is irrelevant in medical education (Box 6; also refer to section on relevance of gender in medical education).

Box 6: Responses regarding irrelevance of gender in curriculum

No, nothing is taught! It is not at all an issue which needs to be included in medicine curriculum. We only teach about differences in diseases in males and in females.We learn about other things only during our practice. (Medicine, Assistant Professor, Female)

These social issues have no relevance for medical students. The teachers have to stick to the medical text books only and there is no scope for teaching any additional things. (FMT, Assistant Professor, Male)

The findings of this study resonated with evidence that educators often find gender relevant in the course of consultations and not so much while teaching the medical curriculum (Risberg et. al., 2003). In this study, many educators claimed that gender concerns are practice-oriented and so, they are not included in the medical textbooks (Box 7). This may also explain why a number

of educators spoke of community/field visits and the work of rural and urban health centres while discussing SDH as shown in the previous section.

Box 7: Responses related to gender being more practice-oriented

These are social diseases, like HIV. Till today there is a taboo in the minds of people. If the patient has tuberculosis, then isolating the patient will not cure him/her. Even for HIV they will ask how she had it. They will not ask whether her husband is HIV positive, but they will ask how she got it. Then they will try to hide it, which leads to more complications in her life. These factors we teach in case presentation or when they come to us for postings …These are not a part of textbooks, but are taught when the students come for postings, because these topics are different...so whenever the topic of social factors arises we are teaching them - but not in every case. These topics are not dwelled upon in classroom teaching. (PSM, Assistant Professor, Female)

MBBS teaching is mostly focused on theory and core medicine. Practical issues such as difference in treating a male and a female patient are not taught in the classroom. It is when the students come for internship and deal with patients that they notice the subtle differences, which are important. These issues are taught to students on one to one basis and they are relevant in practice. (Medicine, Assistant Professor, Male)

Respondents told us about the gender-related topics that were covered in the medical syllabus while they were students and those covered in the current syllabus that they are teaching (Table 9). Significantly, psychiatry educators claimed that gender topics were absent in their student years as well as in the present. According to respondents, earlier the PSM syllabus only had minor references to gender; this has expanded over the years to include discussions related to women's health and women's empowerment. Topics such as sex-related diseases and biological differences are generally the same across subjects.

Table 9: Gender in past and present medical curriculum as per respondents

Discipline	Topics in past syllabus-student years (1974-2009)	Topics in present syllabus - teaching years 2014/15
FMT	Mention of crimes against women	Gender identity and sex determination of foetus (post-mortem examination not in theory); Biological differences between male and female; sexual jurisprudence - examination of survivors of sexual assault.
Medicine	Sex disaggregated suicide or literacy rates; sex ratio; sex related diseases	Sex related diseases
ObGyn	Sex-related diseases or conditions such as health during pregnancy, menopause, anaemia, malnutrition, heart ailments, hypertension among women; difference in human anatomy	Sex-related diseases or conditions; PCPNDT Act; Violence against women
PSM	Only passing reference to male dominance	Women's health; women's empowerment; Occupational health; More practical knowledge through community visits
Psychiatry	No gender topics	No gender topics

IV. Pedagogy in Medical Education

This section presents the responses of educators relating to the pedagogy of medical education.The pedagogy is explored in terms of teaching methods used by the educators in the different departments and how the medical curriculum is designed for the students. An examination of the pedagogy in medical education aids in establishing whether the current teaching approaches and schedule allow for the introduction of new concepts such as gender.

Methods of teaching

In all the departments, theory is taught largely through lectures and practice is achieved in the course of internships, clinical or community posting (Table 10).

Table 10: Department-wise teaching methods as per respondents

Particulars	FMT	Medicine	ObGyn	PSM	Psychiatry
Pedagogy	Theory lectures; Practical: inter nships, clinical posting	Theory lectures; Practical: internships clinical posting	Theory lectures; Practical: clinical posting	Theory lectures; Practical: community posting	Theory lectures; Practical: clinical posting
Practicals	Clinical postings start with internship, Demonstrations of 20 post-mortems in second year, students asked to reconstruct	Internship; attending OPD - case study where students are asked to examine the patients and present their case	30% for practical; second year-attending OPD and IPD, case study where students are asked to examine the patients and present their case	School and household visits made in second year, students follow 5 families for 3 years as part of community posting; Ward rounds and OPD in second semester	Mandatory rural postings; attending psychiatric clinics in third year - cases are discussed

The methods of teaching theory classes are fairly traditional and conventional as per most respondents. Many educators take theory classes using lecture notes and a blackboard when required. A number of respondents shared that at present even audio-visual aids such as PowerPoint (PPT) presentations are used in delivering lectures. There were mixed responses regarding the use of aids such as PPT (Box 8).

Box 8: Responses regarding the use of aids in teaching

(Using PPT) is a good thing but also not. Most of the time the students are looking at the PPT while thinking of other things. Interpersonal attachment is lost. During chalk and board tradition (students would interact with the teacher) on a one-to-one (basis). They used to ask, "What is this topic? What do you mean by injury?"... Yes, the teacher is teaching, but somehow the soul has been lost. (FMT, Assistant Professor, Male)

The heavy emphasis on theoretical understanding in the pedagogy of medical education was seen as a problem by some respondents. The educators who critiqued this aspect of the medical education pointed to the lack of basic skills among students even as they reach the post-graduation level (Box 9). Respondents pointed to how the MBBS course had become redundant as at the post-graduate level the results of the MBBS course are not taken into account for the PG entrance examination. According to the respondents, the MBBS students are disinterested in the course preferring to prepare for the PG entrance examinations. Educators claim that the teaching pattern in MBBS is affected as greater emphasis is laid on PG entrances.

Box 9: Responses related to emphasis on theory over practice in medical education

Students are just getting theoretical knowledge. They don't know how to interact with patients. (When we were students) in the first year of Physiology, we were taught how to communicate with the patient, the basics of the doctor-patient relationship. It was refreshed in the second year when clinical postings started. Now teachers assume students know everything but it is not a fact. So when final year students come to us for postings and we ask them to interact with the patients and demonstrate some findings, they straight away go to the patient as if the patient is sitting there for demonstrations and start touching him or her [sic]. It is a normal procedure that you have to first introduce yourself to the patient, explain what you are going to do and also tell them if the procedure is likely to cause any pain or discomfort. After that only if they consent, we can proceed. This is missing - due to the decrease in student's interaction with patients. (Medicine, Assistant Professor, Male)

We know that for a disease a certain injection is to be given, but nobody taught them (students) how to give that injection. When they come to PG, they don't know because they also don't do their

internship properly as they want to study (for the PG entrance). And it's okay - I mean, how many years are they going to waste? There are 4 ½ years of MBBS, then one year internship, then maybe bond for one year [sic], after that they come for PG. Sometimes they lose a year or two in between. So when they come for PG, they are not able to do basic skills like IV setting, administering injections etc. In our times we did our UG and our posting sincerely as there was no entrance. So if we got good marks in ObGyn, it was sure we were going to get into that department for PG. So if we were interested we were doing all the labour room duties and night shifts. So this is a major change which I feel is dangerous. (ObGyn, Associate Professor, Female)

Marks obtained in MBBS aren't given much importance these days. Students are interested in getting a PG seat. So, they aren't interested in clinical practice that we teach during these five years. Attendance has dropped majorly as MBBS marks don't matter any where. The PG entrance exam is given more importance. Thus, there is no skill development. There is no practical exam, but only theoretical exam. So, clinical skills are not practiced. So, PG entrance should include at least the final year MBBS marks and how the student fared throughout the five years and the entrance examination. (Medicine, Assistant Professor, Female)

In the discussion with educators, they identified a worrying trend of lack of practical skills among MBBS students. With the emphasis on theory, there is a risk that medical students are not adequately skilled in dealing with patients and their health needs. Further, as seen in the earlier sections, theory in medical curriculum is largely biomedical with little or no focus on gender and other social concerns. Therefore, at the end of the MBBS curriculum with poor practical skills of dealing with patients and a biomedical theoretical orientation, the students are ill-equipped to grasp how social determinants such as gender are central to the concept of health.

V. Perceptions regarding Patients

This section presents educators' perceptions about their patients. The respondents' views are categorised as the socio-economic profile of the patients; difference between male and female patients; attitudes of patients, and perceptions regarding survivors of violence.

Socio-economic profile of patients

All participant-medical colleges, except MGM college, are government hospitals located in districts with predominantly rural populations.So, most of their patients are from rural areas. Hospitals such as the Nagpur Medical College operate as referral centres with a high referral case load from the area. Most respondents said that a majority of the patients who visited the respondent doctors were of low socio-economic status. The respondents were largely doctors in government medical colleges located at the district level. Existing literature on utilisation of public health services corroborates their responses that the lower socio-economic groups are the largest consumers of public health services (Misra, Duggal, Lingam, Pitre, 2008). Only a few respondents claimed that they also treated patients belonging to middle or high income groups (Box 10).

Box 10: Response regarding socio-economic status of patients

> *Patients are from lower to middle to very low income groups. We also get patients who are from below poverty line households. We get all sorts. About 10 percent would be middle income and the rest would be low to middle income. 45 percent would be very low middle income. (ObGyn, Assistant Professor, Female)*

Differences between male and female patients

On the basis of their experience respondents identified certain conditions or diseases to be more common among women than men and vice versa (Table 11). An educator of Medicine said that psychological problems were seen to be common among women. PSM educators identified more nutrition related problems among women than in men who came with complaints related to lifestyle or communicable diseases. Medicine, ObGyn and PSM educators identified anaemia as a common condition among women.

Table 11: Discipline-wise identification of common health conditions or complaints among male and female patients

Discipline	Male patients	Female patients
FMT	Road accidents (death)	Assault cases
Medicine	Heart problems; aches and pains (psychosomatic)	Anaemia; psychological problems; heart problems; fibromyalgia; poor nutritional status.
ObGyn	-	Anaemia; Pregnancy; fertility; menstrual disorders; prolapse; fibroids; irregular bleeding
PSM	Hypertension, tuberculosis, bronchitis; skin diseases; HIV; communicable diseases; lifestyle diseases	Anaemia; osteoporosis, thyroid related problems, malnutrition, gastro-intestinal typhoid
Psychiatry	Substance abuse; depression; psychosis erectile dysfunction	Depression; anxiety; insomnia; Obsessive Compulsive Disorder; hysterical symptoms e.g. convulsion (other than substance abuse same as men); Intentional Hysterical Episodes; somatic complaints

In psychiatry, respondents said that substance abuse is much higher among men than women while depression and anxiety were more frequently seen among women. This perception of the respondents is echoed in research conducted worldwide where the incidence of alcohol or drug abuse was high among men while more women suffered from anxiety disorders (Snow 2007; Patel 2005). Psychiatry educators claimed that women displayed 'hysterical symptoms' and 'housewives' in particular experienced 'Intentional Hysterical Episodes' (Box 11). 'Hysteria' is no longer a part of the psychiatric classifications and instead, the term 'Conversion and Dissociative Disorders' is used for the purpose of diagnoses (Patel, 2005).

Box 11: Responses of psychiatry educators related to hysteria

So it has been observed that female patients are more somatic than male patients. They present what we call hysteric symptoms e.g. convulsion, not able to speak, not able to walk. This is observed more in females as compared to males. (Psychiatry, Professor, Female)

There is something called Intentional Hysterical Episodes, which are cases of deliberate self-harm, that are more common amongst housewives. (Psychiatry, Assistant Professor, Female)

In the course of discussing their patients, respondents were asked to distinguish between male and female patients. A number of the educators held fairly stereotypical views of men and women who seek their care (Table 12). In the presentation of complaints, many of the educators were of the opinion that women are not as straightforward as men. Women tend to seek medical attention for minor health complaints whereas men came in with 'significant complaints'. Medicine educators were of the opinion that women tend to be susceptible to psychological disorders and less tolerant of pain. One PSM educator was of the opinion that women tend to exaggerate their pain or symptoms.

Table 12: Discipline-wise gender stereotypes related to patients and their complaints according to respondents

Discipline	Male patients	Female patients
FMT[2]	-	-
Medicine	Significant complaints; able to pinpoint their complaint; more strength	Susceptible to psychological disorders; minor complaints; irrelevant complaints; less tolerance (for pain); shrink (deteriorate) rapidly.
ObGyn	Men at fault (for transmitting HIV)	Reluctant to take healthy diet or iron tablets
PSM	Significant complaints	Minor complaints; come with vague symptoms/complaints; show more symptoms; likely to exaggerate symptoms and pain.
Psychiatry	Express themselves through anger and violence; straightforward in their complaints	Need more care as compared to men; naturally have more problems; hysteria among housewives

Because of these stereotypes one respondent was more comfortable working with men than women (Box 12). This perception that it was easier to work with men than women came to be imparted to them in the course of their training, according to a medicine educator. Another psychiatry educator claimed that women required more care than men for the same illness. At the heart of this understanding lies the stereotype that women are weaker owing to their 'natural' condition of having more health problems. Further, the doctor contended that the support base should comprise the women of the household. There is no mention of the role of the male relatives, particularly the partner, in supporting the woman through these problems. Certain educators

[2] As most of the FMT respondents work on post-mortem, ante-mortem and assault cases (for injury certificates), their views regarding patients are shared in the sections related to survivors of sexual or domestic violence and management of these cases.

expressed paternalistic i.e. a fatherly attitude towards women patients further perpetuating the stereotypes of women needing protection and constant or extra care.

Box 12: Gender stereotypes as expressed by respondents vis-a-vis male and female patients

Regarding male patients, we think that they are more comfortable. We had teachings also. We had postings in male wards and female wards. So, in both the wards it was a different experience. Working in male wards was much easier for us because gents used to pin-point their complaints. That was our experience. Whereas in female wards we had to ask repeatedly which is the relevant and which is the less relevant complaint. So that was an added task. (Medicine, Professor, Male)

Females naturally have more problems than males. For females, there are not just mental/ psychological problems, but also her biological problems. If she is suffering from a mental illness and she also has her menstrual periods then the relatives have to be sensitised. She has to be given extra care and support. Her mother or sister-in-law has to help her in dealing with her problem. Females need more care as compared to males when they're suffering from the same illness. (Psychiatry, Assistant Professor, Male)

In case of HIV, innocent females suffer because of her husband, who gets infected with HIV as he works outside the house, the woman is not at fault but she and her child suffer. (ObGyn, Associate Professor, Male)

However, there were also several respondents who notwithstanding the dominant stereotypes of male and female patients attempted a more sensitive uncovering of the social factors underlying health complaints or patients' behaviours (Box 13).These respondents identified societal structures and gender roles and expectations at the heart of how men and women experience health problems or present complaints. This shows a degree of sensitivity and gender-awareness among the respondents in dealing with patients and understanding their problems.

Box 13: Responses related to social factors underlying health problems/complaint presentation of men and women

As far as the health problems are concerned like heart problem, brain related problems etc.the percentage for male and female patients are same. But anaemia and poor nutritional status is common among women. In fact, we hardly find any females having HB of more than 8 or 9…We still give better food to men, better chances of economic development to men, better social status to men. So,naturally, women's food intake, hygiene and their overall health is low. (Medicine, Associate Professor, Male)

Overall it has been observed in Asian countries that females are not usually allowed to or they are not expected to show their complaints...So in Asian countries, female patients present more of somatic symptoms as compared to male patients. So a male patient would come and say that he's feeling depressed but the female patient will not come with depression, but with ache or multiple body pains or some other somatic symptoms. It has been observed that somatic patients have (been) doing household work and because of the over-exertion, she will present headache or stomach pain. These are presented more by female patients than male patients…what we call hysteric symptoms like convulsion, not able to speak, not able to walk are more observed in females as compared to males. (Psychiatry, Professor, Female)

There are certain different approaches towards the treatment of a male patient and a female patient because our society has determined certain roles for the genders. For a female patient, she has to recover and get back to her household work. For males, many a time, even if they don't work, they are getting support from other family members so there are certain different approaches in patient care. The outcomes expected of these patients are also different. (Psychiatry, Associate Professor, Female)

Well, women may be more willing to talk about the emotional aspects of it than the men. But in India in general psychiatric awareness is low, so they do not notice the emotional symptoms more. So both men and women will give you more of physical symptoms. If you probe though, women are much more forthcoming about emotional symptoms. Men think it is not so macho to talk about the fact that they are feeling sad, or feel like crying, and they are getting such negative thoughts. (Psychiatry, Assistant Professor, Female)

Perceptions regarding survivors of violence

Dealing with cases of sexual or domestic violence necessitates utmost care and sensitivity towards the survivor. Views of doctors regarding survivors and their dilemmas give a glimpse of the prejudices and misconceptions operative within doctor-patient interactions in sexual or domestic violence cases (Box14).While discussing SDH, an educator observed that most survivors of sexual offences belong to the lower socio-economic strata (see Box 3). A psychiatry educator was of the opinion that a survivor of domestic violence would prefer to continue living with her abusive husband as he is the provider in the household. Counselling is, therefore, considered of little use as the woman would live with the partner regardless of the violence perpetrated. It is possible that the educator recognises that counselling over 'three days' may not help her deal effectively with an abusive relationship. However, the contention that counselling would not help the woman is not a very useful position to take, especially for a psychiatrist. Also, the educator's opinion seems to pigeon hole all abused women without giving much consideration to the dilemmas of the survivors and the motivations of the perpetrators.

Similarly, the contention of the FMT educators that unless an assault is proven there is no reason to detain the accused in any way, stems from a deep distrust of women who seek justice for the crimes committed against them. Both the educators' statements regarding false charges, when taken in conjunction with their proposition to refrain from detaining the accused, reveal a potential tendency to discredit accounts given by survivors who seek care. An associate professor rightly points out that an allegation should be proven in court for a conviction of the accused. However, the suggestion that the accused need not be put on trial or in custody is blind to the survivor's vulnerability to subsequent threat and harassment at the hands of the accused.

Box 14: Responses related to views on survivors of violence

But, that (intervention in the form of counselling) doesn't matter because the woman has to live with her husband. Even if the husband is cruel she will prefer to live with him, because he is the breadwinner. You go there for three days and give sympathy. Social workers and NGOs - they (patients) don't have faith in all of these. (Psychiatry, Assistant Professor, Male)

Like in one sexual assault case, the woman had had a fight with her neighbour, so she levelled false charges against him that he forced himself on her. So, there are such instances where false cases are registered...The accused should not be put on trial or in custody till the charges against him are proven. (FMT, Assistant Professor, Male)

Today's complainant, tomorrow denies complaining...Many times…they (accused) are put behind bars…Until and unless it is proven that the person has done it, he should not be thought of as accused. Let it be proven in the court of law… (Accused should be) left in the open. Yes I believe that in 90% of the cases the offence is committed by the accused but 10% cases will be such that they may not have done it but were alleged to have done it…I feel that 99% offenders can be let go but not a single innocent person should be punished. (FMT, Associate Professor, Male)

At this juncture, it is important to note that an Assistant Professor of Psychiatry highlighted that partners of alcohol abusers constitute an invisible group of survivors of domestic violence. She shared that in her experience, although many women who accompanied their husbands for treatment were facing violence, they did not present for any treatment or counselling for the violence they faced. She contended that this category of women is often easily overlooked in identification of survivors of violence.

In this section, the perceptions of medical educators regarding patients were explored to reveal a tendency among some doctors to hold prejudiced and harmful views regarding their patients affecting their interaction with them. It is also important to note that there were also some educators who rightly explained certain health problems and patient behaviours as a consequence of the social structure and its prescriptive gender identities.

VI. Perceptions regarding gender and medical profession

In this section we report varied gender related concerns on the perceptions of educators regarding gender and the medical profession, that have so far not been addressed in the report. The section begins with a subsection on the respondents' understanding of gender in medicine followed by views of respondents which explicate how gender operates or is absent in the profession. Subsequently, subsections on gender issues viz. abortion rights and health of sexual minorities are presented.

Respondents understood gender in a variety of ways. This was also seen earlier in the section on gender as an SDH. Gender was understood as:

- a demographic category;
- health issues of women;
- increased violence against women;
- increased presence of women in the workforce; and
- gendered nature of medical institutions

The understanding was at best limited and at worst harmful. The absence of a gender perspective in medicine can well explain the limited understanding among the respondents. However, regressive and conservative views related to gender politics are a matter of grave ‘concern’ (Box 15). A PSM associate professor identified women's increased work participation as the cause of sexual harassment while an assistant professor of medicine claimed that the interaction (or common residences) of men and women cause men to 'flirt' or 'to get attracted'. Both these statements show that the responsibility of not being sexually harassed or 'getting attracted to' lay squarely with the women, according to the respondents. Moreover, in the second statement there is a serious conflation of the notions of 'sexuality' and 'sexual harassment' which could result in the encroachment of the sexual rights of individuals. In another response, men were absolved from any responsibility in gender discrimination as the problem was seen to exist only between women. A paternalistic attitude towards female students as expressed by a respondent could result in students feeling discouraged or dissuaded from pursuing the kind of research they're interested in.

Box 15: Gendered views among respondents

Sexual harassment resulting from increased participation of women in the workforce/education

Medicine is a field where ratio of intake is now more in favour of female candidates. In a new batch of 100, now we see at least 60-70% female students. Things are in favour of female sex. So, at the workplace when you have so many females, these issues (sexual harassment) are bound to be there. We have separate committees also to deal with sexual harassment at workplace. With so much interaction between male and female colleagues, with odd working hours for both the sexes, these things become all the more important in today's context. (PSM, Associate Professor, Male)

See, now it's (gender integration in medicine) required. Earlier, females were respected. Now, females can be seen in every field, so they (taken to mean, men) get a chance to flirt! Females should also be taught self-protection. Sexual harassment can occur anytime and this is applicable for all types of professions…nowadays because harassments are occurring very frequently. In a discussion that I conducted, there was a debate. Female students believed that both boys and girls should stay in the same hostel. But I said it's difficult. Why should we give men a chance to get attracted? (Medicine, Assistant Professor, Female)

Women's relationship with other women

Men are not responsible for the discrimination against women in the society…it has to do with the relationships between mother-in law and daughter-in law which needs to improve. (PSM, Associate Professor, Male)

Paternalistic attitude towards female students

In my subject, when students take research projects, most of the male students prefer field projects. But the girls prefer research projects in the hospital. I don't say that hospital research is not good and field research is good, but it is the thing. We also are bothered if one of our female students is out for field work for reasons of their own security. Boys, if they have to go to different places they can go by their own motorcycle and time also is not the concern. (PSM, Associate Professor, Male)

Conflating right to safe abortion with issue of sex determination

According to many respondents from the ObGyn department, several adhoc and informal conditions were applied in the provision of MTP at the health facilities. This was especially the case for abortions sought in the second trimester. In some cases, the conditions were so commonplace that they were deemed by the respondents to be the policy of the institution in question.We could infer that the doctors wereindeed following the instructions given to them by the medical college or hospital where they were working. The conditions for provision of MTP varied from case to case, depending on the stage of pregnancy, family size, number of daughters etc. (Table 13). Not

all ObGyn educators cited conditions for provision of abortion. First trimester abortions were accompanied with a strict advice/ insistence on the insertion of IUCD or undergoing sterilisation. Sterilisation was especially recommended if the woman had two or more children. It was quite common, according to respondents from the ObGyn department, to conduct abortions only till the 12th week of pregnancy. The assumption was that the chances of sex-selection would increase in the later stages of pregnancy (Box 16). This assumption, according to some respondents, served to ensure that MTP was denied to women in their second trimester (Table 13 and Box 16).

Table 13: Conditions applied to provision of abortion by some respondents

S. no.	Case scenarios shared by respondents	Yes	No	Conditional	Post abortion recommendation/ advice
1	First trimester	✓			Insistence on IUCD or sterilisation
2	First trimester with two or more children	✓			Strongly advice sterilisation. MTP is then followed by sterilisation
3	Second trimester		✓	✓	
4	Second trimester with two daughters			✓ If she is willing to undergo sterilisation or allows for a MLC to be filed	-
5	Second trimester with one child			✓ Insist on IUCD	-
6	Second trimester with two children ('complete family' - at least one son)			✓ Sterilisation is mandatory	-

Conditional MTP took place in the case of women in their second trimester of pregnancy. In some abortion cases if the woman had two or more children, then she was strongly advised to be sterilised after the termination of pregnancy or else a medico-legal case (MLC) was filed by the doctor before conducting the termination, in violation of provisions of the MTP Act to maintain patient confidentiality[3]. Nearly all the respondents were sceptical about performing second trimester

[3] An MLC is filed so that if post-facto it is revealed that the woman has undergone sex determination, then the doctor would not be held responsible for having performed the abortion.

abortions especially, if they did not meet the criteria given in the MTP Act. One of the respondents categorically stated that without sterilisation, MTP is simply not provided at the institution. The underlying misconceptions and assumptions that emerge in these responses are:

- A couple with two children (with at least one son) form a 'complete family'.
- Women with two daughters in their second trimester of pregnancy seeking abortion must have undergone sex determination.
- Women in their second trimester of pregnancy who are seeking abortion but are not willing to undergo sterilisation have undergone sex determination.
- Second trimester abortions are conducted on account of female foetus detected during sex determination.

Box 16: Responses related to Abortion

If the patient comes before 20 weeks then we do the abortion. And if there are two or more than two children, then we strongly recommend tubectomy. So the MTP is followed immediately by tubectomy. (ObGyn, Assistant Professor, Male)

A lady with two daughters was 16 weeks pregnant. She claimed that she had not done sex determination. I still don't trust her. I make it a point to register a medico-legal case and then offer her the MTP or else if she's willing for sterilisation alongside, then there is no need for an MLC. So, we are not that liberal in conducting a second trimester abortion as we are in the case of a first trimester abortion at this juncture. (ObGyn, Associate Professor, Male)

First trimester abortion is done but we don't do second trimester abortions…Yes, sterilisation is mandatory. If the female has a second child or if the female has one child and now she wants to abort, may be due to some other reason, she would say it was a contraceptive failure or my first child is too young - she will give many such reasons. So then, we insist that at least she should insert a CuT. If she has completed her family, i.e. she has two children then it is compulsory that she should undergo sterilisation. Then, the couple usually say that they will think about it. We cannot force them, we can counsel them...Even for first trimester abortion we motivate the women to get something done (family planning) depending on their family size…It is the policy of this institution that abortion would not be provided unless they agree to theinsertion of CuT. (PSM, Assistant Professor, Female)

It is important to contextualise the above responses of doctors with a note on the current policy environment. The sex ratio figures in Maharashtra as per the 2011 Census show a disturbing trend from 1991 to 2011. The sex ratio declined from 932 in 1991 to 929 in 2011. To counter this, the Government of Maharashtra sprang into action. The government measures ranged from

proposed tracking of pregnant women so they do not abort to increasing documentation of second trimester abortions through pictures of abortus as recommended by the Oak Committee[4]. Consequently, the provision of medical abortion and specifically, second trimester terminations was restricted considerably in Maharashtra. Individual providers and facilities claimed that in cases seeking second-trimester abortions it was difficult to ascertain whether sex-determination was carried out or not. According to a paper published prior to the above-mentioned government initiatives in 2011, doctors were reluctant to provide second trimester abortions owing to the enforcement of the PCPNDT Act (Dalvie, 2008: 42). Recent research has shed light on the common perception among doctors in Maharashtra that the Act is used unreasonably by the government authorities to target them (Potdar et. al. 2015).

It is hence apparent that the views of the study respondents are in line with the government's measures to curb sex selection. However, going by the responses in this study, these measures also appear to have effectively led to a clampdown on the provision of second trimester abortions.

Consent for abortion

As per the MTP Act, a woman if she is above the age of 18 years can give consent for a medical termination of pregnancy. Her parents or guardians need not be involved in this formal act of giving consent for the termination. Consent of parents or guardians is required only in the case of minors.

All the respondents asserted that in case the woman is above 18 years of age, she gives the consent herself but if she is a minor then her parents' or guardian's consent is essential. However, one of the respondents' also added that in case the girl is unmarried and is not a minor, then her parents are called to give consent for the abortion (Box 17). Also, an MLC is registered in case the woman is unmarried or minor, as it is understood by the educator that it 'could' be a case of sexual assault and so the police must be involved[5]. In the case of married women, some of the respondents claimed that the consent of the husband is also taken along with that of the woman to make sure that later on there would not be any problems. According to one of the doctors, the husband's consent is 'compulsory'. However, another respondent clarified that in case the husband withholds consent but the doctor believes that the MTP is indicated, the procedure is carried out as long as the woman consents to the same.

[4]A nine-member Committee headed by Dr. Sanjay Oak (Dean of King Edward Memorial Hospital) was set up in September 2011 to recommend changes to the MTP Act to address the declining sex ratio.
[5] Under the Protection of Children against Sexual Offences Act 2012, all sexual activity whether consensual or not must be reported to the police.

The underlying gendered assumptions and misconceptions regarding access to abortion that emerge in the responses are:

- Guardians or parents must be informed in case of MTP sought by unmarried woman who is not a minor.
- The husband's consent could be essential in some cases of MTP.
- Unmarried women are not sexually active.

It is important to bear in mind that the MTP Act allows the provision of abortion under conditions of risk to the life of the pregnant woman or grave injury to her physical or mental health; risk to the child, if born; pregnancy caused by rape and failure of contraception in married women. Within this, the health care providers decide how to categorise cases of termination. Based on the responses, clearly it was the doctor's discretion [a] to provide the MTP services or not and [b] if the service was to be provided then under which condition of the MTP Act to provide the service.

Box 17: Responses related to consent for abortion

If the patient is unmarried, then we do register an MLC. There is a possibility that it is a case of rape, so the police are always involved. (ObGyn, Associate Professor, Male)

In the case of unmarried women or minors, a guardian has to be present with the woman. Also, we have to report it to the police, without which we don't provide services. (ObGyn, Professor, Female)

Usually we take consent from the patient. Along with that we try to take consent from her husband. We usually call her husband and ask for his consent. So, compulsorily we take consent from both of them. But if the husband is not ready to give consent and if at that time her abortion is indicated and necessary we take her consent and not consider her husband's consent. (ObGyn, Associate Professor, Male)

Usually we also take the husband's consent because otherwise the husband goes to the court to claim that the termination was done without his consent even though by law it is not required at all. If the husband comes (to the facility) then we take his consent. But when we think that there might be some problem, judging from the case history or if the patient reveals that she has problems with her husband, then we do ask for his consent. (ObGyn, Assistant Professor, Female)

Sexuality and sexual minorities

Some respondents discussed sexuality and issues faced by sexual minorities. According to respondents, undergraduate textbooks did not cover issues related to sexuality and health concerns of sexual minorities (Box 18). A respondent suggested that when students commence clinical practice, it is important that issues of sexuality are reiterated to enable them to better deal with transgenders and sexual minorities.

Box 18: Responses related to addressing sexuality and health concerns of sexual minorities

The undergraduate curriculum does not deal with issues like homosexuality and transgender, but some of the recent PG textbooks have short chapters on these....Issues like homosexuality and intersexuality only find a mention in the textbooks of forensic medicine but when students start clinical subjects in the second year, they should be taught about these things there. (ObGyn, Associate Professor, Male)

Recently the Supreme Court identified transgender as a third gender, but we have not included it in medical education. They are treated as human patients by us but their social status is not dealt with. (Medicine, Associate Professor, Male)

About gender identity, sexuality in MBBS...basic biology is taught; basic differentiation is taught in the first year itself. But their health concerns are not considered. Their vulnerabilities are known. Skin and venereal diseases department even treat these patients. But now there is the Supreme Court judgement - they are given right to live as third gender - as neither male not female.... They do come to the hospital but they are treated on the basis of illness...Admitting them to a particular ward (male or female) is a problem, so depending on the condition, we admit them to skin or VD ward or orthopaedics ward in the male ward. (FMT, Associate Professor, Male)

VII. Conclusion

The data presented in this report clearly point to the need for the introduction of gender in the MBBS curriculum. The findings of the study lay the foundation for critically examining the entire medical curriculum and training in order to link medicine with gender theory and concepts. The study findings pointing in this direction are as follows:

- **Resistance to inclusion of social theories and concepts related to SDH**: There was a consistent view among many of the doctors that the topic of SDH falls in the purview of the PSM syllabus. There was some resistance to the inclusion of SDH in medicine. In certain cases, SDH was also seen as entirely divorced from the subjects such as FMT. The linkages between medicine and SDH were not clearly identified or articulated by the respondents. Within this, a couple of Psychiatry educators stood out as they alone contended that SDH is important for all disciplines.

  Moreover, the contentions that discussing caste would result in casteism or that gender's pervasive nature eliminates the need for further discussion are symptomatic of a tendency to simply deal with social reality as givens. Better definition of social phenomenon and its ramifications are not deemed to be necessary. Whereas critical theories demand the identification of power structures that perpetuate social phenomenon for the advantage of dominant groups and the exploitation and oppression of others. In the medical profession, the integration of social theory would aid in addressing discrimination and bias stemming from such circumvention of issues and concerns.

- **Some degree of gender awareness but ambiguity about its relevance to medical practice or education**: Another tell-tale sign of the need to include gender in medicine was the interchangeable use of the terms 'sex' and 'gender' with a lack of understanding regarding why the concept of 'gender' is useful in medical practice. The articulations of the respondents regarding gender were centred on anatomical differences between men and women, sex-specific diseases and violence against women. These issues were rightly associated with the concept of 'gender', however limiting it solely to these concerns can lead to adverse doctor-patient relationships or inadequate treatment and care. A reasonable level of conceptual understanding of gender and its implications on health is essential in medicine. Issues related to women were rightly pointed out in discussions related to gender but the deeper social implications and ramifications were missing in the responses.

- **Gender-insensitivity among educators/doctors:** The medical educators are perfectly placed to transfer knowledge, attitudes and skills to the future generation of doctors studying in medical colleges at present. In this context, prejudiced and misogynist views held by educators are disturbing as these could easily be transferred to their students in the course of the teacher-student interactions. In the study, some educators revealed their conservatism and prejudice while discussing sexual harassment, sexuality, women's relationship with other women, gender discrimination and the gendered nature of medical institutions. Psychiatry educators continue to use the term 'hysteria' to describe depressive or anxiety disorders among women patients. Gender stereotypes regarding patients were very common among the educators. Male patients were seen to be more forthcoming and more precise with their complaints as opposed to female patients.

- **Misconceptions and fears associated with MTP and PCPNDT Acts:** The educators' misconceptions and assumptions associated with the Abortion law and the PCPNDT Act were alarming. The abortion service was either conditional or simply denied to women with two daughters or women in their second trimester. Conditions such as filing MLC or undergoing sterilisation found root in doctors' fear that the demand for abortion was a result of sex determination. Through conditional MTPs, the doctors safeguard themselves from any liability under the PCPNDT Act. Conditions of this kind are not applicable to abortion services neither under the MTP Act nor the PCPNDT Act. It is important to remember that the current policy environment is largely responsible for the doctors' conduct and attitude to women seeking abortion. It could be inferred that the provision of abortions is as per the institutional norms even if in contravention of the acts. In protecting themselves from harm the doctors/institutions coerce women to [a] continue with an unwanted pregnancy or [b] undergo sterilisation or [c] adopt IUCD or [d] file an MLC.

A more nuanced understanding of gender among medical educators and students is imperative in ensuring the currently prevalent highly positivist underpinnings of medicine make way for relatively more critical forms of inquiry on the well-being of individuals in society. The introduction of gender could pave the way for an opening up of medicine to delve deeper into how signifiers such as class, caste, gender etc. have a bearing on health.

This could have far-reaching effects on how diagnosis and treatment is currently carried out in medicine. Professionals and students would be compelled to acknowledge alternative ways of approaching health and medicine. In this way, the centrality of the biomedical approach in medicine would undergo a much-needed revision. This would further lead to an improvement in the doctor-patient relationship, where the doctor understands the concerns of the patient from various angles and is willing to engage with the problem to the extent possible. In case a doctor is unable to

address a problem in its entirety then s/he identifies mechanisms, institutions or other professionals who can be of assistance to the patient. This would also allow for more interaction between departments in a medical college. Currently, it appears that the departments operate in silos, without informing or being informed by the work done in other departments. Ultimately, a holistic approach with greater gender-sensitivity in dealing with health concerns can be achieved through a deeper engagement with gender issues by medical educators and students.

In conclusion, it is important to highlight the need for further research in identifying specific ways in which gender can be effectively integrated into the medical curriculum and training. A gender-based review of medical textbooks which are currently used in medical colleges is also long overdue. In light of the study findings, medical curriculum and training must undergo fundamental changes to integrate gender so as to ensure the creation of a gender-sensitive and socially-relevant medical force in the country.

References

Agnes, F. (2005).To Whom Do Experts Testify? Ideological Challenges of Feminist Jurisprudence. *Economic and Political Weekly* Vol. 40, Issue No. 18.

Bhate, K. & Acharya, S. (2005). Preventive and Social Medicine: Practitioner's Review of Gender Content. *Economic and Political Weekly* Vol. 40, Issue No. 18.

Central Bureau of Health Intelligence. (2013). *Health Infrastructure* Retrieved from http://cbhidghs.nic.in/writereaddata/mainlinkFile/Health%20Infrastructure-2013.pdf

Chauhan R.C., Purty, A. J. & Singh Z. (2013). A study on usefulness of Re-Orientation of Medical Education (ROME) posting in enhancing the research oriented knowledge among undergraduate medical students. *International Journal of Pharmaceutical and Medical Research* Volume – 1 Issue – 1 December 2013 Retrieved from https://www.woarjournals.org/admin/vol_issue2/upload%20Image/IJPMR011106.pdf

Davar, B. (2005). Teaching Psychiatry with a Gender Perspective. *Economic and Political Weekly.*Vol. 40, Issue No. 18.

Dalvie, S. (2008). Second Trimester Abortions in India. *Reproductive Health Matters* 16 (31 Supplement):37–45.

DMER. (2015). *DMER-Research Activities* Retrieved from http://www.dmer.org/aboutdmer.html

Gaitonde, R. (2005). Community Medicine: Incorporating Gender Sensitivity. *Economic and Political Weekly* Vol. 40, Issue No. 18.

Iyengar, K. (2005). How Gender-Sensitive Are Obstetrics and Gynaecology Textbooks?. *Economic and Political Weekly* Vol. 40, Issue No. 18.

Iyer, A, Sen, G. & George, A. (2007). The Dynamics of Gender and Class in Access to Health Care: evidence from rural Karnataka, India, *International Journal of Health Services*, Volume 37, Number 3.

Khanna, R.Koning, K. D., Pongurlekar, S., Ubale, U., Manjiri, S. (2002). Sexual Coercion and PID in Slum women of Mumbai: Role of the Health Care Provider. In *Gender and Medical Education* Eds. Jesani, A. & Madhiwalla, N., CEHAT and AMCHSS.

Misra, S., Duggal, R., Lingam, L., Pitre, A. (2008). A Report on Health Inequities in Maharashtra. Retrieved from, https://www.academia.edu/2981080/report_on_health_inequities_in_Maharashtra

MUHS. (2015). *Syllabus* Retrieved from http://www.muhs.ac.in/Default.aspx

Patel, V. (2005). Gender and Mental Health: A Review of Two Textbooks of Psychiatry. *Economic and Political Weekly* Vol. 40, Issue No. 18.

Planning Commission. (1985). *7th Five Year Plan* Retrieved from http://planningcommission.nic.in/plans/planrel/fiveyr/7th/vol2/7v2ch11.html

Prakash, P. (2005). Where Is the Woman in Preventive and Social Medicine?: Sociological Perspectives. *Economic and Political Weekly* Vol. 40, Issue No. 18.

Potdar, P., Barua, A., Dalvie, S. & Pawar, A. (2015). "If a woman has even one daughter, I refuse to perform the abortion": Sex determination and safe abortion in India. *Reproductive Health Matters* 23(45):XX–XX

Qadeer, I & Nayar, K. R. (2011). Politics of Pedagogy in Public Health. In Qadeer, I, *Public Health in India: Critical Reflections.* Delhi, Daanish Books.

Rangan, S. & Uplekar, M. (1993). Community Health Awareness in Recently Graduated Medical Students. *The National Medical Journal of India*, Vol. 6, No. 2.

Risberg, G., Johansson, E. E., Westman, G., Hamberg, K. (2003). Gender in Medicine-An Issue for Women Only? A Survey of Physician Teacher's Gender Attitudes. *International Journal For Equity in Health* 2(1):10.

Sen, G., Ostlin, P., George, A. (2007). 'Unequal, Unfair, Ineffective and Inefficient Gender Inequity in Health: Why it exists and how we can change it – Final Report to the WHO Commission on Social Determinants of Health' Retrieved from http:/ / www.who.int/social_determinants/resources/csdh_media/wgekn_final_report_07.pdf

Snow, R. C. (2007). Sex, Gender and Vulnerability. *Population Studies Centre Research Report* 07-628, School of Public Health, University of Michigan.

Subha Sri. (2010). Women's bodies and the Medical Profession. *Economic and Political Weekly* Vol. XLV no. 17.

Times of India. (2015). Only 5 of 17 Maha public medical colleges offer PG in psychiatry. Retrieved from http://timesofindia.indiatimes.com/city/mumbai/Only-5-of-17-Maha-public-medical-colleges-offer-PG-in-psychiatry/articleshow/50259066.cms

WHO. (1991). *Reorientation of Medical Education: Goals, Strategies and Targets* Retrieved from http://apps.searo.who.int/pds_docs/B0083.pdf

WHO. (2006). *Integrating gender into the curricula for health professionals: Meeting Report* Retrieved from http://www.who.int/gender/documents/GWH_curricula_web2.pdf.

WHO. (2015). *Gender Factsheet* Retrieved from http://www.who.int/mediacentre/factsheets/fs403/en/

Annexure 1:

Interview Schedule for Doctors (non-FMT)

Integrating Gender in Medical Education: Situational Analysis of Medical Colleges
Interview Schedule for Doctors (non-FMT)

Schedule Number: _____

Name of Respondent	
Designation	
Name of College	
Department	
Date of interview	
Place	
Duration	
Interview Conducted by	
Documentation	

(I) In-depth interviews of teachers:

1. Which year did you finish your MBBS? What have been the changes in curriculum, or in teaching?
2. If yes, what do you think about these changes? If no, is there any need for changes in curriculum? In what way?
3. What was the teaching on social determinants of health (Poverty, gender, caste, rural/ urban location, religion)? Was gender also covered? If yes, what was taught?
4. How did you integrate your learning of gender in practice?
5. How is gender currently taught? (Eg. Women's health, gender identity, sexuality) Has there been any change? How has it changed? Do you have any suggestions on the way it is being taught?
6. Have you undergone any training on gender after completing your education?
7. What do you think of the need for integration of gender in medical education?
8. Would you like to be involved in the project? In what way?

(Qs 9 and 10 only for participants of 1st training)

9. How do you understand gender issues now after your training? (Eg. Did you revisit your textbooks after the training? Did you find any bias in language, or laws, procedures, etc that need to be updated?)
10. Have you informally introduced any discussion on gender issues in your teaching? If yes, what has been the students' response?
11. Can you tell us about the socioeconomic profile of your patients?
12. What kind of complaints do women patients usually present? What are the differences in presentation of health complaints between men and women? (Second qn.not for Obs/ Gyn)
13. What health complaints do women who have suffered violence usually present? (Whether screening questions are asked - multiple abortions, vaginal discharge, injuries, depression)
14. What do you do if a woman says she is facing domestic violence?
15. What is the procedure in the hospital for responding to survivors of sexual violence? (Keep in mind the following points: consent, non-refusal of treatment, giving treatment for free, informing the police).
16. Specific questions for each dept:

Obs/Gyn:

a. What is the protocol on abortion? (Whose consent is required? What methods are used? What happens in case of a minor or unmarried woman?)
b. Is post-abortion care provided? Of what nature?
c. How is reporting of maternal deaths done?
d. What are the common causes of maternal death? (anaemia, malnutrition, delay in seeking care, etc) What are the preventive strategies followed?

Medicine:

a. How is the identification and reporting of cases of suicide/attempt to suicide done? Eg. A case of accidental poisoning may be an attempted suicide. Are the patients provided any counselling or psychological first aid?

Psychiatry:

a. Are survivors of a suicide attempt/suspected suicide attempt referred to you? What is the nature of counselling/treatment provided?
b. Are survivors of sexual/domestic violence referred to you from other departments? What is the nature of counselling/treatment provided?

Preventive and Social Medicine:

a. Do you conduct any health awareness programmes on domestic violence or rape?
17. What is the mechanism for reporting sexual harassment in your institution?

(II) Pedagogy:

1. What is the teaching plan of your subject over the course of MBBS? In which year does your subject teaching start? What are the hours given to your subject per week?
2. What are the methods of teaching followed? (Lectures, clinics, labs, ward rounds)
3. What is the distribution of hours for each method of teaching?
4. Which year do students start attending OPD and IPD?
5. Is there use of case studies in teaching?
6. Is classroom participation evaluated?
7. Are there any periodic guest lectures? From which different fields are experts invited for these lectures (medical/non-medical)? Is there any provision for conducting guest lectures over videoconferencing?
8. Which textbooks do you use (edition)? Which textbooks are commonly referred to by the students?
9. Which are the topics for which use of web-based resources is encouraged? Does the college provide computers and internet access to the students?
10. Does the dept have its own journal or that of any society? When does it come out?
11. How many hours of teaching and clinical practice do you have per week?
12. What are the challenges you face as a teacher in this institution?

(III) Activities being conducted

1. What are the activities for undergraduate students? (Annual functions, competitions, through student associations)
2. What are the activities for post-graduate students? (Internship, CME courses)
3. Are there community outreach services? What do they involve? (visits, camps, etc.)
4. For which subjects are CME courses offered? How many hours are required for registration to be renewed?

(IV) Teachers' participation in research and other activities:

1. What kind of research is conducted by the college? (Community-based, clinical, drug trials)
2. What have been the departmental publications in the past one year?
3. Is there an institutional ethics committee?
4. What kind of capacity-building activities do teachers participate in? (Conferences, workshops, refresher courses, etc.) On what topics? What is the level of participation? How often do these activities take place in a year?

Annexure 2:

Interview Schedule for Doctors (FMT)

Integrating Gender in Medical Education: Situational Analysis of Medical Colleges Interview Schedule for Doctors (FMT)

Schedule Number: _____

Name of Respondent	
Designation	
Name of College	
Department	
Date of interview	
Place	
Duration	
Interview Conducted by	
Documentation	

(I) In-depth interviews of teachers:

1. Which year did you finish your MBBS? What have been the changes in curriculum, or in teaching?
2. If yes, what do you think about these changes? If no, is there any need for changes in curriculum? In what way?
3. What was the teaching on social determinants of health (Poverty, gender, caste, rural/ urban location, religion)? Was gender also covered? If yes, what was taught?
4. How did you integrate your learning of gender in practice?
5. How is gender currently taught? (Eg. Women's health, gender identity, sexuality) Has there been any change? How has it changed? Do you have any suggestions on the way it is being taught?
6. Have you undergone any training on gender after completing your education?
7. What do you think of the need for integration of gender in medical education?
8. Would you like to be involved in the project? In what way?

(Qs 9 and 10 only for participants of 1st training)

9. How do you understand gender issues now after your training? (Eg. Did you revisit your textbooks after the training? Did you find any bias in language, or laws, procedures, etc that need to be updated?)
10. Have you informally introduced any discussion on gender issues in your teaching? If yes, what has been the students' response?
11. Can you tell us about the socioeconomic profile of your patients: both post mortem cases and survivors?
12. What are the common causes of death/injury that you see? Are there differences between cases of men and women? Can you give examples?
13. What injuries are seen on patients (of any gender) who are survivors of violence?
14. If a woman patient presents a certain pattern of injuries indicative of possible domestic violence, do you enquire for history of domestic violence?
15. What is the procedure in the hospital for responding to survivors of sexual violence? (Keep in mind the following points: consent, non-refusal of treatment, giving treatment for free, informing the police).
16. Specific question for the dept:

a. How many post-mortems are conducted in a month for the following cases: accidents, assaults, suicides
b. What is the male/female prevalence in each? (If not exact figures, atleast greater/lesser prevalence)

17. What is the mechanism for reporting sexual harassment in your institution?

(II) Pedagogy:

13. What is the teaching plan of your subject over the course of MBBS? In which year does your subject teaching start? What are the hours given to your subject per week?
14. What are the methods of teaching followed? (Lectures, clinics, labs, ward rounds) What is the distribution of hours for each method of teaching? Which year do students start attending OPD and IPD? Is there use of case studies in teaching?
15. Is classroom participation evaluated?
16. Are there any periodic guest lectures? From which different fields are experts invited for these lectures (medical/non-medical)? Is there any provision for conducting guest lectures over videoconferencing?
17. Which textbooks do you use (edition)? Which textbooks are commonly referred to by the students?
18. Which are the topics for which use of web-based resources is encouraged? Does the college provide computers and internet access to the students?
19. Does the dept have its own journal or that of any society? When does it come out?
20. How many hours of teaching and clinical practice do you have per week?

21. What are the challenges you face as a teacher in this institution?

(III) Activities being conducted

1. What are the activities for undergraduate students? (Annual functions, competitions, through student associations)
2. What are the activities for post-graduate students? (Internship, CME courses)
3. Are there community outreach services? What do they involve? (visits, camps, etc)
4. For which subjects are CME courses offered? How many hours are required for registration to be renewed?

(IV) Teachers' participation in research and other activities:

1. What kind of research is conducted by the college? (Community-based, clinical, drug trials)
2. What have been the departmental publications in the past one year?
3. Is there an institutional ethics committee?
4. What kind of capacity-building activities do teachers participate in? (Conferences, workshops, refresher courses, etc) On what topics? What is the level of participation? How often do these activities take place in a year?

Annexure 3:

Consent Form

Dear Health Care Provider,

Integrating Gender in Medical Education is a joint project by the Directorate of Medical Education and Research (DMER) and the Maharashtra University of Health Sciences (MUHS) to introduce a gender perspective in medical education. Globally, many countries have integrated gender in their medical curriculum and this is a pilot project in Maharashtra.

The focus of this project is on medical educators who are in a position to shape the training of future doctors in the state. Therefore, your perspective on how best to implement the project is critical. We need to know the existing systems and structures, views and experiences of the doctors. Your opinions, views and suggestions would be useful in designing the project. The information will be used to develop the modules for training and formulating changes in the curriculum.

We will be conducting interviews with staff of the hospital, where two of the team members will interact with you for about 35-40 minutes. In order that we do not miss out on documenting any information that you provide us with, we request that you allow us to take notes while we interview you.

We would like to assure you that the information shared with us will remain confidential and will be used only for the purpose of the study. The report will not contain any personal information or identification, nor will any individual or group be named. Everything you tell us would be kept anonymous and no identifiable information would be shared with anybody including the hospital authorities.

We seek your cooperation in conducting the study and it is for this purpose that we have approached you. If you have any doubts, questions, clarifications or suggestions, please feel free to call us, meet us or talk to us.

I have read and understood the above and I consent to participating in the study.

Name: _____ Date: _____

Signature: _____ Place: _____

Annexure 4:

District-wise government medical colleges

S. no.	Name of college	District
1	Armed Forces Medical College	Pune
2	B. J. GMC	Pune
3	Dr.Vaishampayam Memorial Medical College	Solapur
4	Dr. Shankarrao Chavan GMC	Nanded
5	GMC	Aurangabad
6	GMC	Nagpur
7	GMC	Akola
8	GMC	Latur
9	GMC	Sangli
10	Grant Medical College	Mumbai
11	Indira Gandhi Medical College & Hospital	Nagpur
12	Lokmanya Tilak Municipal Medical College	Mumbai
13	Rajshree Chatrapati Shahu Maharaj GMC	Kolhapur
14	Rajiv Gandhi Medical College & Chhatrapati Shivaji Maharaj Hospital	Thane
15	Seth G S Medical College	Mumbai
16	Shri Vasant Rao Naik GMC	Yavatmal
17	Shri Bhausaheb Hire GMC	Dhule
18	SRTR Medical College	Ambejogai
19	Topiwala National Medical College	Mumbai

Source: CBHI 2013

Annexure 5:

Infrastructure and facilities in medical colleges

Medical college	Total staff	Bed strength	Blood bank	No. of operation theatres	List of departments/ specialities	ICUs	ICCU	Labs	Level of care
GMC Aurangabad	-	1177	yes	Major: 4, Minor: 1	17	5	yes	yes	Tertiary
GMC Miraj	DNG	390 Sangli +310 Miraj	yes	7 Sangli +9 Miraj	23	4 Sangli + 4 Miraj	yes	Path, Biochemistry, Microbiology, & 2 central labs	Tertiary
GMC Kolhapur	1015	750	yes	12	18 +8 sp.	5	yes	yes	Tertiary
GMC Dhule	DNG	545	yes	10+4	10	2	No	yes	Tertiary
GMC Ambejogai	541	518	yes	6	DNP	ICCU, Med. ICU, Neonatal ICU	Yes	Path, Microbiology, Biochemistry	Tertiary
GMC Nagpur	1010	1401	Yes	6	21	NICU, Paediatrics ICU, ICCU, ICU, Surgery. ICU	1	11	Tertiary
MGM Navi Mumbai	>1000	770+	yes	14+1	14+23 Super sp.	4	yes	Yes (1 central lab consisting of different research labs in college)	Tertiary

DNP - Data not provided

Centre for Enquiry Into Health And Allied Themes

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Violence and Health.

ISBN: 978-81-89042-69-1