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Research Article

Women in Medical Profession

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Abstract

Researchers everywhere around the world are finding gender inequality in medicine, even with obvious evidence of substantial economic, health and social gains that could be achieved by addressing inequality in gender norms. Actually it should be equity which is a matter of justice and rights in view of gender differences in body functions. It is crucial for the best of global health.

Keywords: women in health; harvard medical school

Introduction

Researchers everywhere around the world are finding gender inequality in medicine, even with obvious evidence of substantial economic, health and social gains that could be achieved by addressing inequality in gender norms. Actually it should be equity which is a matter of justice and rights in view of gender differences in body functions. It is crucial for the best of global health. Shanon et al [1] reported that intersectional approaches have provided insights into how differences in ethnicity, class, geography, disability, and sexuality interact with gender to compound gender inequalities in health. It seems women are underrepresented in positions of power, leadership be it health care, medical education or research and are undervalued. They experience discrimination and gender-based violence in health disciplines globally. However most submissions on the issue have come from high-income countries, highlighting the need to look into the issues around the world. Gender is a social construction- influencing and in turn influenced by the distribution of power and resources, division of the work and labour, distinction between production and reproduction, and expectations and opportunities available to everyone in the society [2]. Gender is embedded within and across organizations, systemic structures, and institutional norms, including in science, medicine, and health [3]. The persistent imbalance between the 70% workers who are females and the 70% of health-care leadership who are males [4].

Objectives: To look into present status of women in health policies, health planning, health management, health care systems, and health professionals' education.

Methodology

Literature was searched by available search engines for getting the desired information in relation to the objectives. There were no special criteria for inclusion of studies or reviews. Whatever was accessible, was looked into. Opinions were also searched and added. Also, self-experiences and observations were added.

Results

Jackson [4] after looking at history of medicine reported that 'on 18 Nov, 1870, seven women arrived at the Surgeons' Hall in Edinburgh, UK, to appear for their anatomy examination. They were met by a mob of youths, fellow medical students, who pelted mud, shouted obscenities, and blocked the gates. However a sympathetic student let them through. The women completed their examinations while the protestors continued to yell outside. The "Surgeons' Hall Riot", as it was dubbed, was probably the lowest point in a 4-year campaign aimed at preventing the seven women from completing their medical degrees at the University of Edinburgh. The women, who became known as the "Edinburgh Seven" were refused the right to graduate and had to seek their medical qualifications elsewhere'. One hundred fifty years after those women were first enrolled to study medicine, the university of Edinburgh sought to make amends by awarding the ES posthumous degree during its annual graduation ceremony on 6 July 2019. On behalf of E.S. degrees were presented to seven other medical students, in front of an audience that included descendants of the original pioneers. Although women now comprise of 55% of Edinburgh medical schools' intake in line with the UK average, women are still under - represented in the higher academic medicine within the university itself.

Betro [5] reported that women comprised of 70% of health workers and contributed to US3 Trillion $ annually to global health, half of which was in the form of unpaid work. Minkina [6] reported that the history of gender discrimination in medicine in the USA began in the mid-19th century when the first woman attempted to become a doctor. Harriot Kezia Hunt (1805–75) was the first woman to apply to Harvard Medical School in 1847, but she was asked to withdraw her application. Robinson [7] reported that Harvard Medical School admitted the first batch of women only in 1945. According to the Association of American Medical Colleges, since 2015 around 34% of active American doctors were women, and now more women than men get enrolled in US medical schools [8]. However, the enrolment increase did not address gender in the recruitment and advancement of women into faculty ranks. Within global health, approach of Swedish government [9] has been demonstrated by commitments to sexual and reproductive health and rights, including access to contraceptives, and safe abortions and maternity care. Anandibai Gopalrao Joshi was one of the first Indian female practitioners of

western medicine, alongside Kadambini Ganguli [10 11 12 13]. She was the first woman from Bombay presidency of India to study and graduate with a two-year degree in western medicine in the United Status [14] she was married at the age at nine to a widower who was twenty year older to her [15]. She gave birth to a boy who check expired after 10 days due to lack of medical care. This proved to be a turning point in her life and inspired her to become a physician [16].

In a recent review Betron[5] reported that a key challenge to gender-transformative change in the health workforce could be traced to women not being in decision making and leadership positions. Only 25% of global health organizations have gender parity at senior management levels, and only 20% of organizations have gender parity in their governing bodies. Consequently, policy making remains male-dominated and policies are implicitly set to male norms. The absence of gender parity in health-care and leadership is not due to lack of interest, difference in career commitment, or years of education, it is due to systemic gender bias, scarcity of opportunities for advancement and ceiling that exists within health care, as in other sectors in society. Other forms of discrimination include wage gaps between men and women in the health sector, estimated at 26% in high-income countries and 29% in upper-middle income countries [9]. Both under compensation and no compensation can be traced to the devaluing skills of largely female health workers, in which their tasks or roles are assumed to be an extension of their household work, specially for community health workers [17] Mackee [18] reported that in leadership positions women were under-represented, as academic leaders. Australian Academy of Science [10] also reported that in obstetrics and gynecology only 17% of senior academicians were women. In a study by Mathad et al[19] it was revealed that 47% participants stated that their jobs resulted in insufficient time for their families and 37% reported that it negatively affected their childbearing decisions. Gender discrimination included experiences of being made to feel inferior, discouragement from promotions at leadership positions on the basis of gender. Addressing the spectrum of micro- and macro-aggressions and inequities that women in medicine face on a daily basis. Penning [20] reported gender inequalities contributed to increase in stress and anxiety, among women through their role as caregivers and, men as breadwinners [21] and among transgender people, in whom non-conformity to gender was often socially penalized [22 23 24]. Although nearly half of all doctors in the UK are women, but at senior level there are proportionately low numbers. No evidence suggested that they were disadvantaged in their endeavors or unwilling to deliver the necessary commitment, which could result in few women reaching medical leadership roles.

Gender issues of sexual harassment and violence also continue in medicine. In a study researchers reported that unwelcome sexual advances were reported by 29% women, however only 22%of those who experienced violence reported it to someone. Reasons for not reporting included assumptions that it was normal, or the feeling that it would not be resolved even if reported or lack of a reporting system, or fear of negative repercussions, or fear of jeopardizing their academic standing and worst was fear of not being believed . Anderson [25] and Sen [26] also reported that many women experienced violence and harassment in the workplaces and lacked safe and unbiased system for seeking help following harassment or assault. Betron [5] reported that the devaluation of women's work in the health sector can also be linked to their disproportionate experience of violence and harassment in the workplaces. Violence and harassment limit many health workers' abilities to effectively optimize new work and stifle their voice when advocating for advancement and increased responsibility [27]. Experiences of gender inequity, sexual harassment, and assault became viable globally when the #MeToo, movement went viral. Academia and tertiary education have joined the movement, with the notable examples of #MeToo STEM#MeToo Academia [28]. A 2018 report by the US National Academies identified sexual harassment as an enduring problem in medicine [29]. A random sample of 3332 full time faculty in 24 medical schools across the US found that the women reported 47–70% rates of discrimination [30] unfortunately, sexual harassment and suicide rates among women physicians have not changed over the years. Harassment happens both in faculty–student relationships and in manager–employee relationships, between doctors, medical personnel, management, and academic faculty. After a systematic review Barker [31] reported that nearly 60% of medical students and trainees of all grades had experienced harassment or discrimination of some kind during their training. Policies against sexual harassment are widely in place and have been for many years, but nonetheless sexual harassment in academia continues to exist and has not decreased [32]. Women in medicine have reported sexual harassment for decades [33]. Raj et.al [34] reported a decrease in sexual harassment over the time among female academic physicians and further, that experiencing more severe harassment aligned with reaching a higher academic rank. (But an enduring environment of gender discrimination that likely enable ongoing victimization of 1 in 5 female faculty.

Research Results with Gender Differences and Researchers Challenges.

Disparities in the inclusion of the sexes in medical research substantially reduces the utility of the results when research results are reported for the entire population in a way that is useful to all segments. As of now large scale studies are needed to identify the extent of sex-related reporting. Researchers did a cross disciplinary analysis of the degree of sex- related reporting across the health sciences biomedical, clinical, and public health research and the role of gender in reporting and found that between 1980, and 2016, sex-related reporting increased from 59% to only 67% in clinical medicine and from 36% to 69% in public health research in biomedical research[35]. Lariviere [36] reported less inclusion of women into medical research. Also several studies have shown that there are less women researcher in medicine. Some have also evaluated whether scarcity of women in research might also lead to disparities in sex inclusion and reporting. Papers with women as first and last authors had an increased probability of reporting sex releated findings but publications in journals with low journal impact factors. Gender disparities in the scientific workforce and scarcity of policies on sex-related reporting at the journal and institutional level could inhibit effective research translation from bench to clinical studies. In the recent past Hawkes [37] reported that over several centuries, medical and health research has generally been dominated by men from the earliest days of anatomical research, the bodies used for dissection and drawings were overwhelmingly male. Thompson [38] also reported that sex blindness in educational materials and medical research has consequences like erroneous diagnosis, missed opportunities for interventions, or the wrong dose of the wrong drug given to sick. Peters [39] and Peters [40] reported that women are underrepresented in cardiovascular disease trials despite known sex differences in risk, prevention, treatment, and outcome parameters. Millett [40] reported that the incidence of myocardial infarction was higher in men in the UK, but important risk factors, included hypertension, smoking intensity, and diabetes, were more strongly associated with myocardial infarction in women than in men. Thompson [38] and Holly [42] reported that across countries and disciplines, research revealed men received more research funding than women. There may be small differences but they have the potential to yield substantial disparities when compounded over the times [43]. The American College of Physicians has specifically stated in its ethics manual that gender discrimination violated the principles of professionalism, one of the core competencies mandated by the Accreditation Council for Graduate Medical Education in the USA Synder [44]. For more than 20 years: equity on editorial boards and many reports have also detailed gender inequities associated with medical journals [45, 46]. Aakhus [47] reported that among mixed-gender co-first authors publishing in high-impact clinical journals, women were significantly more likely to be placed second. Organizations must be held accountable for the ethical inclusion of all broader implications of first co authorship for gender equity. Rose-Clarke [48] opined that co-first authorship offered a flexible way for women to lead on high-impact research and to obtain the academic recognition, they deserved. Failure to recognise the importance of sex and gender in health and medical research is closely intertwined with the gendered nature of academic publishing[49, 50]Even in reviewers for journals like, The Lancet Global Health, there is difference in numbers if gender is considered[51] Others

A systematic review of 52 studies from 13 countries on women's choice or rejection of careers in academic medicine found that women were interested in teaching more than in research. But they lacked adequate mentors and role models; and experienced gender discrimination and bias[52]. In physician-focused medical specialty societies, an analysis of gender equity in leadership revealed that between 2008 and 2017, advancing women in science, medicine, and global health, illuminated crucial problems about gender equity, gender gaps [53]. Liang et al [54] identified factors, like inability to take leave, poor mental health, inadequate support, and fear of repercussion, which led to attrition of women in surgical training. Khoushhal [55] identified other issues like insufficient role models and institutional support, gender discrimination and harassment, sleep deprivation, adverse interaction with seniors, pregnancy and birth, and childrearing duties. In a survey [56] in Great Britain and Ireland, women perceived surgery as a male-dominated field, and many had experienced discrimination, and reported use of gendered language at work. Poor work–life balance was the main perceived barrier for women in their surgical careers. Results of a similar US national survey by Yeo [57] revealed that the attitudes, experiences, and expectations of general surgery residents varied by sex and number of years in training. Female surgeons in Africa were 9% of all practising surgeons [58]. In Australia and New Zealand, unavailability of leave, a distinction between valid and invalid reasons for leave, poor mental health, absence of interactions with the women in their professional body and other supports, fear of repercussion, and lack of pathways for independent and specific support were the reasons of not taking surgical specialties [59]. The interventions seeking to improve retention and advancement of women in surgical specialties must address the underlying multiple and constituent factors rather than narrow focus on the ultimate triggers. Ideally, such interventions should not overtly focus on women alone. However the relationships between factors are complex and sometimes paradoxical.

Ghadirian [60] reported that providing medical services to women by women was introduced in Iran after Iran's Islamic revolution. Reported that the Iranian Ministry of Health and Medical Education adjusted its services in line with Islamic rules, which was known as the gender conformity plan (GCP). Almost 40 years since the Islamic revolution, the GCP still presented a serious challenge in providing health services.

Nearly 70% of the global health workforce are women, but the leading decision makers in global health policy and research are still a small, closely connected network of mostly western, male, senior individuals [61]. Gender equality also matters for improving health quality which is dependent on women being able to plan, be it their pregnancies, or access to contraceptives and other such issues [62]. Acker[63] reported that it's about challenging the structures that entrench inequality, and also about challenging the behavior and attitudes. Career advancement of female scientists is reported to be adversely affected by gender disparities in start-up packages[64,65] and grant application review processes because attainment of career development awards was associated with subsequent grant funding[66,67]. Norms on health could be context-specific, demanding care when designing effective gender-transformative health policies and programs [68]. Gender inequality and gender norms unequal power dynamics, and other intersecting factors within society that often leave women disempowered, disenfranchised, and vulnerable also impede progress on the global goal to achieve health for all [69,70]. There remains considerable uncertainty as to which law protects medical students, residents, and physicians in medical school and academic medical centers [71].

Discussion

Women's representation in all aspects of health training, care and research have slowly increased over the past few decades. But women still encounter bias and discrimination compared with men across a variety of outcomes. It is essential to understand exactly how power operates within class rooms and at the bedside in health care institutions. The evolving landscape of global gender data, the overall pattern of gender equality for women's health is one of mixed gains and persistent challenge too. It has the potential to lead to substantial health, social, and economic gains. Gender inequality is transformed into health risk through discriminatory values, norms, beliefs, and practices; differential exposures and susceptibilities to disease, disability, and injuries biases in health systems; and biases in health research. The inability of the health sector to accelerate progress on a range of health outcomes brings into sharp focus the substantial impact of gender inequalities and restrictive gender norms on health risks and behaviors. Heise et al [71] reported that for decades, advocates have worked to eliminate gender discrimination in global health, but only with modest success. New plans and political commitments are needed if these global health aspirations and the SDGs are to be achieved. Hay [73] reported that without addressing the role of restrictive gender norms and gender inequalities, within and outside health systems, it will be not possible to reach the collective ambitions of universal health coverage and the SDGs. Serano[74] reported need of intersectional, equitable, and inclusive efforts to embrace women and girls in the gender equality movements in science, medicine, and global health, particularly in the training and educational contexts. Female volunteers are behind the reduction in child and maternal mortality through various programs. Every governmental health-care programme prefers to use the female community health volunteers to achieve the targets for their community-based programmes, owing to the trust women have developed selflessly volunteering their services to the community. It was reported that girls' interest in health was also influenced by the broader sociocultural environment that could enhance or thwart parent modeling [75]. Potential advances in health and development are thwarted by systemic neglect of gender norms and inequalities in program design, implementation, monitoring, and evaluation, despite the adoption of gender mainstreaming by global health institutions [76]. There is almost no aspect of health and health care that isn't affected by gender norms. Leaders and practitioners in medicine continue to be unaware and poorly educated about the nature, extent, and impact of barriers to full participation of women in health around the world. Connecting the gender, health workforce, and act on SDGs is the need of hour. Collective action is needed to fight pervasive threats to health and rights; many groups have long led such actions call on governments to recognize women's role in the health workforce, including unpaid care work.

Connecting gender, health workforce, and the work agendas is a win–win situation for achieving health gains. Many groups have long led such actions. But the world's community does not seem to be on track to meet the sustainable development goals (SDGs) for health or for gender equality [77]. A collective and strategic understanding of the need to mobilize individuals and institutions to redress imbalances in the gender- health relationship, producing a politically informed, globally relevant, and intersectional feminist strategy for structural change for global health is the need of hour.

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