"I'm too used to it": A longitudinal qualitative study of third year female medical students' experiences of gendered encounters in medical education

Palav Babaria, Sakena Abedin, David Berg, Marcella Nunez-Smith

A R T I C L E   I N F O
Article history:
Available online 7 February 2012

Keywords:
Gender
Medical education
USA
Sexual harassment
Identity
Discrimination
Medical profession

A B S T R A C T
Although the number of women entering medical school has been steadily rising in the USA, female medical students continue to report instances of sexual harassment and gender discrimination. The full spectrum of such experiences and their effect on the professional identity formation of female students over time remains largely unknown. To investigate these experiences, we interviewed 12 third year female medical students at a private New England medical school over several points during the 2006–2007 academic year. Using theoretical frameworks of gender performance and the centrality of gender discrimination (Nora et al., 2002; Stratton, McLaughlin, Witte, Fosson, & Nora, 2005; Wear, Aultman, & Borges, 2007). However, they did not feel equipped to respond to the unprofessional behavior of male supervisors, resulting in feelings of guilt and resignation over time that such events would be a part of their professional identity. The rapid acculturation to unprofessional behavior and resignation described by participants has implications for not only professional identity formation of female students but specialty choices and issues of future physician workforce.

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Introduction

The number of women in medicine has risen steadily over the past three decades, with females now comprising almost 50% of all American medical school matriculates (Barzansky & Etzel, 2008). Despite this relatively rapid rise in the number of women within this once all-male profession, studies have shown that female medical students in the U.S. continue to experience high rates of gender discrimination (Nora et al., 2002; Stratton, McLaughlin, Witte, Fosson, & Nora, 2005; Wear, Aultman, & Borges, 2007). More recent work has attempted to clarify how male and female students differentially view their own professional identity formation as physicians (Blanch, Hall, Roter, & Frankel, 2008; Gude et al., 2005). However, little work has been done to localize the professional identity formation of female students within the larger framework of a largely masculine medical hierarchy and constantly evolving professional relationships. We therefore utilize a dual theoretical framework of gender performance and the centrality of relationships to analyze the longitudinal gendered experiences of third year female medical students and their effect on professional identity formation.

Early sociological work such as Becker’s “Boys in White” provides a useful starting point for understanding the process of American medical socialization. As Becker pointed out that “science and skill do not make a physician; one must also be initiated into the status of physician; to be accepted, one must have learned to play the part of a physician in the drama of medicine” (Becker, Geer, Hughes, & Strauss, 1961, p.4). Numerous studies have described the socialization process that occurs during medical training as students learn how to be “initiated” into their profession (Beagan, 2000; Becker et al., 1961; Shapiro, 1987). The transition from pre-clinical to clinical years of medical training is an important period in the socialization process (Beagan, 2000) and largely signifies the beginning of professional identity formation for physician trainees. In this new learning environment, a complex series of clinical encounters with peers, patients and supervisors, medical students first experience the “hidden” and “informal curriculum” (Hafferty & Franks, 1994), which has a substantial and profound effect on medical education (Karnieli-
Miller, Vu, Holtman, Clyman, & Inui, 2010). It is during this time that students subtly learn “what medicine values,” (Delvecchio Good, 1998, chap. 6 & 7; Karnieli-Miller et al., 2010). The clinical years of medical education are almost entirely based upon hierarchical team dynamics and interpersonal relationships that can either enhance or impair learning (Conrad, 1988; Daugherty, Baldwin, & Rowley, 1998; Dyrbye et al., 2009; Richman, Flaherty, Rospenda, & Christensen, 1992). Unlike other professions, both male and female medical students in the U.S. routinely report experiences of harassment and belittlement (Richman et al., 1992; Sheehan, Sheehan, White, Leibowitz, & Baldwin, 1990), and complacency is seen as a crucial component of both learning and professional advancement (Wear & Aultman, 2005).

Much of the earlier work on medical socialization, however, largely ignores gender and “talk[s] mainly of boys becoming medical men” (Becker et al., 1961, p.3), reflecting an outdated white male demographic of medical students. More recent work has shown that women report greater levels of abuse than men, and that for both genders, experiences of mistreatment and harassment have been shown to have profound implications on student well-being and learning (Dyrbye, Thomas, & Shanafelt, 2006; Richman et al., 1992). Yet, mistreatment and harassment are only a small fraction of the gendered experiences that female medical students encounter during their clinical training (Baharia, Ahmadlin, & Nuner-Smith, 2009) and little is known about the process of socialization in medical school as it occurs for female medical students. Beagen’s study of Canadian medical students and the effect of gender, class and race on their experiences is one of the few that touches upon how female students are socialized, describing how students adopt the prevailing [male] culture and learn to neutralize their gender in mannerisms, behavior and dress (Beagan, 2000).

Prior work focusing specifically on gender and professional identity has been centered around differential attributes between male and female students. Multiple studies have documented that although female students tend to perform equally to their male peers on objective assessments of their clinical skills, they consistently report less confidence in their abilities and significant anxiety over their performance (Blanch et al., 2008; Kilmelener, Downes, Gough, Murdoch-Eaton, & Roberts, 2007; Whittle & Eaton, 2001). Similarly, male medical students are more likely than female students to feel like they are “doctors” by the end of medical school (Gude et al., 2005). Interestingly, in some studies, although male and female students enter medical school with similar levels of stress and anxiety, females report increased anxiety about their skills compared with males by the third year, suggesting the milieu of medical education may be differentially affecting confidence levels (Blanch et al., 2008). These gender differences are often perpetuated by external bias, with female students being rated consistently as ‘less confident’ than their male peers (Kilmelner et al., 2007) and or referred to as “nurses” rather than “doctors” by other staff and patients (Houry, Shockley, & Markovich, 2000).

Other scholars have examined gender differences in professional identity formation by examining what attributes are valued within medical culture. As one historian of women in medicine states, “Indeed a central theme in the story of women in medicine has been the tension between ‘femininity,’ ‘feminism’ and ‘morality,’ on the one hand; and ‘masculinity,’ ‘professionalism,’ and ‘science,’ on the other” (Morantz-Sanchez, 2000, p. 200). Hinzen’s 1999 sociological study of the gendered hierarchy of medical specialties exemplifies the complex gender performance that underlies individual attributes of ‘confidence’ or ‘toughness’ in medicine. Participants defined the most “prestigious” specialties, such as surgery, as having “hands-on” experiences and “balls,” (Hinze, 1999, p. 12). What becomes valued then, in terms of professional identity, is defined by male attributes and a male-defined system of behavior.

There is a gap between these two literatures, one on medical student socialization and the other on gender and professional identity, with neither addressing the question of how female medical students develop a professional identity that takes into account the gendered aspects of medical culture. We set out to understand how these problems of gender and professional identity manifest themselves and are addressed by female students during the third year of medical school. Our analysis is organized around two main concerns. The first, borrowed from gender theory, is the idea of gender performance. As Judith Butler describes, “what is called gender identity is a performative accomplishment compelled by social sanction and taboo,” (Butler, 1988, p. 520). We contend that professional identity, like gender identity, is being constantly made and re-made. As third year medical students get drawn into the culture of medicine, they learn how to perform the role of doctor; for female medical students, this learning process includes learning how to perform or enact the role of ‘woman doctor.’ (Butler, 1988). We posit that “woman doctor” is not a fixed construct, but a dynamic identity that represents female students’ re-conceptualization of their identities as females and physicians-to-be. This identity is constantly evolving based upon student experiences, but is informed by institutional culture and stereotypical gender roles.

Our second analytic mainstay is the centrality of relationships to the formation of professional identity in medicine, notably the student—patient and student—supervisor relationships. As Haidet et al. have concluded, “Students proceed through medical school embedded in complex webs of relationships that exert a powerful influence (both positive and negative) on their formation as physicians.” (Haidet et al., 2008, p. 382) and it is likely these relationships that enact much of the hidden curriculum that has been previously described (Hafferty & Franks, 1994). Through our participants’ accounts of these relationships, we are able to see in which contexts they develop a coherent identity and at what points their attempts at becoming female physicians falter. Issues of power become central in the analysis of these relationships. The patient—student and student—supervisor relationship exhibit parallel power differentials (Ekstein & WALLERSTEIN, 1958), such that the student’s power in the student—patient relationship parallels the supervisor’s power in the student—supervisor relationship. Position in the hierarchy and the associated power over those lower in the hierarchy shape the educational experience and the associated process of identity formation. Utilizing theories of the performance of gender and the centrality of relationships, we sought to characterize how gender effected the professional identity formation of third year female medical students.

Methods

Study design and sample

We conducted a longitudinal study of 12 female third year medical students, using serial in-depth interviews at regular intervals over an entire academic year (Murray et al., 2009). Given that little was known about the longitudinal experiences of female medical students, we chose a qualitative approach in order to characterize participants’ perceptions regarding the influence of gender on their clinical training experiences. We used grounded theory to inform data collection and did not form any a priori hypotheses about what would emerge as thematic content. The initial code structure reflected ideas raised by participants in early
interviews and evolved over subsequent interviews (Glaser & Strauss, 1967; Miles & Huberman, 1994). We used a purposive sampling technique with attention to recruiting students that would represent diversity across several participant characteristics such as age, self-identified racial/ethnic background, childhood experiences, type of undergraduate education, work experience, and relationship status (Patton, 2002). An N of 12 was chosen as a feasible cohort for one interviewer to follow, and represented almost 25% of females in that class at a private U.S. medical school. Two invited students declined to participate in the study; one student cited time constraints and the other student expressed concern about the potential for study participation to negatively affect her career. Participants’ clinical experiences took place across three large hospitals, over twelve specialties and sub-specialties, and over fifteen community-based training sites representing academic and private settings. This research protocol was approved by the Institutional Review Board and signed consent was obtained from all participants (Table 1).

Data collection

We conducted in-depth, in-person interviews with all participants from June 2006–June 2007. We interviewed participants at the end of every 4- or 6-week clinical clerkship; we also conducted baseline interviews prior to the start of the third year and exit interviews within 3 months of completion of their third year. All interviews were conducted by one member of the research team (PB), who was also a third year female medical student at the time interviews were conducted by one member of the research team (PB), who was also a third year female medical student at the time of the interviews. A gender- and role-concordant interviewer was chosen to facilitate a comfortable relationship with participants (Edwards, 1990; Wilde, 1992). Although the interviewer’s previous experiences suggested gender had an effect on medical education, she was aware of this bias prior to the start of the study, and took precautions to minimize its influence on data collection and analysis. Members of the research team had differing degrees of gender attribution to professional experiences in medicine, allowing for skepticism in the analytic process. Caution was taken to ensure that the interview guide and all follow-up questions were neutral and open-ended. Initial interview transcripts were reviewed by other members of the coding team to ensure that leading questions were not being used and to provide feedback to the interviewer.

Interviews averaged 35 min and were conducted with only the interviewer and participant present. Interviews were audiorecorded, transcribed, and verified by the interviewer. Interval interviews were conducted using a standardized interview guide and started with the general question, “What do you think the impact of gender has been, if any, on your experiences on the wards during the past rotation?” Specific probes regarding participants’ perceptions of interactions with patients, medical staff and other students followed.

Data analysis

We used qualitative principles of inductive reasoning to guide our data analysis and interpretation (Bradley, Curry, & Devers, 2007). A coding team composed of three women — a medical student, an internist and a pediatrician (PB, MNS, SA) — developed an initial code list based on three randomly chosen transcripts from interviews from the first month of clinical clerkships. This code list was then revised using the constant comparative method of data analysis. Because we were interested in each participant’s individual journey over the year, each code team member assumed responsibility for four participants, whom she then followed closely forward in time. In order to identify recurrent themes across participants, each coding team member was responsible for the line-by-line coding of all transcripts for these four participants. Code team members created a summary document based upon standardized analytic questions (Fig. 1) to provide an overview of the longitudinal experience for each study participant. In addition, the coding team maintained an electronic document of ideas that emerged from ongoing analysis of the transcripts using the scientific software, ATLAS.ti 5.0 (Berlin). Once all of the transcripts were analyzed, the entire research team (including DB) met regularly to develop a construct for the research findings.

Findings

We found that the contrast between participants’ interactions with patients and supervisors, as well as their evolving reactions to these interactions were salient to their ideas of what it meant to be a “woman doctor,” our primary phenomenon of interest. Participants began their clerkships with expectations of professional learning environments; subsequent gendered experiences that were deemed inappropriate and unprofessional challenged their self-views as women doctors. Although each of our participants’ experiences was unique, all reported that they were ill equipped to respond to most inappropriate workplace experiences. Almost all participants also concluded by the end of their year that gender would play a substantial role in their future careers, but had accepted the inevitability of inappropriate gendered behavior in their medical training.

The student—patient relationship

All participants described numerous workplace interactions with male patients that involved flirting or sexual innuendo. Most participants described being routinely called “honey” or “sweetie” by male patients. One participant on a surgical rotation described male patients that “were very excited...one guy wanted me to change his underwear.” Sexualized encounters with patients were

Table 1

<table>
<thead>
<tr>
<th>Characteristics of 12 study participants</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Median age (range), y</td>
<td>25 (23–30)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>9 (75)</td>
</tr>
<tr>
<td>Black</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Asian</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>7 (58)</td>
</tr>
<tr>
<td>None</td>
<td>5 (42)</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>5 (42)</td>
</tr>
<tr>
<td>In a relationship</td>
<td>5 (42)</td>
</tr>
<tr>
<td>Married</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Parent</td>
<td>1 (8)</td>
</tr>
<tr>
<td>Undergraduate education completed at a single-sex institution</td>
<td>2 (17)</td>
</tr>
<tr>
<td>Took time off before coming to medical school</td>
<td>7 (58)</td>
</tr>
<tr>
<td>Median gap in years (range), y</td>
<td>2 (1–6)</td>
</tr>
</tbody>
</table>

1. How are the subject’s views/experiences the same or different from last month?
2. How are the subject’s views/experiences the same or different from the other 3 subjects you are following?
3. Choose a salient quotation that is representative of this participant’s experience over the past month.

Fig. 1. Summary document questions.
more explicit in some cases, such as one patient who began masturbating while a participant was obtaining a history. Participants were typically very tolerant of sexualized comments and behaviors from male patients, often minimizing or denying any subsequent emotional impact. As one participant explained: “[The flirting from patients] didn’t really bother me deeply. I just thought…this is just…where he’s coming from and, and then I’ll have him for a few days and then we’ll move on.”

By the second and third months of third year, as participants’ comfort level increased, they developed ways of addressing exposure to inappropriate patient behavior. As one participant described, “Men always have sexual…comments and stuff…I’m getting more comfortable with it as in I just dismiss it or just talk back if I feel that it’s more than I find acceptable.” Despite learning how to navigate such encounters, repeated exposure to inappropriate behavior from male patients affected participants’ self-image as women doctors, sometimes affecting their ability to function effectively as medical students. Several participants described becoming “a little more distant from [male patients]” and altering their dress in an attempt to “hide [their] womanhood.” As one participant described, “I didn’t want to be perceived as sort of a feminine kind of role. And I didn’t want my body to ever be noticed…I sort of used my coat as a cover sometimes.”

Participants often reported being more upset by administrators and clinical team members who reinforced inappropriate patient encounters rather than addressing them. Responses of team members to inappropriate patient behavior ranged from silence, where the “attending didn’t say anything,” to laughing and actively teasing a student who was perceived as sort of a feminine kind of role. And I didn’t want my body to ever be noticed…I sort of used my coat as a cover sometimes.”

Participants also reported being easier to endure such behavior rather than report it, because, as one participant described, I didn’t acknowledge it was happening to another human…But I felt that a lot of times, as a woman, I felt that I was filling in that gap for them. And like I said I was more vocal and assertive than I’d ever been in the whole rotation because of that."

**Student–supervisor relationship**

Participants also consistently reported inappropriate encounters with male attendings, ranging from sexist comments and sexual innuendo to inappropriate touching and solicitation throughout the year. These experiences spanned a range of clinical settings and degrees of familiarity between student and attending. One participant described an outpatient clinic attending who would “put his arms around you and be very very touchy with you and in your personal space, with all the females.” Another participant described an encounter with a married attending who had a primary teaching role on the clerkship who started massaging her:

“[He] started saying, ‘[You’re] just such a good medical student. You’re always just so interested. I can’t tell you, like, how gratifying it is for me to have you here,’ and he didn’t say anything that was outrageously inappropriate but it was also clearly inappropriate for him to be like rubbing my neck while we’re alone walking through this hallway at eight p.m.”

A few male attendings were responsible for repeatedly harassing students every month, such that every single participant rotating through two particular services apparently had inappropriate encounters with the same male attendings. In some cases, the egregious behavior of specific attendings seemed to escalate over the year. A participant who encountered one of these “notorious” attendings later in the year described his behavior:

I heard about [this attending] before I started this particular rotation…and he was supposed to be one of these head people to actually make us feel comfortable and to facilitate our learning on the clerkship but yet he was probably the one being the most invasive and definitely inappropriate towards women specifically. And then when I got on the clerkship he did that to me even to a greater extent…And now a good friend of mine is on that same clerkship and she’s gotten the same sort of harassment but vastly worse.

In contrast to inappropriate patient encounters, participants did not report finding satisfactory mechanisms of addressing inappropriate attendings, even at the end of their third year. As one participant reflected in her exit interview about several of these experiences, “I had no idea what to do and frankly didn’t tell anyone about it. I mean it’s only been recorded in these interviews because…I didn’t know like what to do.” Another participant described attempts to mitigate inappropriate touching, “I would sort of keep my elbow between my hip and [the attending] so it wasn’t easy to grab [my waist].” However, such measures did not alleviate her discomfort. As she concluded her description of the encounter, “[It made me feel] just kind of dirty. Like is this what I’m doing to get a good education.”

Participants thought that reporting inappropriate encounters with attendings would only “make things worse,” and resigned themselves that it “was just going to be an uncomfortable situation.” For some, the transient nature of clinical clerkships made it easier to endure such behavior rather than report it, because, as one participant described: “We wouldn’t have to be in the same place at the same time basically at all anymore…If it went on for yesterday and then was over, then it was fine.” Several participants “recognized the power dynamic” that prevented them from reporting inappropriate behavior. As one participant reflected in her exit interview months later, “[The attending who wanted] me to date his son had all the power, all the power in the relationship…and I felt pretty much helpless in the situation.” In several instances, participants reported that attendings contributed to non-reporting by actively mocking students’ ability to report them; one particular
attending was described by several participants throughout the year:

A: Every time [the male surgeons] said a misogynistic thing, after three or four misogynistic comments in like one hour, they would say, ‘Oh, what are you going to do? Tell [the dean]? What are you going to do, tell [the ombudsman]?’ Or they would say something offensive and then say, “Oh, it’s ok if you tell [the dean], she knows I’m an asshole”…being in that kind of situation made me feel totally silenced and disempowered…it reminded me of the stories of women that I read about, who were raped. This has kind of heightened that sense, because it’s like-an abuser is always saying, ‘What are you going to do about it?’…I know if they ever heard this, they’d be like, you’re over-reacting, you’re being over-sensitive, we wouldn’t have done it if you’d said it was making you uncomfortable. All this crap that’s meaningless, if you’re going to do it anyway, again and again. And you do it to the student before me and the student after me. And the nurses, and the staff that you work with everyday.

Q: How did you deal with those situations?
A: Zoned out. I just stopped listening to them. So it’d be twelve hours of standing there retracting, and not listening. You know, but, I mean—I’m paying a lot of money for this. Paying a lot of money to be silent and not listen.

As described previously, participants rarely reported inappropriate experiences to anyone; when they did, they perceived that administrators usually did not take action. One student described the clerkship coordinator’s reaction to student complaints about one of the “notorious” male attendings: “When students told—when numerous students told the course directors about this, the course directors were like, ‘yeah, there’s not so much we can do.’” In some cases, clerkship coordinators appeared to be aware of the reputation of some male faculty members and warned students in advance of rotations. However, such warnings seemed to place the onus of addressing inappropriate attending behavior on the student. As one participant described, “We were warned actually by [program administrator]. He said, ‘Doctor [Y] sort of has a reputation for being inappropriate. It’s part of his personality. We try to keep him in line, every now and then he slips back out of line…Just let him know if he’s going out of bounds.’” This participant then proceeded to recount inappropriate and sexist jokes that this attending engaged in throughout the rotation. When asked in their exit interviews to provide advice to clerkship directors, almost all participants wished that directors were “more honest about what goes on,” enforced a “very little tolerance policy for things that are grossly out of proportion,” and “communicate[d]…that there are resources [and] support.”

Of import, negative gendered interactions also directly influenced the future sub-specialty choice of some participants. As one student described of her decision to not apply in urology after completing her sub-internship:

I heard a lot, just a fair bit of trash talking in particular of, of a female surgeon…it just seemed like it could conceivably be a pathway to like a really unhappy future. And I don’t think it’s a coincidence that she’s a woman…I just had several [female emergency medicine] mentors…that were completely confident and, and competent and great teachers and seemed happy in what they’re doing.

Another participant who decided to apply in OB-Gyn felt that medicine was “an old boy’s club” and jokingly described how she was “going to run away to a field that has fewer men.”

Unlike the student—patient relationship in which participants evolved methods of dealing with inappropriate behavior, participants did not evolve methods by which to address inappropriate supervisor behavior. Over the course of the year, participants did develop progressive feelings of guilt and isolation, as well as desensitization and resignation to continued inappropriate behavior by attendings. These feelings appeared to be reinforced by the responses of clinical team members and perceived lack of institutional response, and undermined participants’ perceived professional identities. Many participants described a tension between viewing themselves as the type of individuals who would “take action in response to things that were inappropriate” and resigning themselves to the barriers of reporting and saying “well that wasn’t so bad.” Participants often blamed themselves when they did not know how to respond effectively. As one participant described, “I would never stand for that kind of talk in my life, and I was often silent, and so it was feeling bad twice. It was feeling bad being in that situation, hearing that kind of stuff and then it was feeling bad for not saying anything and for feeling totally silenced and powerless.” In many cases, participants felt vulnerable and isolated by what they had experienced and might have acted differently if they had had support from other students. One participant felt she “wouldn’t react the same way now” in her exit interview because of, “hearing accounts of people who went through very similar situations with the same attending… I no longer have this tendency to just compartmentalize it as this isolated incident that was probably just me.” However, even when asked in exit interviews to reflect upon how they reacted in such situations, most participants reiterated that they were unsure how they should have acted. Some stated that they wished they had been more vocal at the time, but none identified any systemic channels through which they felt comfortable reporting such experiences.

Moreover, as the year progressed, many participants described a process of desensitization that occurred and felt that they were “much more live and let live” and “impervious” to gendered encounters by the end of the year. When one participant was asked if she had told anyone about the attending who always put his arms around her, she responded, “No. No… it’s too late in the year. I’m too used to it.” This desensitization was evident in participants’ exit interviews, in which participants largely dismissed the importance of uncomfortable situations with attendings, a stark contrast from their prior interviews throughout the year. Even when confronted with the discrepancy between earlier interviews where participants were very upset by inappropriate gendered experiences and their seeming acceptance of such behavior at the end of the year, participants reiterated that “it’s probably a lot better than it used to be…there’re going to be bad situations where you feel like you can’t say anything without causing problems… that’s awful and it’s unfair and um, you know, I guess just know that it happens to other people too; you’re not alone.” Another participant who described learning how to ignore egregious behavior over the course of the year and to not “trouble yourself too much” cast her experiences as a learning opportunity: “So like what this highlighted to me, all these experiences was I’m not, this is not the place that I want to be. And I’m not going to be able to change the world so why should I put myself in these situations.” Only one participant directly acknowledged her discrepant reaction:

Just me hearing myself talk and recognizing just the absurdity for how I would so passively let things occur and recognizing how illogical it is for me to let certain things have just passed by…hearing how much it sort of contradicts some of the other things that I say that I stand for has allowed me to…want to be strong in those situations.
Some participants felt that much of this desensitization was related to fatigue from repeatedly dealing with inappropriate behavior and that they were “just too tired to care.”

Toward the end of the year, some participants also identified how gendered encounters were part of the system of medical education. As one participant explained, “This is the way a system has been set up. This is the way things go and you either adapt… or you revolutionize and at least at this point in the time I don’t think I can revolutionize.” Another participant shared similar views:

I think it’s tiresome to always be the person who’s speaking up… And so at some point I definitely made a decision that one out of ten times I was going to say something and the rest of the times I wasn’t and that’s at an emotional price. I mean, it takes an emotional toll to not speak up when you feel like you should.

For other participants, desensitization was a means by which to actively avoid dealing with inappropriate experiences. As one participant recounted in her last interview, “I don’t want to record [gendered experiences] in my mind because I don’t want to remember them.” Another student who remained optimistic about women finding a way to enter male-dominated fields such as surgery explained, “I just have to believe that because it’s the only way I can go through life without going insane.”

In contrast to the inappropriate experiences described, participants provided numerous examples of interactions in which they felt either valued as female physicians-in-training or gender-neutral interactions with equal aspirations for both male and female students.

These experiences almost universally involved interactions with female supervisors. Interestingly, all participants at the beginning of the year felt that their female attendings were “really disappointing,” or “poor teachers” or “mean.” However, by halfway through the year, many participants began describing how the culture of medicine affected the behavior of female physicians. As one participant explained, “I ended up bonding with most [male supervisors] and clashing with all of my female superiors… I think it speaks to what women have to go through in order to get to the positions that they’re in.”

By the end of the year, several participants commented upon how their “expectations of women are higher.” One participant described being disturbed by a female intern who “wasn’t caring and loving at the bedside” but barely noticing when a male resident enacted the same behavior. As she reflected, “It’s interesting how the standards are so different and I don’t think that’s necessarily fair. Especially in a field where women are expected to excel in all these areas that are categorized for quote unquote men only and we’re supposed to transition ourselves into those expectations.”

Despite participants’ complicated and evolving relationships with female attendings, participants reported that “gender lines” were “obscured, or more unnoticeable,” on all-female and female-led clinical teams. Participants also felt that interactions with female supervisors allowed them to be ‘women doctors.’ One participant described how she enjoyed working with women because, “I feel like I can be more of myself and there doesn’t have to be this attitude of no fear, no emotion.” Often, participants’ affirmation of their professional identity was intimately tied to their negative experiences with male attendings, as evidenced by four participants who independently used the word “refreshing” to describe their experiences with all-female clinical teams or female attendings. Even on surgery, a “very male-dominated” and “uncomfortable” rotation, gendered experiences were mitigated by all-female teams, as one participant described:

If I wasn’t retracting properly, it wasn’t like, “come on, pull like a man” it was “come on, pull like a woman!”…people acknowledged me like a human being-and so people would ask me questions about my life, and what I was interested in and sort of the reasons for such. It was just a completely different world and one that I really appreciated.

Discussion

Utilizing the differences between student—patient and student—supervisor relationships, we were better able to understand how female medical students enact (and continuously reinterpret) the role of ‘woman doctor’ and the effect of negative and positive gendered interactions on their professional identity development. In the former relationship, participants were able to confront and respond to inappropriate behavior from male patients and derive positive reinforcement from their connections with female patients. In the latter relationship, participants did not feel equipped to respond to the unprofessional behavior of male supervisors, resulting in feelings of guilt and resignation over time that such events would be a part of their professional identity.

Using Butler’s concept of gender identity as a performance (Butler, 1988), it becomes apparent that much of the “hidden curriculum” (Hafferty & Franks, 1994) for third year female medical students lies in understanding and performing what it means to be a “woman doctor,” often with conflicting messages. Participants’ interpretations of “woman doctor” were constantly shifting based upon their clinical experiences, ranging from adopting stereotypically female attributes to erasing their sexuality and adopting masculine behavior to challenging their own expectations of female doctors. Within the student—male patient relationship, participants were able to identify their own power within the medical hierarchy in terms of medical knowledge and the role of caregiver and address inappropriate behavior. However, participants still felt they had to adapt their identity to inappropriate messages from patients, and tried to “hide their femininity” or appear more “androgy nous;” thus erasing their gender in order to play the role of physician. In male-dominated clinical teams, participants reported having to adopt a “no emotion, no fear” attitude, and found it “refreshing” when all-female clinical teams offered a respite from such performance. Numerous inappropriate interactions with male supervisors reaffirmed the female medical student identity as one of a sexualized token, and less valued in the hierarchy of medicine. At other times, participants felt internal and external expectations to adopt a more stereotypical gender role based on views that female students are more nurturing (Clack & Head, 1999; Lempp & Seale, 2006). Patients and peers often expect female physicians to be “more sympathetic, approachable and empathetic,” and are disappointed when their encounters deviate from such perceptions (Kilminster et al., 2007). As the author points out, “These attributes were viewed as an optional extra and not integral to male physician’s work identity” (Kilminster et al., 2007). And in fact, many of our participants described having similar expectations of female supervisors at the beginning of their third year, and it was only as they underwent their own gendered encounters with patients and supervisors that they were able to objectively appreciate their own unrealistic expectations of female supervisors. Participants’ experiences of becoming “women doctors” were not always negative. In appropriate and professional learning environments, usually with female patients and supervisors, participants’ enactment of the role of “woman doctor” was seen as a positive, reaffirming experience.

The difficulty, however, with gender performance, as Butler describes, lies in the fact that, “In the theatre, one can say, ‘this is just an act,’” and de-realize the act, make acting into something quite distinct from what is real… on the street or in the bus, there is
no presumption that the act is distinct from a reality; the disquieting effect of the act is that there are no conventions that facilitate making this separation,” (Butler, 1988, p. 527). Such blurring of reality was echoed in Hinze’s analysis of sub-speciality hierarchies. As one female surgeon explained, “I didn’t want to be a man. I didn’t want to be like real tough and have to chew people out and play hardball with them, that wasn’t the goal...[crying harder now] You know, if this is what, you know, if everyone hates working with me then it wasn’t worth it at all. Toughness, being macho, having balls, suffering.” (Hinze, 1999, p. 230). As the author concluded, “for women to survive in the highest prestige specialty and sub-specialties asks them to ‘exchange major aspects of their gender identity for a masculine version without prescribing a similar ‘degendering’ process for men,’” (Hinze, 1999, p. 233). Such descriptions parallel the experiences of our participants who described the “emotional toll” and guilt of enacting institutionally prescribed gendered identities. Ironically, despite stating repeatedly in exit interviews that they would advocate “just dealing with it” or that they were “too used to it,” when asked what advice they had for incoming female medical students participants universally advocated that they “be themselves.”

Perhaps the most salient effect of gendered experiences on participants’ professional identity was the progressive desensitization toward inappropriate behavior that occurred throughout the year. Even when participants were confronted with individual experiences that they had found distressing earlier in the year, they tended to minimize their importance in their exit interviews, stating that they were “just too tired to care” or “impervious to [gendered situations].” When asked to explain such contradictions, most participants recognized the prevalence of gendered encounters but advocated for “just dealing with it” and resigned themselves to the fact that “they’re going to be bad situations.” Such responses exemplify a stark learning point that was universally internalized by all of our participants—that medicine itself is gendered and inappropriate encounters would continue to be a part of their medical training.

Importantly, the messages of tolerating inappropriate behavior voiced in the exit interviews closely mirrored teachings by senior female residents and attendings who advised female students to “just deal with it.” Through the course of their third year education, participants experienced the contradictory roles of female supervisors, and came to their own realizations of what it means to be a female attending. The adoption of cultural norms expressed by female supervisors in their exit interviews can thus be seen as simply another manifestation of gender performance. Prior qualitative studies have shown that female students are often advocates of just “sucking it up” (Wear et al., 2007). Although previous studies have documented how medical students are acculturated over time (Hafferty & Franks, 1994), and that higher rates of gender discrimination have been reported during the clinical years of medical education (Baldwin, Daughtery, & Eckenfels, 1991; Richman et al., 1992), our study adds to the existing literature by characterizing how female students systematically learn to tolerate gender discrimination through the course of their medical education.

The above findings should be considered in the context of some important limitations. This study was conducted with 12 participants of the same graduating class at a single, private, New England medical school because we purposefully wanted all study participants to have been exposed to the identical formal curriculum and classroom environments. Still, we purposefully sampled a diverse group of students representing a variety of backgrounds, ages, and race/ethnicities. We also employed rigorous qualitative methods such as consistent use of a structured code sheet, audiotaped interviews, transcript verification, and the use of a single interviewer. No participants were lost to follow-up, and the longitudinal nature of the study allowed us to capture experiences over multiple points in time. In addition, the utilization of a mixed gender, racial and hierarchical research team (involving a medical student, fellow and faculty from different specialties, and socio-demographic groups) enhanced the diversity of perspectives in the analytic process. Future work is needed to include the perspective of male medical students.

Our findings have several important implications for research and policy related to gender discrimination in medical education. Acculturation to inappropriate behavior is influenced by the institutional culture and structures in place to address gendered experiences. Given that the majority of students never report experiences of gender discrimination, the lack of institutional response experienced by our participants to reported complaints likely will contribute to future non-reporting (Komaromy, Bindman, Haber, & Sande, 1993; Wear et al., 2007).

Participants in our study identified a number of barriers to reporting gendered experiences, including the incident being not serious enough, the transient nature of clinical clerkships, effect of reporting on future career, and lack of institutional response, consistent with previous studies (Komaromy et al., 1993; Wear et al., 2007). The differential participant response to inappropriate student—patient and student—supervisor also underscores the continued hierarchy and power dynamics within medicine. Participants repeatedly did not feel that they had adequate power to challenge inappropriate supervisor behavior.

Notably, none of the participants referred to the instances described as “sexual harassment” although many situations would likely be appropriately termed as such, a phenomenon that has been described in similar populations previously (Wear et al., 2007). Institutions that explicitly seek reports of “sexual harassment” may be missing the true spectrum of inappropriate gendered behavior. Additionally, our findings that female students become progressively acculturated over time and deny the effect of previous gendered experiences suggest that surveys conducted at the end of medical school may grossly underestimate the true prevalence of gender discrimination amongst medical students.

Comments by our participants regarding the effect of gendered experiences on sub-specialty choice suggest that in addition to guiding their professional identities, such experiences may also influence future career choices as physicians. Such preliminary findings are consistent with studies with female faculty illustrating women in medicine continue to experience lower rates of job satisfaction, inequitable remuneration, and higher rates of sexual harassment (SH) and gender discrimination (GD) compared with their male peers (Bickel, 1997; Carr et al., 2000; Corbie-Smith, Frank, Nickens, & Elon, 1999; Nonnemaker, 2000). Some studies have also suggested that experiences of gender discrimination have an effect on the specialty choices of female medical students (Lambert & Holmboe, 2005; Stratton et al., 2005). This is an increasingly salient issue for medical education in an era with increasing numbers of female medical school graduates.

Conclusion

Third year female medical students are educated on what it means to be a woman doctor throughout the course of their third year through student—patient and student—physician relationships. Positive and negative experiences value and devalue, respectively, their identities as women doctors. Female medical students must commonly use a strategy of denial and minimization in the face of these negative experiences. They become rapidly acculturated to inappropriate experiences over the course of their third year clinical clerkships, and come to emulate their female
supervisors in resigning themselves to the inevitability of negative gendered experiences in their clinical training. Perhaps what is most distressing is such acculturation is actively advocated by superiors and promoted by the institutional silence surrounding issues of gender. The resultant desensitization and fatigue have implications not only for students’ identities as female physicians, but also for specialty choices and issues of future physician workforce.

Acknowledgments

The authors received funding from the Yale University School of Medicine Office of Student Research and the Yale University School of Medicine Office of Education.

References


Hinze, S. (1999). Gender and the body of medicine or at least some body parts: (re) constructing the prestige hierarchy of medical specialties. Sociological Quarterly, 40(2), 217–239.


