WOMEN IN MEDICAL SCHOOL: AN EXPERIENTIAL ACCOUNT OF THE PERSISTENCE OF SEXISM AND ITS CONSEQUENCES

by

Jo-Anne Kirk

A Thesis
Submitted to the Faculty of Graduate Studies
in Partial Fulfillment of the Requirements
for the Degree of

MASTER OF ARTS

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This thesis is dedicated to my mother,

Julia Patson Kirk

who instilled in me the value of education,
and the spirit and passion
for what I have come to know as feminism.

'The Feminist revolution'...it is occurring now. It occurs as and when women, individually and together, hesitantly and rampantly, joyously and with deep sorrow, come to see our lives differently and to reject externally imposed frames of reference for understanding these lives, instead beginning the slow process of constructing our own ways of seeing them, understanding them, and living them. For us, the insistence on the deeply political nature of everyday life and on seeing political change as personal change is, quite simply, 'feminism' (Stanley and Wise, 1983:192).

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ABSTRACT

This study explores the experiences of women in medical school. In general, the orientation of this research was towards the validation of women's subjective experiences as students by way of in-depth, qualitative interviews. This study was directed at discovering how women medical students perceived their environment and how this perception was relevant to their overall experience. More specifically, the study aimed to identify the effects and consequences of the medical school environment at the University of Manitoba, in terms of women's perceptions of the persistence of sexism within their training programs. The emphasis was not solely on women in medicine but, rather, on women's experiences within the institution of medicine, which exists within a patriarchal society. In essence, this study was an examination of the **latent patriarchal culture** of medical school.

This research adds experiential interview data to the body of literature on women in medicine. This study was unique in that it provided a forum for women's voices to be heard. I interviewed twenty-one women who were at various stages of the four year undergraduate medical training program at the University of Manitoba. Students were asked if they, themselves, had experienced differential treatment based on their gender, and if they had observed similar treatment of classmates and/or faculty. The interview touched on all aspects of the medical school experience, and the form of the questions allowed students to report both favourable and unfavourable treatment. The in-depth interview data that I gathered supported my theoretical contention that the Faculty of Medicine at the University of Manitoba is strongly characterized by a latent patriarchal culture which, in turn, influences every aspect of the medical school experience. The research findings offer support for the existence of a **latent patriarchal culture** within medical school at the University of Manitoba.

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And finally, to Zachary Zimmer, my best friend and biggest supporter - thank you for your humour, your insights, your expertise and wisdom, your unending encouragement, and especially for helping me to keep it all in perspective.

The purpose of this study is to explore the experiences of women in medical school. In particular, the study aims to identify the effects and consequences of the medical school environment in terms of women medical students' perceptions of the persistence of sexism within their training programs. The emphasis is not solely on women in medicine, but rather on women's experiences within the institution of medicine, which exists within a patriarchal society.

Today, we have certain understandings about medicine as an institution - about the experience and climate of medical school, as well as the nature of medical practice. However, this vast body of literature about medicine is incomplete. We have only a limited understanding of the relevant issues because the majority of analyses have either completely excluded women in medicine as subjects of analysis, have discounted women's experiences as insignificant or irrelevant, and/or have assumed that women's experiences are identical to those of male medical students and practitioners.

Clearly, then, an accurate account of women's experiences within the institution of medicine is missing from the overall understanding of medicine. What is further absent is experiential interview data, that is, women's own accounts of their experiences as members of the field of medicine. This study attempts to address this serious gap in the literature and, therefore, expands the common understandings about

medicine. In general, the orientation of this research is towards the validation of women's subjective experiences as students in medical school. This study is directed at discovering how women medical students perceive their environment and how this perception is relevant to their overall experience. More specifically, the study aims to identify the effects and consequences of the medical school environment at the University of Manitoba, in terms of women medical students' perceptions of the persistence of sexism within their training programs. While the number of quantitative studies on women in medicine is increasing, this study is unique in that it provides a forum for women's voices to be heard. Therefore, it is an opportunity to construct a more complete description and, thus, will broaden the understandings about the institution of medicine. In brief, this study is an examination of the **latent patriarchal culture** of medical school.

This thesis is divided into several sections. A discussion of the theoretical framework which guides the research follows directly. Then, I present an exploration of the relevant historical and contemporary literature on women in medicine. This review of the literature is followed by an elaboration of the research methodology, and then, a report of the research findings. Finally, I present my analysis of the data and the study conclusions.

CHAPTER ONE - THEORETICAL FRAMEWORK

The concept **latent patriarchal culture** is central to this research and, as such, requires definition. On its own, the term **culture** is commonly defined as "...a body of ideas and practices considered to support each other and expected of each other by members of some group of people" (Becker et al., 1961:435). Culture that is further distinguished as 'latent' is described as having "...its origin and social support in a group other than the one in which persons are now participating" (Becker et al., 1961:143). Thus, in reference to medical school, the term 'latent culture' refers to the patterns of meanings, behaviours and beliefs that are intrinsic to the larger community within which the school is situated. The **latent culture,** then, includes the deeply entrenched ways of perceiving, understanding and controlling the reality of the situation that the majority of the people in the medical school community share, based on their membership in the larger outside community.

In their book, Boys in White, Becker, Geer, Hughes and Strauss (1961) argue that the internal climate of medical school is strongly influenced by a latent culture. Moreover, they contend that those who share the latent culture have a sense of belonging, while those who do not may feel alienated and marginal (Becker et al., 1961:143). Similarly, Goode (1957) in his article entitled "Community Within a Community: The Professions," states that the professions, including medicine, both exist within and are dependent upon the larger society (1957:200). Furthermore, Goode contends that medicine is one of the few professions that puts its recruits through a set of rigorous adult socialization

processes, which include punishment for inappropriate attitudes or behaviour, as well as procedures for continuing social controls over the practicing professional. However, he adds that "this socialization cannot be so complete as that of the child in the lay world, but that is not necessary, for the values of the professional community do not differ drastically from those of the larger society" (Goode, 1957:196-97). Thus, it is evident that the cultural values of medicine are closely linked with the dominant cultural values of the larger society. In other words, the prevailing latent culture of medical school students and faculty members at the University of Manitoba corresponds with the prevailing cultural values of contemporary Canadian society.

A second concept that is equally important to this research is the concept **patriarchy.** Patriarchy is not a precise or simple concept. Rather, it has many dimensions and embodies various meanings, all of which have been articulated and developed within feminist literature. While the significance and usefulness of the concept is rarely challenged, debates within feminist theoretical writings continue to highlight the lack of consensus about the meaning and/or status of the term (McDonough and Harrison, 1978:12; Beechey, 1979:66; Fox, 1988:164).

At the most general level, the concept of patriarchy refers to the collective male dominance which permeates society "...and to the power relationships by which men dominate women" (Millet in Beechey, 1979:66). Patriarchal ideology is both maintained by, and in turn manifests itself, within the basic structures and institutions of society, including the family and the economy (Hunter College Women's Studies

Collective, 1983:186). The term has been central to feminist theoretical analyses which attempt to identify and understand the principles and dynamics underlying women's oppression (McDonough and Harrison, 1978:12; Beechey,1979:66; Fox, 1988:164). Patriarchy has also been recognized as a significant concept politically because it identifies women's oppression as a distinct and real entity - a form of discrimination which is both the basis and the object of the politics of sex and gender. Indeed, as Fox (1988:164) articulates:

> For feminist theory, use of the concept 'patriarchy' has been a means of asserting that gender inequality is a pervasive feature of the society in which we live, that women's oppression is different from other kinds of oppression, and that gender inequality calls for specific explanation and analysis. In short the concept has been important because it problematizes gender and gender relations.

In light of the current lack of consensus over the precise meaning and status of the concept, it may seem confusing and even contradictory to highlight its prominence and significance within feminist discourse. However, as stated, patriarchy has remained a concept central to feminist analyses because it has proven to be extremely useful, even essential in nature. This is not to dismiss or devalue the important critical work by many feminist scholars to consolidate the various dimensions of patriarchy and, to refine and strengthen the concept itself (cf. McDonough and Harrison, 1978; Beechey, 1979; Fox,1988; Muszynski, 1989). A recurrent theme in such attempts at synthesis and clarification, as Beechey states in her article "On Patriarchy," is that "the different conceptions of patriarchy within contemporary feminist theory correspond to some extent to different political tendencies within feminist politics" (1979:67). Therefore, the debate that exists

over the meaning and status of patriarchy tends to reflect the differences in theory, strategy and politics that exist between the different currents of feminism.

A review of the literature reveals that, in terms of patriarchy, there are three key conceptual paradigms. Fox has identified these as (1) patriarchy as collective male dominance permeating society; (2) patriarchy as a self-contained system; and (3) patriarchy specifically as the sex-gender system (Fox, 1988:165). To begin with, radical and revolutionary feminist theory has focused on patriarchy as a universal and transhistorical "...system of male domination and female subordination" (Beechey, 1979:66). According to radical and revolutionary feminist theory, patriarchal relations have existed in all societies, regardless of the particular economic and cultural structures in place. Such feminist theory, then, has been concerned with isolating and analyzing - with the goal of overcoming - the specific nature of women's oppression. In particular, radical feminism has focused on how patriarchal ideology is manifested in, and reproduced through, social institutions. Specifically, the family, marriage and heterosexuality are seen as fundamental units of patriarchy (Beechey, 1979:66). Revolutionary feminist theory has further expanded on radical feminist analysis and specifies that male control over women's reproductive capacity is the basis of patriarchal ideology (Beechey, 1979:69). Thus, the key feature of this paradigm is that patriarchy is seen to be universal and transhistorical, and is inherent in the relations between women and men.

The second major paradigm, patriarchy as a self-contained system, refers primarily to Marxist and socialist feminist theoretical developments of the concept. This analysis focuses on the relationship between patriarchy, still conceptualized as male dominance, and the capitalist mode of production (Beechey, 1979:67). Within Marxist and socialist feminist theory, patriarchy is seen as a system of oppression which exists along side of, yet is also materially based in, capitalist relations of production. That is, patriarchy is male control over women's labour power. This conceptualization has also been expanded to highlight specifically male control of women's sexuality and fertility or, in other words, women's reproductive labour power (Fox, 1988:167-170). However, the key to Marxist and socialist feminist conceptual analysis is that patriarchy cannot be separated from other forms of exploitation and oppression which are intrinsic to capitalist societies (such as classism and racism), nor from capitalism itself (Beechey, 1979:67). Thus, patriarchy is not an inherent characteristic of societies generally, but rather it is historically specific and, in this instance, is one characteristic of capitalist society.

The third paradigm identifies patriarchy as the sex-gender system. This area of feminist analysis is unique in that it focuses on "...the way psyche and social structure connect, or the way gendered subjectivity and male dominance are related to each other" (Fox, 1988:171). Each theoretical work found within this paradigm is different from the other, ranging from Freudian analysis of the creation of patriarchal ideology within the individual psyche, to analysis of the social construction of traditionally gendered human beings. However,

all theories, as Fox states "...explore the power dimension inherent in gender and, in doing so, give 'patriarchy' a referent, involving a set of goal-directed activities (i.e. producing the heterosexual and gendered individual) and characteristic social relations (i.e. in the family)" (1988:171). Thus, this third paradigm of feminist thought introduces and explores the power of subjectivity in relation to patriarchal ideology.

For the purpose of this research, the concept of patriarchy that I apply is not simply drawn from one of the previously mentioned paradigms of feminist theory. Rather, the conceptualization that I find most useful originates from Fox's (1988) attempt to synthesize the existing feminist analyses of patriarchy. In essence, this conceptualization is more complete because it explicitly links both social structure and gendered subjectivity as "...two different but inseparable and constantly interacting levels of reality" which are responsible for the creation and maintenance of patriarchal ideology (Fox, 1988:176). Thus, the focus is not merely the individual or society alone, but rather the process and products of the interaction of both.

Much of this analysis is based on the theoretical writing of Zillah Eisenstein. Eisenstein argues that the sex-class division, which is not simply a dichotomy but in fact a sexual hierarchy, is more fundamental to patriarchy than the economic class division (Fox, 1988:175). The critical distinction is that the former is seen to be the basis of human cultural relations which have carried through time, while economic organization and, therefore, the economic class division has varied historically (Fox, 1988:175; Beechey, 1979:77). For Eisenstein, then,

patriarchy is inherently linked to human cultural relations and, in particular, to the social relations and practices that organize human generational reproduction (Fox, 1988:175). Thus, in general, "...patriarchy is the system of practices, arrangements and social relations that ensure biological reproduction, child rearing, and the reproduction of gendered subjectivity" (Fox, 1988:175). Moreover, characteristic of such relations of reproduction is a system of hierarchical ordering and control. This, in turn, is seen to be the basis of various forms of social organization, including capitalism (Beechey, 1979:77). Therefore, to reiterate, patriarchy is not simply located in the individual psyche, nor is it maintained solely by the institutions of society. Rather, it is a product of the relationship between social structure - which includes the family, the economy and the state - and individual subjectivity (Fox, 1988:176).

For Eisenstein, the essence of women's oppression is the pervasive social definition of woman as mother first and, in conjunction, the social and political institutions and structures which are in place to reinforce this 'ideology of difference.' This 'natural' division of labour by sex, which serves to limit both women's and men's life options, is further entrenched in society through the division of social life into public and private spheres (Fox, 1988:175). Thus, a basic tenet of patriarchy is the need to differentiate women from men. As Eisenstein states in Feminism and Sexual Equality (1984:90),

> Patriarchy ...is the politics of transforming biological sex into politicized gender, which prioritizes the man while making the woman different (unequal), less than, or the 'other.' This process of differentiating woman from man while establishing the privilege of men operates partially on the level of ideology that centers the phallus in the series of symbols, signs, and language while dividing the private world

> from the public world. And it simultaneously establishes the sexual division of labor, the distinctness of family and market, patriarchal controls within the market, and so on.

Interestingly, in her article entitled "What is Patriarchy?," Muszynski (1989) attempts to trace the emergence of patriarchy historically, and in doing so, to explore the origin and dynamics of the politics of gendered subjectivity. Beginning with Hannah Arendt's analysis of Marx as presented in The Human Condition (1958), Muszynski links the creation of the polis or public sphere in Athenian Greece to the establishment of patriarchy (Muszynski, 1989:70). The establishment of a public realm by and for important men, also known as 'citizens,' relegated all that was associated with nature as well as all activity necessary for the maintenance of human life, to the private sphere. As Muszynski (1989:68) reveals,

> Arendt acknowledges the fact that the creation of the polis was based on the enslavement of those excluded from membership. In order to participate as free and equal beings, citizens had to have their needs satisfied elsewhere, and by others. ...Thus the polis was marked by boundaries between itself and the private realm of the household, where the needs of the citizen were satisfied by forcing others to labour for him. The relationship between these two spheres was "that the mastering of the necessities of life in the household was the condition for freedom of the polis."

It was, therefore, the establishment of the public realm and the corresponding necessity of the private domain that resulted in a pervasive division of labour between women and men, and the creation and perpetuation of patriarchy.

This dichotomy further necessitated corresponding social, cultural, political and economic change, which in turn resulted in the institutionalization and subsequent 'naturalization' of gendered

consciousness - that is, patriarchal ideology (Armstrong and Armstrong, 1990:49; Muszynski, 1989:71). What is particularly significant in Muszynski's analysis is her acknowledgement that while the material composition of the public and private realms has been historically dynamic, the fundamental patriarchal ideology which underlies the need for such a division has remained intact. As Muszynski notes, this is of particular consequence because even though women are no longer relegated strictly to the private sphere, the 'natural' connection between women and motherhood (with all of its associated functions and duties as the creator and sustainer of life) still remains engrained within the collective consciousness of society. The result is that "...labouring as necessity and, therefore, as non-human activity continues to be attached to the work of women whether in the private realm of the household or in the public realm of salaried employment" (Muszynski, 1989:69).

Clearly, this point is critical to understanding the pervasive discrimination women face in the public sphere. The identification of woman as mother is so much a part of our 'natural consciousness' that not only is 'traditional women's work' devalued as public labour (e.g., the service industry), but, moreover, all women's work outside of the household tends to be devalued or undervalued when compared to men's work. That is, women are discriminated against simply for participating in the public realm. Furthermore, this discrimination is enforced, maintained and legitimized through social structures such as the family, the economy and the state, and engrained in the generational reproduction of gendered subjectivity. Fox's conclusion also supports this theory. She states (1988:176-177):

> In short, conceptions of male-female difference correspond to those of the distinction between public and private and originate not only in the family's creation of subjectivity, but also in an ideology that is sustained (if not created) by the state. ...It is the production of gendered subjectivity, and the gendered subjectivity/ideology itself to which 'patriarchy' can be seen to refer. Because the historical actor - in subsistence production, whether inside or outside the household, and in sexual relations - is gendered, gender relations in turn shape subsistence production and sexuality. ...Any analysis (of patriarchy) must work with two levels of reality: that of social structure and that of the individual, including both interpersonal relations and subjectivity.

Thus, the key to patriarchy is the creation and maintenance of difference - the transformation of biological sex into politicized gender, along with the social institutions which reflect and perpetuate this ideology of difference. Furthermore, the notion that the world is divided according to sex, and that each sex has claim to part of the world and must disclaim the other, always operates against women.

Having defined separately the two concepts that are integral to this research, it is now necessary to bring each of these two conceptualizations together to define **latent patriarchal culture.** Simply stated, **latent patriarchal culture** is an expression which identifies the larger patriarchal community from which medical students and faculty originate. That is, medicine exists within, and is dependent upon, a society which is organized according to the general principle of differentiation and privilege based upon gender.

Why is the concept of **latent patriarchal culture** important to this research? From the previous discussions of latent culture and patriarchy, it is evident that beliefs about women and men, and expectations of appropriate behaviour, constitute an important part of

the latent culture of medical school. The implications of this statement are clear when it is juxtaposed with with Goode's (1957) observation that the medical profession sanctions its recruits and practicing members for violating the cultural norms of the profession. Since a fundamental principle of patriarchal ideology is the implicit definition of woman as mother in the private sphere, then women in medical school are indeed violating a norm of the **latent patriarchal culture.** While the actual activities which constitute the public and private domains have changed with time, the underlying patriarchal ideology which necessitates the concept of difference has remained intact. The purpose of this research, then, is to investigate how **latent patriarchal culture** manifests itself within the medical school environment, how female medical school students perceive their environment, and how this perception is relevant to their overall experience.

In sum, the emphasis of this research is not merely on women in medicine, but rather on women's experiences within the institution of medicine, which exists within, and is dependent upon, a patriarchal society. Consequently, the enduring and damaging stereotypes, the formal and informal barriers, and the collective and individual discrimination experienced by women in medicine must be recognized as products of a patriarchal society which are used to oppress women systematically and systemically. In particular, this study is in response to Beechey's assertion that "...the forms of patriarchy which exist in particular social institutions have to be investigated. ...(That) we are wrong to assume that domination assumes the same form

in all social formations and in all kinds of social institutions within a society" (1979:80). This research attempts to identify and examine the mechanisms of **latent patriarchal culture** that are specific to the medical school environment at the University of Manitoba.

This research situates the issue of women in medicine, specifically women in medical school, within a historical as well as a contemporary perspective. A review of the relevant literature on women in medicine follows.

CHAPTER TWO - REVIEW OF THE LITERATURE

An Historical Perspective

Mary Roth Walsh prefaces her book Doctors Wanted: No Women Need Apply with a quote from Leigh Marlowe, who states: "Sexism cannot be experienced on an individual basis. Its roots are cultural, though it works out on a personal and interpersonal level. Consequently, sexism has to be treated institutionally" (Walsh, 1977:xvii). The rise of women in medicine is neither a recent occurrence nor a steady development. Rather, there have been previous peaks and declines in the number of women physicians. An exploration of historical patterns is therefore essential in understanding and explaining women's current status in medicine. The parallels between Victorian sexual politics and contemporary expressions of sexism are fundamental to the recognition that arrangements between women, men and work rest primarily on a patriarchal mythology and ideology, devised to justify exploitive social arrangements.

In the middle of the 19th century, when women began to seek medical training within male institutions, they met overwhelming rejection more often than admission. Discrimination was visible. Arguments against women entering the medical profession stemmed from men's self-interest in maintaining control over 'their' profession (Walsh, 1984:393), however, by mid-century American and British medical schools slowly began to graduate women (Strong-Boag, 1981:210). In 1849, Elizabeth Blackwell was the first woman in the U.S. to earn a medical degree, but she also stated that, once trained, she still was not welcome as a member of the medical community (Rosenthal and Eaton, 1982:129).

In Canada, women gained access to institutionalized medical education at a later date. By the 1850s, women were only beginning to win entry to some Canadian universities, and it was 40 years later when women were finally admitted to all universities across the country (Strong-Boag, 1981:208). Consequently, all women practicing medicine in Canada before 1884 received their training outside of Canada (generally the U.S. or Britain), and some Canadian women were still forced to go elsewhere to complete their medical education up until the 1860s (Strong-Boag, 1981:211). In 1875, Jennie Kidd Trout (Women's Medical College of Philadelphia, 1875) became the first woman to be licensed as a physician in Canada (Hacker, 1974:39). Shortly thereafter, Emily Howard Stowe was also granted legal permission to practice medicine, even though she had been practicing in Canada without a license since 1867, when she graduated from the New York Medical College for Women (Hacker, 1974:21). Stowe's daughter, Augusta Stowe-Gullen was the first woman to complete her medical education in Canada (Toronto) in 1883 (Hacker, 1974:29).

In both Canada and the United States, even though women struggled for and won the formal privilege of registration and access, they were also confronted with the prejudices and imposed restrictions of the male professional monopolies. Women physicians were collectively barred from practice in city hospitals and dispensaries, and were ignored by male colleagues. Internships and residencies in hospitals were commonly denied women and formal quotas restricting the numbers of women admitted to medical school existed well into the 20th century. Consequently, to gain necessary and valuable clinical experience, female physicians became pioneers and established their own hospitals and teaching

facilities (Walsh, 1984:394). Between 1850 and 1895, Americans founded 19 medical colleges for women (Strong-Boag, 1981:210). In October 1893, the Women's Medical College in Kingston - affiliated with Queen's University - and the Women's Medical College in Toronto - affiliated with the University of Toronto and the University of Trinity College - both opened (Strong-Boag, 1981:218). Not surprisingly, Dr. Trout (Kingston) and Dr. Stowe (Toronto) were the founding spirits behind the two medical colleges (Hacker, 1974:31-32). While neither college could confer its own degree, women were able to write the medical exams and received the degrees of the affiliated universities (Strong-Boag, 1981:218). In 1895, the Kingston college closed down and moved its students to Toronto, and the two colleges amalgamated under the name the Ontario Medical College for Women (Hacker, 1974:50). Here, women could now take the exams of the medical school of their own choosing (Strong-Boag, 1981:218). Other Canadian universities that followed and opened their medical schools to women were: Dalhousie University (1890), Bishops University (1890), the University of Western Ontario (1890s) and the University of Manitoba (1891) (Strong-Boag, 1981:218).

Unfortunately, as the percentage of women in medicine rose in the U.S. between 1850 and 1890 to approximately 18 percent (Rosenthal and Eaton, 1982:130), and in Canada, to 1.7 percent (76 women doctors) by 1891 (Strong-Boag, 1981:231), the male backlash also grew stronger. Many parallels between the U.S. and Canadian reaction are evident. In the 1860s, Dr. Horatio Storer, an American, insisted that because of menstrual irregularities women were too unstable to practice medicine (Rosenthal and Eaton, 1982:130). Similarly, Dr. Edward Clarke, a

Harvard Medical School professor, wrote a book entitled Sex in Education: or, A Fair Chance for Girls and concluded that higher education for women produced "monstrous brains and puny bodies; abnormally active cerebration and abnormally weak digestion; flowing thought and constipated bowels" (Walsh, 1977:126). Clarke further maintained that women could not be physicians and remain feminine. Since the uterus was connected to the central nervous system, he argued, energy expended in that one area was necessarily removed from the other. In Canada, similar arguments were common. Women were said to be uniquely susceptible to a multitude of nervous and emotional disorders and would collapse under rigorous study (Strong-Boag, 1981:208).

In the U.S., Clarke also warned that an increasing number of educated women would reduce the size of families. In other words, a woman's primary obligation to society was a total commitment to the role of mother. This conservative defense of idealized womanhood was also an important part of the 'backlash ideology' in Canada (Rosenthal and Eaton, 1982:130).

Clarke's opposition to women entering medicine was also financial; he pointed out that men typically received lower wages and experienced higher unemployment rates in occupations with higher percentages of women (Rosenthal and Eaton, 1982:130). Again in Canada, women were also presented as an economic threat, wanting to enter an occupation already thought to be overcrowded. Interestingly, women physicians were seen as a 'special hazard.' The possibility that pregnant women might prefer female physicians for gynecological and obstetric matters posed a serious threat, considering that "childbirth was often the occasion

which initiated a doctor's association with a family and its illnesses" (Strong-Boag, 1981:210). Furthermore, in view of the male medical profession's open hostility towards midwives, medical education was also seen as a means by which midwives might enter and threaten the "...kingdom of 'legitimate' medicine" (Strong-Boag, 1981:210).

It was no coincidence that, at this time, women were prohibited from practicing as midwives in the U.S. and, by the mid 1800s, male physicians established medical societies exclusively for men (Walsh, 1977:8). Later licensing sought to exclude women from medicine. When they were allowed to take medical exams they often did better than men, but to little effect because they were often not permitted to take qualifying examinations or to practice (Rosenthal and Eaton,1982:130). In Canada, women were offered less vigorous and less scientific training at every level. For example, women were routinely discouraged from attempting the 'onerous' Latin requirement (Strong-Boag, 1981:209-210). Interestingly, men could see women as nurses because nurses were viewed as docile and submissive (Walsh, 1977:143). As the numbers of women physicians increased, new labels were used to denigrate them. In the late 1800s, they were labeled witches; later they were called abortionists (Rosenthal and Eaton, 1982:130).

Another related and immediate concern of the male medical profession was that women were a potential risk to the standards and status of the emerging profession. In the late 1800s, medicine was undergoing an intense period of professionalization in North America. Professional prestige and power depended on the establishment and maintenance of clear and identifiable standards in medical ideology, education and

practice. In turn, this process required the creation of ruling bodies and the tightening up of qualifications and restrictions on accreditation (Strong-Boag, 1981:209). As Strong-Boag reveals in her article on Canadian women pioneer doctors (1981:209):

> Deviance of any kind was suspect lest it raise doubts about hard-won professional standards. The association of some female doctors, excluded from most orthodox schools in North America, with controversial remedies such as electrotherapy, hydropathy, and homeopathy linked the entire sex with just the kind of questionable practices the orthodox were attempting to eliminate,...(and) provided further justification for anti-female prejudices.

In response, the feminist communities in Canada and the U.S. launched a full-scale counterattack against male backlash and the Clarke thesis (Walsh, 1977:130-131). At this time, Canadian advocates for training women physicians included the YWCA and the Women's Christian Temperance Union. Interestingly, support was based on the argument that medicine was a natural and appropriate outlet for women's 'nurturing instincts' (Strong-Boag, 191:211). Similarly, the Ontario Medical College for Women placed an emphasis on courses in areas deemed of utmost importance to women practitioners such as gynecology, obstetrics, and diseases of children (De La Cour and Sheinin, 1990:115). The College even established a midwifery service in 1891 (De La Cour and Sheinin, 1990:115). Clearly, then, women's medical schools reflected women's 'own' interests, which in turn, reflected society's prescription for women. Consequently, women were absent from most medical specialties such as surgery and, furthermore, there were no females in institutions such as the McGill Medical School, "...where 'maternal' qualities were believed of little importance" (Strong-Boag, 1981:225). In fact, it was not until much later that the universities of McGill, Laval and Montreal

opened their medical schools to female candidates (Strong-Boag, 1981:232).

At the end of the 19th century, 96 percent of American female physicians were affiliated with women's institutions. In 1892, 63 percent of women in U.S. medical schools were in all-female ones (Hunter College Women's Studies Collective, 1983:424). By 1905, the two Canadian women's medical colleges had graduated 146 doctors, 34 from Kingston and 112 from Toronto (Strong-Boag, 1981:218).

However, also by the close of the 19th century, female medical institutions began to pass out of existence. Encouraged by the prospects of equal opportunity for medical education at existing male schools, many good women's schools were closed, or merged with male institutions, all to the detriment of women (Hunter College Women's Studies Collective, 1983:425). For example, when the Kingston Women's Medical College was forced to close in 1893 due to financial difficulties and faltering enrolment, Queen's University did not admit women again until 1943 (Strong-Boag, 1981:218). When the University of Toronto agreed to permit women in its medical courses, the Ontario Medical College for Women was unable to resist the pressures to shut down and, in 1906, its students were transfered to the University of Toronto Faculty of Medicine (Strong-Boag, 1981:218).

Women's medical schools had allowed female doctors full participation in affiliated women's hospitals after graduation and women physicians were appointed to the schools' teaching staffs. For example, it was part of the feminist policy of the Ontario Medical College for Women to

include women in its administration and, when it closed in 1906, 11 women represented one third of the school's staff (Hacker, 1974:32,51). A dispensary associated with the Ontario Medical College for Women also gave women students and graduates the valuable work experience that they were denied in the male medical community (Hacker, 1984:47). When the women's medical schools closed, women were restricted to a 5 percent quota in men's schools in the U.S. and were further limited in their appointments to internships and residencies, faculties and hospital staffs (Walsh, 1977:xviii). As De La Cour and Sheinin observe (1984:118):

> Quotas on female enrolment, discrimination in admission criteria, lack of financial support, lack of positive reinforcement in career plans, as well as unpleasant and prejudicial attitudes in university classrooms resulted not only in decreased numbers of female medical students, but also in deteriorated conditions of study.

In Canada, when the Ontario Medical College for Women closed, not only were women deprived of practical reinforcements, but women students and doctors were now without an "...important stronghold of psychological reassurance" (Strong-Boag, 1981:231). This loss was only offset in part when the Women's College Hospital opened in Toronto in 1915, and offered residencies and specialist opportunities to women (Strong-Boag, 1981:231).

Interestingly, it has also been shown that women's restricted access and privilege within the medical community began to occur before the Flexner Report was published in 1910 (Lorber, 1990:20). This report was carried out under the auspices of the Carnegie Foundation, to strengthen the established white male medical monopoly, by essentially outlawing all 'nonscientific' types of medicine (Conrad and Schneider,

1986:131-32). The report recommended the closing of many existing medical schools and "...urged stricter (licensing) laws, rigid standards for medical education, and more rigorous examinations for certification to practice" (Conrad and Schneider, 1986:128). While the Flexner Report also concluded that "'Women's choice is free and varied' in medicine" (Strong-Boag, 1981:231), this clearly was not the case. Thus, for Canadian and American women doctors, upgrading of the medical profession (which barely concealed the underlying and escalating discrimination, and monopolistic tendencies of the 'regulars') and co-education meant restrictions in the opportunities to compete with men for the scarce resources of the professional community.

Following this early peak in female medical school enrollment, women faced a period of stagnation and repression over the next 60 years (Rosenthal and Eaton, 1982:131). After a decline in women's medical school enrolment, the numbers again increased during World War I, when the number of male medical students decreased and the need for doctors simultaneously increased. After World War I, primarily because they were no longer needed to fill empty positions, the number of women in medical school again declined. In Canada, the trend in the percentage of female doctors during the early 1900s similarly reveals the marginality of their position. Strong-Boag insists that the decline between 1911 and 1921 from 2.7 percent (n=196) to 1.8 percent (n=152) was directly related to the closing of the Ontario Medical College for Women (1981:232). The number of women physicians rose again to some extent during World War II, when they were needed to fill the medical schools. At this time, women were finally allowed to intern and serve

as physicians on hospital staffs (Rosenthal and Eaton, 1982:131). In 1941, women increased to 3.7 percent (n=384) of all physicians in Canada. Yet when the need for doctors was again satisfied by men returning from the war, many hospitals closed their staffs to women.

The 1950s and 1960s saw another decline in the participation of women in medicine. In 1955, for example, women comprised only 4.7 percent of medical school students in the U.S. (Rosenthal and Eaton, 1982:131). During this period, women encountered many negative responses to their combining medicine with marriage and pregnancy; they were also given less financial aid than men (Rosenthal and Eaton, 1982:132). In her book, Women Physicians, Judith Lorber identifies the 1940s, 50s and 60s in the U.S. as a "heyday of autonomy, prestige, and expansion of the medical profession" (Lorber, 1984:133). Yet, during this time, quotas were in effect which significantly restricted women's participation in medicine (Rosenthal and Eaton, 1982:133). Moreover, even in the few instances where women faced no overt discrimination in regulations, they rarely encountered positive reinforcement. As Strong-Boag asserts: "This failure went beyond the universities themselves. Nowhere in Canada's education system were girls encouraged to consider high status professional, especially scientific employments" (1981:232).

Strong-Boag also draws an interesting and compelling parallel between the presence of feminism and the corresponding societal acceptance of female physicians. She states that (1981:232):

> The establishment of a professional medical role for women was dependent on the vitality of Canadian feminism. When this faith faltered so did the cause of female physicians. Ironically enough, medical pioneers, by stressing women's unique nurturing "instinct," contributed to unfavourable trends. Like other feminists, they had no substantial

> critique of the "cult of domesticity" which overwhelmed war-weary Canadians by the 1920s.

Even though the Federation of Medical Women of Canada was founded in 1924 by six women (including four graduates of the women's medical colleges), according to Strong-Boag, it was not "...representative of the earlier outward-looking feminism of female physicians" (1981:231). The foundation served primarily as a communication link between women doctors, not as an organization which agitated for women's rights by ensuring that women's place was both preserved and promoted within the male-dominated medical profession (Strong-Boag, 1981:231-32).

Despite the constant struggles that Canadian and American pioneer women doctors faced, their accomplishments and contributions to medicine and society stand out. Some of the many noteworthy Canadian women include: Jennie Kidd Trout, Emily Howard Stowe and Augusta Stowe-Gullen. As mentioned previously, these were, respectively, the first two women to become licensed practitioners, and the first woman to graduate from a Canadian medical school. Helen Elizabeth Reynolds Ryan (Queens 1885) was the first woman to be granted membership to the Canadian Medical Association (Hacker, 1974:72). In 1892, Harriet Foxton Clarke was the first woman graduate from the Manitoba Medical College (Hacker, 1974:145). Mary Crawford (Trinity 1900), Margaret Ellen Douglas (Trinity 1905) and Edith Ross (Manitoba 1913) were all pioneer doctors who practiced in Winnipeg. In fact, Dr. Ross won the Gold Medal when she graduated from the Manitoba Medical College and was the first woman to practice as an anesthetist at the Winnipeg General Hospital (Hacker, 1974:146). Finally, Rowene Hume Douglas (Trinity 1899) and Elizabeth Bagshaw (Trinity 1905) share the distinction of having established

Canada's first Planned Parenthood Association and Clinic in 1930 (Strong-Boag, 1981:227).

This list includes only a small number of the outstanding pioneer women doctors. Without doubt, the innovative and inspiring aspects of their individual and collective experiences serve as a reminder of their struggles, but they mostly serve as a tribute to the achievement of these women in ensuring all women a place in medicine.

This brief account of women's participation in Canadian and U.S. medicine reveals that formidable barriers based entirely on patriarchal ideology and mythology were erected by men to discredit and impede highly qualified women in their attempt to attain equal status in a male-dominated work world.

A Contemporary Perspective

In general, medical education has been described as the most grueling and demanding form of professional training. The prolonged, esoteric, rigorous training process has also been viewed as especially depriving to students. It has been seen as a dehumanizing, psychologically stressful experience, often detrimental both to students' identities and to their interpersonal relationships, including those between patient and physician (Shapiro, 1978:27-28). As well, until relatively recently, medical school recruits were selected almost exclusively from a narrow segment of the population: intelligent, well-educated, and affluent white males. Similarly, this social and cultural background was shared by medical faculty and administrators (Grant, 1988:109).

However, over the last two decades, the profile of medical students in Canada has changed dramatically in many respects. In 1990-91, women comprised 44.4 percent of the total enrolment in Canadian faculties of medicine, compared with 7.0 percent in 1957-58, and 17.8 percent in 1970-71. In 1991, women also earned 44.8 percent of the M.D. degrees at all Canadian universities, compared with 4.1 percent in 1940, and 12.0 percent in 1970. That same year, the percentage of female graduates from the 16 Canadian universities with medical degree programs ranged from a low of 27.8 percent at the University of Saskatchewan, to a high of 65.1 percent at L'Universite de Sherbrooke (Association of Canadian Medical Colleges [ACMC], 1991). As well, women comprised the following percentages of the 1991 graduating classes across the country: 63.9 percent at L'Universite de Montreal; 58.2 percent at both L'Universite Laval and McMaster University; 51.8 percent at the University of Ottawa; 44.8 percent at Memorial University; 44.7 percent at the University of British Columbia; 44.1 percent at the University of Calgary; 39.7 percent at Queen's University; 39.5 at McGill University; 37.4 percent at the University of Western Ontario; 36.3 percent at Dalhousie University; 34.8 percent at the University of Alberta; and, 33.7 percent at the University of Toronto (ACMC, 1991:37). At the University of Manitoba (U of M), there were 34 (40%) first year women medical students as of December 1, 1990, and women comprised 38.8 percent (n=137) of the total enrollment in the four-year undergraduate medical training program (Institutional Analysis U of M, 1991). In 1991, women comprised 36.8 percent of the graduating class at the U of M (ACMC, 1991:37).

It is clear from these statistics that women are now better represented in medical schools and in the profession than in the past. Yet, the question arises as to whether these numbers actually represent a positive and progressive change in the medical profession's attitudes toward women as students, as physicians and as professionals. In part, this research takes as its aim to explore this very issue. In the review which follows, the current literature relevant to women in contemporary medicine will be examined.

The proportion of women enrolled in the first year of Canadian medical studies was 10.3 percent in 1960/61; 20.2 percent in 1970/71; 40.0 percent in 1980/81; and in 1990/91, women comprised 45.5 percent of the entering classes in all schools of medicine in Canada (ACMC, 1991:11). In fact, according to statistics compiled by the Association of Canadian Medical Colleges, for the last 15 years, the proportion of women admitted into medicine has consistently been a function of the increasing number of women who have applied to medical programs (ACMC, 1988:6). While figures vary among each of the 16 universities with medical degree programs, overall, women have fared slightly better than men in the admissions competition, when the proportions of successful applicants are compared (ACMC, 1988:6). To illustrate, in 1990/91, 22.99 women per 100 applications were admitted, compared with 22.52 men per 100 applications. In real numbers, this ratio represents 823 women to 943 men who were selected out of 4188 male and 3580 female applicants. A more apparent difference still exists, however, in the total number of applications submitted by men and women. Again, in the 1990/91 academic year, women submitted 9,354 applications, while men

submitted a total of 12,020 (ACMC, 1991:119). When looking at the applicants who were residents of Canada only (that is, excluding foreign candidates), men submitted an average of 4.83 applications each, compared with an average of 4.09 by each woman (ACMC, 1991:1058). However, even though men filed almost one third more applications than women did in 1990/91, over the past two decades, the number of male applicants has steadily decreased, while the number of female applicants has steadily increased (Kinesis, 1988:24). Furthermore, since the early 1980s, there continues to be an overall gradual reduction in the number of first year spaces at Canadian faculties of medicine. Essentially, then, women today appear to have an equal chance of being admitted to medical school, within the context of keener competition, because of reduced first year spaces (ACMC, 1988:5-6).

This increase of women and the corresponding decrease of men entering Canadian medical schools has not gone unnoticed. According to Dr. Peter van Nostrand of the University of Toronto, "medicine is ceasing to appeal because of government intervention...limiting billing numbers, deciding where doctors can practice. The profession has lost its lustre" (Kinesis, 1988:25). Dr. Luis Branda, Chair of McMaster's Faculty of Health Sciences Admissions Committee suggests that a combination of factors, including the "...historical progression that goes along with the changing roles of society" (Sleightholm, 1991:4), is responsible for the majority of women in the McMaster medical program since 1975. However, all reactions to the shift in the sex ratio in Canadian medical schools have not been as reflective. Branda stated that even members of the medical profession have asked: "What are we

doing wrong? Why so many women?" In fact, one letter to the Hamilton Spectator complained that McMaster had favoured female candidates and then asked "...who was responsible for a reversal of the course of history (to) deprive males from this noble and desirable profession?" (Sleightholm, 1991:4). Without doubt, it is highly unlikely that such questions in the reverse were contemplated, when men were a clear and growing majority within the medical profession.

Clearly, the discrimination and sexism encountered by contemporary female medical students is rooted much deeper than the institution of medicine; medicine still mirrors larger cultural and social ideologies, primarily patriarchal. The Victorian sexual politics so prevalent in the 1800s and early 1900s parallel the sexual politics of the 20th century. In their article, "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks", Scully and Bart state (1978:214-15):

> It is our thesis that (1) although some of the Victorian sexual prohibitions and stereotypes have been removed from the rules, new, more sophisticated and equally repressive ones have taken their place; and (2) the underlying imagery of woman's purpose and place has changed little in 125 years. Women are still depicted as primarily put on earth for reproduction and homemaking.

There is a connection - past and present - between men's needs in a male-dominated society and the formation and dissemination of an ideology regarding women's appropriate roles. Patriarchy still defines the political, economic and personal contexts of women's lives.

To begin with, numerous factors discourage girls and women from even considering the medical profession, long before application to medical school. That is, a sexual tracking system exists which serves to

circumscribe the adult roles of women. Although young girls and boys show no statistically significant differences in abilities in math and sciences, by approximately the 10th grade females enrol in fewer math and sciences courses (Hyde, 1985:192). Consequently, most women not only have fewer math and science skills, but as a direct result, are also significantly more limited in their range of career choices.

Furthermore, our society is particularly discouraging to girls with an interest in, and a talent for, science and math (Rose, 1986:60). Throughout the socialization process, boys are instructed that they are 'naturally' intelligent, objective, active and independent, while girls are encouraged to be sensitive, emotional, obedient and dependent. Since an aptitude for science and math implies traditional masculine traits, girls are often discouraged, both subtly and actively, from developing their interest in these subjects.

In a 1985 study undertaken for the Women's Bureau of Labour Canada, entitled "When I Grow Up ... Career Expectations and Aspirations of Canadian Schoolchildren," the findings were suggestive of pervasive sex-role stereotyping in Canadian society. A sample of just over 700 elementary-school pupils (approximately equal numbers of boys and girls) was studied to determine children's preferences for a selection of sex-stereotyped activities and their expectations of sex segregation in the labour force they will join as adults. The results showed that even among the youngest of the research subjects, girls and boys were significantly different in their responses. Both girls and boys believed that when they became adults, they would be engaged in many of the same occupations. However, girls' expressed belief in the future

participation of women in predominantly masculine professions was not always reflected in their individual career choices. As the authors state (Labour Canada, 1986:55)

> It was as though girls did not apply to themselves their general belief in the equality of the sexes. Many of them seemed to be saying, 'Yes, women can become doctors, but I expect to be a nurse,' 'Bank managers can be women as well as men, but I am going to be a teller,' or 'Dental assistant is my career goal, although I know that women can be dentists.'

In fact, a recent study released in March 1992 by the American Association of University Women Education Foundation concluded that subtle sexism is still pervasive in schools. The study revealed that teachers pay less attention to girls than boys; few teachers encourage girls to pursue male-dominated maths and sciences; tests are biased against girls; and school textbooks still ignore or stereotype women (Canadian Press, 1992:A2).

The identification of sexist language and the need for a change to non-sexist forms have long been topics of controversy. Language development and use, along with the socialization process, also further instills the notion that the 'physician is male.' The concept of doctor is routinely verbalized as 'he.' This may again contribute to limited career options among women, as well as support the patriarchal myth of appropriate and separate roles for women and men. In fact, a 1981 study of first year medical students in the U.S. revealed that both female and male students (who tended to be very similar to each other on the personality traits measured) attributed very different characteristics to hypothetical physicians who differed in gender only. Moreover, students' ratings for 'most physicians' (sex unspecified) tended to be

most similar to their descriptions of the average male physician. The study concluded that, in general, the first year medical student still sees the typical physician as male. The results also confirmed anecdotal reports that female medical students are more acutely aware of, and stressed by, traditional gender based stereotypes (Dralle et al., 1987:75-81).

Further, a 1979 study in the U.S. revealed that women were more inclined to accept rejection from medical school as 'fair' and, ultimately, to enter careers characterized by relatively lower prestige and educational requirements. In this study, even though the women applying to medical school possessed greater interest and ability in the physical sciences, females appeared less likely than males to persevere in attempts to become physicians, and tended to accept employment at lower levels of the health care hierarchy. The study concluded that females receive substantial societal pressures to select jobs with characteristics approximating the medical profession. Males, by contrast, are encouraged to enter careers approaching the prestige of physicians (Daum, 1979:181). A more recent U.S. study (Fiorentine, 1987) also serves to substantiate this point. The data indicated that while almost the same proportion of female and male college students entered undergraduate premedical programs, substantially fewer females eventually applied to medical school. Furthermore, analysis of transcripts indicated that the differential rate of application is only slightly determined by sex differences in academic performance. According to Fiorentine, most of the variance is a consequence of 'a unique pattern of persistence.' That is, while both females and males

with a high level of performance are equally likely to apply to medical school, females with moderate and low levels of academic performance are substantially less likely than males with similar levels of performance to apply to medical school (Fiorentine, 1987:1118).

Studies also indicate that, relative to men, women tend to evaluate their own performances more harshly in the absence of feedback, are more likely to accept responsibility for their failures, and tend to underestimate how well they will perform in the future (Major, 1987:7). Moreover, in a study based on 'sense of entitlement,' women appear to feel entitled to less than men who have done comparable work, whether they are asked to determine a fair exchange with others, or to decide on fair exchange for themselves alone. Furthermore, even though women recognize that other women obtain less than they deserve from their jobs, they feel they personally receive what they deserve (Major, 1987:7).

Therefore, it is apparent that significant societal factors do influence women's (as well as men's) perceptions of the physician's role, and contribute to discouraging women from considering the medical profession before and during application to medical school. Stereotypes and discrimination based on sexist ideology are important parts of the early sexual tracking system. Differences have been established between men's and women's opportunities for career choice and development in the professions in general, and in medicine in particular.

With the fairly recent increase in women entering medicine, there is a trend developing in the literature on medical education which implies

that the educational process is psychologically more stressful for women than men. Some studies show that female medical students consult with mental health services more frequently than their male peers, and that females report a greater increase in depressive symptoms and a greater decrease in life satisfaction (Hammond, 1981:162; Parkerson et al., 1990:586; Martin et al., 1988:77). Women students also reported more role conflict and less support from their families (Martin et al., 1988:77). Some studies have also suggested that conflicts with authorities may be more problematic for women medical students. Women have scored higher on measures reflecting stressful faculty-student relations and have reported more problems with administrators, who are often responsible for student promotions. Women were also more likely to report feeling hostility and discrimination from faculty members (Speigel et al., 1987:19; Grant, 1988:109-110).

However, this literature can be quite damaging for women, especially when the information is interpreted without acknowledging the influence of patriarchy. The tendency is to conclude that "the victim is ultimately to blame," and consequently, further support is provided for the status quo. To illustrate, other studies have emphasized that while female medical students are reporting higher levels of emotional distress, this is strongly linked to the higher levels of stress that women experience (Archer, 1991:301; Coombs and Hovanessian, 1988:21). Several studies have suggested that women encounter unique obstacles and, consequently, face unique stress during training that is not experienced to the same extent by males. To begin with, most women must deal with more complex role demands in terms of balancing professional

and personal obligations (Elliot and Gerard, 1986:56). Women also have limited female role models and mentors among medical school faculty members (Cohen et al., 1988:142; Nadelson, 1991:95; Osborn et al., 1992:59), and may often be excluded from informal cliques of male colleagues (Elliot and Gerard, 1986:55; Coombs and Hovanessian, 1988:21-22). There is also ample evidence that women's and men's performances, attributes and tasks are valued differently in society. For example, studies have shown that female performances are often seen as less competent than identical male performances, and successful performances by women are often attributed to external or unstable causes such as luck or temporary effort (Major, 1987:3). Similarly, women medical students have also experienced difficulties in appearing credible, and many hold the perception that they have to work twice as hard, even appear superlative, just to qualify as average (Poirier, 1986:83; Dralle et al., 1987:80; Whiting and Bickel, 1990:277).

Therefore, in analyzing the problems and discrimination that women face in the medical system, it is vital that attention not be primarily focused on 'women's special problems' (with the emphasis on women). Rather the nature of the institutional structures and the organization of work must be recognized as significant factors in circumscribing women's opportunities and experiences within the profession of medicine.

To illustrate, within medicine, women are still being encouraged to go into traditional 'female specialties' (which focus on women and children) such as pediatrics, family medicine, and obstetrics and gynecology. Women are also under-represented in the upper echelons of the medical profession. The conventional explanations given for these

patterns most often focus on women's strong commitment (or relegation) to family responsibilities, or women's lesser motivation to achieve higher status which, again, is perceived to be the result of an early choice to consider family over career as a life-long commitment. However, these explanations ignore the reality that, in patriarchal societies, the institution of motherhood prescribes that mothering should exist at the centre of women's lives and that all else should remain secondary (Hunter College Women's Studies Collective, 1983:288). This bias is evident even within the medical school admission interview. One U.S. study revealed that the interview panel asked women more frequently about their plans regarding marriage and children, while men were more often asked about their motivations for entering medicine and their future career plans within the profession (Marquet et al., 1990:411).

Although people now argue that traditional family patterns are disappearing, recent studies show that beneath the apparently egalitarian coping strategies of many dual-career couples with children, there still remains a traditional division of responsibility (Hyde, 1985:176; Cartwright, 1987:143). Interestingly, previous research regarding career decision-making, marriage and family, and the practice of women physicians also confirms that women have legitimate concerns about being successful and satisfied in their roles. A number of studies show that women physicians, when they were compared with male physicians, were often confronted with a disparity between their expectations and their experiences regarding pregnancy, parenting, and family life. Female medical students and residents expected to share

childcare, household chores and financial responsibilities equally with their husbands. Their male peers expected to participate much less in childcare and household chores and to contribute more financially. Since many of these physicians tend to marry one another (Schermerhorn, 1986:74), it is obvious that some of these expectations will not be realized (Altekruse and McDermott, 1988:80).

Further, female medical students, residents and practitioners all reported greater role stress than their male colleagues. When surveyed, between 30 and 60 percent of female physicians felt that family-career conflicts were important influences on their lives (Martin et al., 1988:337). Another survey which asked men and women whether they had changed their career plans because of family influences found that none of the men said they had changed their career plans or behaviours because of family responsibilities, whereas 44 percent of the women surveyed stated they had done so (Martin et al., 1988:337). A recent study of dual-doctor marriages also reported that 19 of 21 women interviewed (as compared with only 1 of 21 men) thought that they had made significant career compromises because of their marriage. Furthermore, the couples revealed that the husband's career was given priority over the wife's in all of the marriages (Johnson et al., 1991:156).

Yet, in light of the above research, and despite a growing body of evidence to the contrary (for example, see: Harris & Conley-Muth 1981; Harward et al. 1981; Brown & Klein 1982; Altekruse & McDermott 1988; Kettner 1988; Martin et al. 1988; Eisenberg 1989; Wheeler et al. 1990; Dickstein,1990; Phelan,1991), the notion still persists that women's

career commitment in medicine is weaker than that of men's. As stated previously, women's socialization emphasizes the importance of family life. Because both professional and family life demand significant time commitments, the career paths of female physicians may be explained partly as an effort to cap excessive demands from professional life and to allow for adequate family time. Thus, while research often reveals that women are over-represented in full-time salaried 'nine to five' positions requiring fewer hours of work to report (Brown and Klein, 1982:157), an 'employee' status, seeing fewer patients, and working fewer hours can lessen the encroachment of professional demands on family life (Martin et al., 1988:336-37). Furthermore, studies now reveal that the gap between the number of hours worked by women and men is steadily diminishing because, for the most part, the number of hours worked by male physicians has decreased (Ramos and Feiner, 1989:24). Recent studies indicate that both male and female medical graduates are choosing, in equal numbers, salaried positions that involve a fixed number of working hours. This may suggest that, increasingly, male physicians are also beginning to value a more humane and balanced lifestyle than that which has been the rule in the past (Phelan, 1991:57). However, as another study concluded: "Women physicians spent 90 percent as much time in medical work as did the men, despite the fact that most of the women had full responsibility for homes and families" (Heins et al., 1977:2514).

Still, women's motivation and career development have been explained by how different women are from men, rather than in terms of the difference in the structure of opportunities available for women and

men. Women are often urged to enter specialties with high interaction with patients because these are felt to be compatible with women's interest in people. Women are also steered to low interaction specialties because the practice hours are seen to be compatible with family responsibilities. Women are often assumed to have traditional feminine qualities that are more suitable for some specialties (such as family medicine, pediatrics, obstetrics and gynecology), whereas other specialties are perceived as unsuitable because stereotypically masculine traits such as physical vigor and competitiveness are required (for example, surgery, orthopedics, urology) (Burnley and Burkett, 1986:144-151). Research has revealed that faculty members recommended different specialties to women and men students based on the belief that some fields are more suitable to women. Women have also reported that surgeons raised questions, directly and indirectly, about physical stamina, emotional stability, motives for being interested in surgery, and perceived lack of aggression - a trait that faculty considered essential for successful surgeons (Osborne, 1983:23; Opinion, 1986:58; Grant, 1988:115).

Not surprisingly, despite the fact that women make up almost 50 percent of today's medical students and represent increasing numbers in all residencies, and despite the fact that pregnancy is a common event among women in this age group, research in the U.S. has shown that there is a lack of administrative and institutional preparedness regarding pregnancy among members of hospital housestaff (cf. Sayres et al., 1986; Sinal et al., 1988; Levinson et al., 1989; Bickel, 1989; Harris et al., 1990; Phelan, 1991). Today, the majority of hospitals still have no

maternity leave policies, especially for residents in training (Phelan, 1991:55), and university policies are limited in terms of job sharing possibilities (Levinson et al., 1989:1514-15). Consequently, there tends to be a 'crisis mentality' around pregnancy among residents in most institutions (Phelan, 1991:55). Even though these studies revealed that no women quit their residencies during or after pregnancy (Sayer et al., 1986:418), and few reduced their working hours during pregnancy (Bickel, 1989:499), pregnancy was seen as an inconvenience and/or a problem resulting in resentment and hostility among the women's colleagues (Sayres et al., 1986:420). As one report indicated, because there is no formal mechanism for handling an inevitable life event such as pregnancy, it is "...experienced as (a) disruption that create(s) considerable stress in an already high-pressure system" (Sayres et al., 1986:40). As a result, in many instances, because of the absence of a formal written policy, "arrangements are often seen as accommodation for a woman who has a problem; they frequently have a persecutory or patronizing quality about them" (Phelan, 1991:56). Consequently, it is not hard to understand why such factors still ensure that most women 'choose' to go into traditional female fields, where they perceive that their support systems can best be maximized.

However, research shows little evidence that female physicians prefer primary care specialties more than male physicians do. When specialty choices of male and female medical students were examined, it was found that the men who specialized in family practice preferred it, but that women who specialized in family medicine did not always prefer it even when they chose it, suggesting strongly that some women are making

career compromises, or being tracked into this type of specialty (Burnley and Burkett, 1986:145). Relatedly, another study reported that even when they prefer it, proportionately fewer female medical students choose surgery residencies (Ramos and Feiner, 1989:24). In addition, another study concluded that more women would select careers in surgery if their initial contact with the specialty provided more relevant work, patient responsibilities and skill development, all conveyed with a more positive attitude by the staff (Calkins et al., 1992:58). Yet another study revealed that women consistently identified the absence of a female role model as a significant detractor from pursuing more typically non-traditional specialties (Cohen et al., 1988:152).

Sponsorship is identified as the process by which promising junior physicians are identified and helped by established physicians. It is recognized as an extremely important factor in a medical career, as the sponsorship-protegee system is very pervasive in medicine (Lorber, 1984:6). Both the standards and opportunities for achievement are controlled by the dominant members. However, researchers have suggested that protegees are not chosen strictly on the basis of their potential as demonstrated by performance during training (Lorber, 1984:6), and that attitudes regarding the appropriateness of women within certain specialties often come into play (Opinion, 1986:58; Martin and Woodring, 1986:50; Robinson et al., 1987:15; Nadelson, 1991:98; Kohman and Hoefer, 1991:92). For example, one U.S. study that surveyed women applicants for orthopedic surgery residencies found prevailing sexist attitudes which centred around the traditional belief that physical strength was of primary importance in the field of orthopedics (now obsolete with the

introduction of technology and machinery). In fact, one woman was told by the chair of the residency program that policy only allowed for one woman every second year (Kohman and Hoefer, 1991:92).

Until relatively recently, medical school recruits, faculty and administration shared a similar social and cultural background: most were intelligent, well-educated, and affluent white males (Grant, 1988:109). Without doubt, when professional school members share a latent culture - that is, share patterns of meanings, behaviours and beliefs - elements of that culture will filter into the school's informal environment. The gender, race, class, ethnicity and religion of faculty and students affect their relationships, even when these attributes are ostensibly irrelevant. Thus, the expectations, informal understandings, and routine behaviour that affect women and men students within a medical school - its 'gender climate' - are part of the shared latent culture (Becker and Geer, in Grant, 1988:109-110).

In addition, it has also been shown that professions are closed, self-regulating communities and, consequently, they have implicit and sometimes explicit expectations about the appropriate characteristics of their members. The purpose of these expectations is to ensure that all members of the profession are similar and hold common values and beliefs, which allows the profession to control the behaviour of its members and preserve its integrity (Goode, 1957:195-200). Within professions, an image of the appropriate candidate still exists. Today, while formal university policies prevent overt discrimination on the basis of gender, race, ethnicity and religion, there is no way of determining the extent to which such factors still play a role in the selection process.

However, while it has been suggested that experiences in medical school are more important than background characteristics when students make career choices, clearly, these factors are interrelated. The availability of relevant role models, attitudes of professors and training opportunities are all important aspects of the medical school experience (Calkins et al., 1992:58). Role models are extremely important in terms of professional learning and development (Coombs and Hovanessian, 1988:22). The problem is significant for female students seeking relevant role models, since women still comprise a relatively small percentage of medical school faculty members (Whiting and Bickel, 1990:277). For example, as of October 1, 1990, there were only 58 women out of 290 full-time teaching staff (20%) in the University of Manitoba Faculty of Medicine (Institutional Analysis U of M, 1991).* Moreover, in the Faculty of Science at the University of Manitoba, where the majority of pre-med students are enrolled, as of 1990/91, women held only 8.3 percent of the full-time academic appointments (Caucus for Women, 1992). Obviously, there are not enough women to serve as role models for the increasing number of female students, particularly in the areas and specialties where women have been traditionally under-represented (Hapchyn and Gold, 1990; Elliot and Gerard, 1986; Osborn et al., 1992; Cohen et al.,1988; Nadelson, 1991). To illustrate, a 1986 U.S. study revealed that the percentage of women physicians in surgery departments is almost the lowest of all specialties (Burnley and Burkett, 1986:146). Furthermore, women are not only under-represented as full-time faculty

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* With regard to instruction and role models in all faculties at the University of Manitoba, based on 1990/91 statistics, the chance of a student encountering a male Full Professor was 40.4 percent (523 of 1295), compared to only a 2.8 percent chance (36 of 1295) of seeing a female Full Professor (Caucus for Women, 1992).

in medical schools, but the percentage of women faculty holding the MD degree is even lower (Burnley and Burkett, 1986:145).

Not surprisingly, female students encountered overt and covert forms of sexism from faculty, peers, and sometimes even patients. Grant (1988:110) concluded that:

> Faculty and hospital physicians were identified most often as the sources of gender discrimination. More than 80 percent of women's reports of discrimination toward themselves involved faculty or other physicians, and more than 75 percent of discrimination toward others emanated from physicians.

Clearly, women still encounter both overt and subtle forms of gender discrimination within the medical school environment. Furthermore, women continue to face gender discrimination primarily from faculty and staff physicians, and this is an important form of discrimination since these doctors can influence students' careers. Research on factors that influence career choice found that non-traditional careers for women are associated with a lack of role models, with not being taken seriously, and with a lack of confidence in one's competence (Calkins et al., 1992:58). Again, it is clear that these factors are all interrelated. Obviously, not only does gender discrimination create stress for women students, but it also reinforces "...the view that sexism is still an accepted and integral part of medicine in the real world, even if it is disavowed in formal policies of the medical school" (Grant, 1988:118).

Finally, it has been shown that female physicians of proven competence usually do not attain a level of reward that male physicians of similar accomplishments often receive. Studies of women in academic medicine uniformly show that women cluster in low level positions and

that their advancement is slower than that of males (Kettner, 1988; Dial et al., 1989; Lehart and Evans, 1991; Dickstein and Stephenson, 1987). Further, women are clustered in low, characteristically untenured faculty positions, largely in traditionally 'nurturant' specialties, and primarily in administrative posts dealing exclusively with student and minority affairs (Scadron, 1980:300). Women almost always earn less than their male colleagues (Scadron, 1980:301; Robinson et al., 1987:15; Ramos and Feiner, 1989:21), women physicians are promoted more slowly than men at all levels of the academic ladder (Silver, 1991:19; Bernstein and Donoghue, 1991:87; Dial et al., 1989:198).*

It has also been shown that the average time necessary for women to attain full professorship was 20.8 years, as compared with 12.3 years for men (Wallis et al., 1981:2350). At the University of Manitoba Faculty of Medicine, there are 6 women out of 94 Full Professors (6.5%), 16 women among 96 Associate Professors (16.6%), 23 women out of 68 at the level of Assistant Professor (33.7%), and 1 woman out of 2 Lecturers (50%) (Institutional Analysis U of M, 1991). Unfortunately, information on the gender breakdown of untenured sessional faculty within the faculty of medicine is not available but, on its own, the ratio of female to male full-time staff clearly illustrates both the under-representation and the comparatively low status of women faculty in medical schools.* In addition, research also indicates that, although women physicians are often valued as colleagues, they are not seen as

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* At the University of Manitoba, on average, women academics earn 80.2 percent of what men earn (Caucus for Women, 1992).
* Overall at the University of Manitoba, women represent 60.7 percent of Instructors, 52.0 percent of Lecturers, 37.4 percent of Assistant Professors, 19.5 percent of Associate Professors, and only 6.4 percent of Full Professors (Caucus for Women,1992).

true equals and, furthermore, male medical students are least supportive of women in leadership positions within academia (Martin and Woodring, 1986:51-52; Coombs and Hovanessian, 1988:21).

Moreover, Lorber (1990) asserts that, although the medical profession can no longer be accused of open discrimination in terms of admitting, training and licensing women, female physicians continue to have limited control over medical resources and priorities (Lorber, 1990:2). She states that, as in other professions, there has been a "glass ceiling" on women's upward mobility: women physicians who aspire to the very visible top tier of positions hit invisible barriers when they try to attain them. As a result, women are under-represented in positions of authority (Nadelson, 1991:95). "Women physicians rarely direct large, prestigious services, are rarely heads of teaching hospitals, and are almost never heads of large medical centers" (Lorber, 1990:5). Lorber cites the 1988 naming of Mary A. Piccone as the head of the teaching hospital and medical center at the University of California as a rare exception, but she then adds that Dr. Piccone was not given the additional position of vice chancellor for administrative and business services at the campus, which was held by her male predecessor (Lorber, 1990:5,15). Clearly, the policy-making positions of greatest authority and greatest control over resource allocation are still held by members of the socially dominant group (i.e. men), "...and it is their values and priorities that prevail" (Lorber, 1990:7). As Lorber concludes, "women are kept out of the top positions by sexism that is ingrained in men's attitudes and built into the structure of career mobility" (Reskin cited in Lorber, 1990:7).

Clearly, there is still a pervasive 'Old Boys' Club' mentality within medicine. In fact, reports show that this informal social network continues to exclude women from the comradery, informal networking and 'fraternity' that develops among male colleagues. As reported in one study, although work obligations were often fully shared, women felt that they were denied access to informal benefits (Coombs and Hovanessian, 1988:21), a point illustrated by one female resident:

> I am easily included in talks about who is going to take call on nights when nobody is around...I'm one of the group then. But when it comes to informal discussions about money-making schemes or how to set up a private practice, I don't get included in those conversations very much.

Not surprisingly, this Old Boys' Club mentality is also reflected in the research describing women's experiences of sexism and discrimination within medical training. One U.S. study reported that female students encountered overt and covert forms of sexism from faculty, peers, and sometimes even patients. Overall, 34 percent of the women said they had personally experienced gender discrimination, while 62 percent had observed gender discrimination toward classmates. Thus, while the majority of women did not perceive themselves to be victims of gender discrimination, they perceived that it existed in the medical school (Grant, 1988:109,110). Compared to women, however, men perceived less discrimination. Most gender discrimination perceived by men was blatant and overt. They were considerably less likely than women classmates to report subtle or covert discrimination. Men were also much more likely than women to attribute a measure of blame to women who were targets of gender discrimination for the incidents they observed. A minority of men perceived that males were disadvantaged on the basis of gender and

were victims of 'reverse discrimination.' Finally, for men, but not women, there appeared to be an association between academic standing and perception of gender discrimination. The men with higher class ranks (in terms of grades and clinical ratings) were more likely to perceive gender discrimination toward women. This was especially true for subtler forms of discrimination (Grant, 1988:117). Similarly, another study reported that 80 percent of the women surveyed encountered discrimination and/or discouragement in professional life - 30 percent during medical school, 15 percent during internship, 40 percent during residency, 20 percent post training (Janus and Janus, 1987:55). Another study stated that within a one year period, 54 percent of women physicians and medical students encountered some form of gender bias and/or sexual harassment (Lenhart and Evans, 1991:121). Most respondents in a study surveying female anesthesiologists also reported that being female had caused problems, including difficulties in obtaining jobs, promotions, and salaries comparable to those of male colleagues (Robinson et al., 1987:15). Finally, yet another study reported that "the same themes - social isolation due to an 'Old Boys Network,' preoccupation with sex status, differential role demands, and inappropriate role models" keep resurfacing in research on women in medicine (Coombs and Hovanessian, 1988:21).

It is apparent that gender inequalities in medicine are pervasive because they are built into social institutions and maintained by everyday assumptions about appropriate work and roles for women and men both inside and outside of the home. Interestingly, it has also been shown that female physicians often structure their own analyses of the

medical system in terms of being "women in medical school," while men more often contextualize their experiences in terms of being "students in medicine" (Poirier, 1986:83). Again, this suggests the importance that gender plays within the medical school environment.

As Ehrenreich and English (cited in Lorber, 1975:89) have argued:

> The sexism of the health system is not incidental, not just the reflection of the sexism of society in general or the sexism of individual doctors. It is historically older than medical science itself; it is deep-rooted, institutional sexism.

The aim of this study is to examine the experiences of women medical students, especially in terms of their perceptions of the persistence and consequences of various forms of sexism within their training programs. As stated earlier, this study is an examination of the **latent patriarchal culture** of the medical school. The issues discussed previously - the gender-tracking system, the absence of female role models and the lack of mentors, and more generally, the unequal expectations, the sexist and/or exclusive behaviours, and the informal understandings that exist within medical school - are all significant in shaping the experiences of women medical students. Researchers have reported that students' adaptation to the medical school environment is important as it directly relates to learning and professional performance (Vitaliano, 1989:1327). Consequently, this study is directed at discovering how women medical students perceive their environment in relation to the issues discussed in the literature, and how this perception is relevant to their overall experience.

CHAPTER THREE - METHODOLOGY

This study was undertaken using qualitative research methods. I conducted individual, face-to-face interviews with each participant. I chose this method of data collection because of its particular strengths and its amenability to the goals of the study. In-person interviews are most efficient when a researcher is attempting "to reach rare sub-groups in the population who can be identified by their location in time or place" (Backstrom and Hursh-Cesar, 1981:20). The face-to-face interview is also recommended when dealing with complicated topics, as it allows considerable flexibility in terms of length of the interview and style of questions (Backstrom and Hursh-Cesar, 1981:18; Woodward and Chambers, 1986:11). Further, the in-person interview is also recommended when the issue is salient to the respondents. In-person interviews facilitates sensitive and appropriate in-person probing which usually can lead to a more in-depth understanding of complex issues (Backstrom and Hursh-Cesar, 1981:19). In addition, the face-to-face interview allows for the development of better personal rapport between the interviewer and respondent (Backstrom and Hursh-Cesar, 1981:19).

For certain issues, qualitative methods are highly appropriate, not because they are necessarily more suited for research involving women, but because they are particularly appropriate for exploring subjective experiences. Moreover, discussions of feminist methodology generally criticize the hierarchical, exploitative relations of traditional research, urging feminist researchers to select and develop more intersubjective and egalitarian research processes.

The overt ideological goal of feminist scholarship in the social sciences is "...to correct both the invisibility and distortion of female experience in ways relevant to ending women's unequal social position" (Lather, 1988:571). Feminism presupposes that women's oppression must end and, therefore, it necessitates a commitment to working for change. Thus, "...feminist research can be defined as research that is informed by a commitment to social justice for women, and/or research that exposes prevailing sexist biases, and/or creates unbiased alternatives, and/or constructs reality from a female perspective" (Eichler, 1987:47). Although, as Eichler admits, this is an extremely broad definition, it nevertheless does make a statement about the content of feminist research. Feminist scholars start by placing women at the centre, as subjects of inquiry and as active agents in the gathering of knowledge (Stacey and Thorne, 1985:303). This strategy makes women's experiences visible and reveals "...the sexist biases and tacitly male assumptions of traditional knowledge" (Stacey and Thorne, 1985:303).

Judged by such criteria, the in-person interview appears ideally suited to feminist research. The approach is contextual, interpersonal and experiential (Dubois, 1983:109). Moreover, because the researcher is the primary 'instrument' of research, this method draws on qualities such as empathy, connection and concern that many feminists argue should be central in feminist research (Stacey, 1988:22). The in-person interview can also provide greater respect for and power to the research 'subjects' who, some feminists propose, "...can and should become full collaborators in feminist research" (Stanley and Wise, 1983:206).

Feminists have also exposed the myth of objectivity and rationality that exists within the patriarchal framework. Their work reveals that all research involves as its basis a relationship or interaction between researcher and researched. Moreover, this relationship and its ensuing effects always exist because the researcher inevitably relates in terms of preferences, likes, dislikes, and sometimes unconscious biases, even if of a theoretical and/or ideological nature (Stanley and Wise, 1983:372).

One disadvantage of in-person interviews that is often cited in traditional sociological literature is that 'accurate' and 'objective' answers are difficult to obtain because of the increased likelihood of social desirability bias and interviewer distortion (Backstrom and Hursh-Cesar, 1981:18). Since this study is informed by feminist analysis and theory, this issue can also be addressed in reference to the feminist critique of social science research.

The ideals of neutrality and objectivity in the social sciences has been extensively criticized. The idea of objectivity is to remove the particular point of view of the observer from the research process so that the results will not be biased by the researcher's subjectivity. The traditional interview has been regarded as (Goode and Hatt cited in Oakley,1981:32):

> An information-gathering tool...designed to minimize the local, concrete, immediate circumstances of the particular encounter - including the respective personalities of the participants - and to emphasize only those aspects that can be kept general enough and demonstrable enough to be counted.

The key to successful traditional interviewing, then, is for the interviewer to strike a balance between the warmth required to generate

'rapport' and the detachment necessary to maintain 'objectivity' (Oakley, 1981:32).

A major preoccupation of traditional interviewing technique is to ensure that respondents do not engage in asking questions back. Guidelines warn the interviewer never to provide any indication of beliefs and values - never to answer questions. The reason why the interviewer must not answer questions or pretend not to have opinions is because doing otherwise might 'bias' the interview. 'Bias' is said to occur when there are differences in the way interviews are conducted, resulting in differences in the data produced. "Such bias clearly invalidates the 'scientific claims' of the research, since the question of which information might be coloured by interviewees' responses to the interviewer's attitudinal stances and which is independent of this 'contamination' cannot be settled in any decisive way" (Oakley, 1981:36). The paradigm of the traditional interview emphasizes, then (Oakley, 1981:36-37):

> (a) its status as a mechanical instrument of data-collection; (b) its function as a specialized form of conversation in which one person asks the questions and another gives the answers; (c) its characterization of interviewees as essentially passive individuals, and (d) its reduction of interviewers to a question asking and rapport-promoting role.

Taking a feminist perspective adds to the critique of traditional social science methodology in some important ways. The feminist critique rejects the notion that such a separation is possible, and argues that "the illusion of this separation can be maintained so long as the knower can be posited as an abstract being and the object can be posited as the 'other' who cannot reflect back on and affect the knower"

(Acker, Barry and Esseveld, 1982:427). It has also been pointed out that traditional research is embedded in a definite social relationship in which there is a power differential in favour of the 'knower' who assumes the power to define in the process of the research. Research reports have thus reflected only one side of this social relationship - that of the more powerful 'knower' (Acker, Barry and Esseveld, 1982:427). Therefore, feminists contend that researchers must openly acknowledge their bias or point of view. Only when an explicit point of view is articulated can others see the implications of the research that is presented and, in turn, evaluate the research within an appropriate context (Adamson, Briskin and McPhail, 1988:17).

In regard to the present study, the open-ended questions dealing with perceived sexism/gender discrimination are of particular importance to the theoretical and methodological framework of the study. Because of their importance, there was a need for informed interaction and appropriate probing by myself, the interviewer. Furthermore, because of the complexity of the issue at hand, it may have been difficult for the respondent to recognize and/or articulate incidents of sexism/gender discrimination within the medical school environment. Therefore, it was necessary that I was sensitive to these issues, as well as to the difficulties surrounding such a complex and controversial topic. It was critical that I ensured that interaction took place within an open and informed, yet non-threatening, non-judgemental and confidential forum. Only if these conditions were met could valuable data be compiled.

As the orientation of this research is towards the validation of women's subjective experiences as women and as students in medical

school, a non-hierarchical relationship was established between myself and each woman I interviewed. The research process became a dialogue between the researcher and researched, and an effort to explore, clarify and expand understandings - as both each medical student and I are individuals who reflect upon our experiences and who can communicate those reflections (Oakley, 1981:33). This is inherent in the situation; neither the subjectivity of the researcher nor the subjectivity of the researched can be eliminated in the process. As Oakley asserts in her critique of traditional sociological research methods, "...the hierarchical, objectifying, and falsely 'objective' stance of the neutral, impersonal interviewer is neither possible nor desirable... meaningful and feminist research depends instead on empathy and mutuality" (Oakley, 1981:65).

The fact that the research process was informed by a feminist theoretical perspective is also made explicit throughout the analysis and reporting of findings. This strategy is again in direct response to the often cited criticism of a lack of 'objectivity' regarding in-person interviews and, indeed, qualitative research in general. As Bunch states, "...we operate consciously or unconsciously out of certain assumptions about what is right or what we value (principles), and out of our sense of what society ought to be (goals)" (Bunch, 1987:244).

The Research Process

Between October and December of 1991, I interviewed 21 women who were at various stages of the 4 year undergraduate medical training program at the University of Manitoba. To begin with, I received permission

from the Faculty of Medicine Committee on the Use of Human Subjects in Research (see Appendix A) to conduct my research at the University of Manitoba Medical School. Then, in early October, with the assistance of the Assistant Dean for Student Affairs, a notice briefly describing the research and soliciting participation of female medical students was left in all students' (both female and male) campus mailboxes at the Faculty of Medicine (see Appendix B). Students then self-selected into the study by leaving a message at a number provided and an interview was set up at their convenience. A second reminder notice was left in the mailboxes of all female medical students approximately mid-way through the data collection (see Appendix C). I received 24 responses in total, but 3 women were ultimately unable to participate because of schedule conflicts during that time period. Ten of the respondents were women in the preclinical stage of medical training (Med I and II), and eleven were women in the clinical component (Med III and IV).

The respondents in this study constitute a purposive sample. Women in medicine at the University of Manitoba have been deliberately selected because they are judged to be knowledgeable about the topics to be covered during the interview (Backstrom and Hursh-Cesar, 1981:65). Purposive sampling is recommended when the researcher is attempting to select a sample of observations that will yield the most comprehensive understanding of the subject under study (Babbie, 1989:269). The objectives of purposive sampling are to select a sample that is both useful in terms of the research aims and representative of the population. A purposive sample, then, is selected based on the researcher's knowledge of the population to be studied, its elements, and the nature of the research aims (Babbie, 1989:204).

Further, quota sampling was also used in an attempt to achieve better representativeness within the sample. In quota sampling, participants are selected into the sample on the basis of prespecified characteristics, so that the total sample will have the same distribution of characteristics that are assumed to exist in the population being studied (Babbie, 1989:205). In light of this research, I made every attempt to ensure that an equal representation of women from each of the four years of medical school were interviewed. In general, my aim was to obtain an equal representation of participants from both the preclinical and clinical stage of medical education.

The nature of the study was discussed with each participant at the time of the interview. Participants were also asked to sign a letter of informed consent outlining the research intent, as well as their rights in the process (see Appendix D). The orientation of this research was towards the validation of women's subjective experiences as students in medical school. This study was directed at discovering how women medical students perceive their environment and how this perception was relevant to their overall experience. More specifically, the study aimed to identify the effects and consequences of the medical school environment at the University of Manitoba in terms of women's perceptions of the persistence of sexism within their training programs.

As stated previously, it has been argued that the internal climate of medical school is strongly influenced by a **latent patriarchal culture** Beliefs about women and men, and expectations of appropriate behaviour are an important part of latent culture. Furthermore, those who share the latent culture have a sense of belonging, while those who do not

share the beliefs, meanings and behaviours may feel alienated and marginal. To the extent, then, that the medical school is a patriarchal institution, and that women experience sexism within this institution, it is presumed that they will also experience the manifest consequences of this sexism. Such consequences may include increased feelings of stress followed by various means for dealing with this stress. The concept of latent culture also suggests that feelings of isolation and marginality may also accompany experiences of sexism. In keeping with the study aims of examining the **latent patriarchal culture** of the medical school environment, these issues were also addressed in the interview. In addition, several questions regarding demographic information were included at the end of the interview for descriptive purposes.

The information was gathered by way of an individual tape-recorded interview that lasted, on average, between 1 and 2 hours. Students were asked if they had experienced differential treatment based on gender, and if they had observed similar treatment of classmates and/or faculty. The form of the questions allowed students to report both favourable and unfavourable treatment. The interview touched on all aspects of medical school experiences, beginning with the admissions interview through to structured learning settings, course content and materials, interactions with professors and peers (both during and outside of class), and informal and social activities related to medical school. Although I directed specific questions, participants were encouraged to elaborate on their answers and to raise issues not directly related to these questions (see Appendix E for interview guide).

Throughout the interviews, I concentrated on not imposing my ideas about what was important. My intention was to let the concepts, explanations and interpretations of those participating in the study become the data that I would analyze (Glaser and Strauss, 1967:64). At the same time, however, it was impossible not to be aware of my own definition of reality, as well as my own theoretical ideas. Indeed, as Unger states, "...models of reality influence our research in terms of question selection, causal factors hypothesized, and interpretation of data" (Unger, 1983:9).

In response to Unger's statement, then, it is important for me to state that I identify myself as a feminist activist who is committed to furthering the feminist movement, both outside of and within academia. I am white, middle-class, and I was 28 years old at the time of the data collection. As a feminist sociologist, I am interested in engaging in research that centres feminist theory and principles within sociological inquiry. However, my position as a feminist activist demands that my research goals go beyond those of traditional sociological research. That is, my aim is to analyze gender within a social and societal context and, consequently, to learn from women's experiences. In addition, my goal is to engage in action-oriented research wherein the results can be used to improve women's position in society. Ristock (1989) uses the term 'location' to describe the differing interests and roles that individuals have (Ristock, 1989:40). She further explores some of the contradictions and struggles that arise when one engages in feminist research while at the same time, attempting to validate and balance the other locations one has as an individual (Ristock,

1989:38-45). Much of her discussion centres around the notion of power within feminist research, and the unclear distinction and resulting tension between empowerment and the misuse and/or abuse of power. As Ristock states (1989:40):

> As feminists we have been aware of the unequal power and the exploitative propensity inherent in this relationship (Harding, 1987). We discuss the issue theoretically and struggle to derive new methodologies and meta-theories to circumvent the power-over kind of research relationship. To this end, we treat our research participants with respect and equality; we locate ourselves within the questions we ask in our research; we seek to make our research socially useful, but - the issue of power remains - regardless of our attempts at sisterhood, thoughtfulness and sensitivity.

While this issue has been explored extensively at a theoretical level within feminist literature, discussion and analysis of the many contradictions and struggles that arise from integrating 'competing' locations during the actual process of feminist research has been absent from the feminist literature. That is, while feminists have criticized extensively the myth of 'hygienic research,' and urged researchers to disclose their inherent theoretical biases and to engage in honest reporting of the research process, I was unable to find anything within the feminist literature that described the struggles and tensions which result from attempting to integrate the principles of feminist research within the reality of patriarchal institutions (i.e. the university, the medical profession). In other words, there is virtually no open discussion of the inherent theoretical and methodological compromises, struggles, and tensions involved in actually. doing feminist research.

To illustrate, Ristock describes the contradictions between her role as a feminist researcher and as a feminist activist, which stemmed from

her discomfort with the power relations embedded in the research process. The range of feelings - from guilt to satisfaction - which she experienced lead her to conclude that, "...the feminist discussions of research have yet to fully describe the complexity of power and struggles with subjectivity in research" (Ristock, 1989:41).

Similarly, during this research, I also experienced tensions and contradictions between my location of feminist activist and feminist sociologist and, similarly, I also experienced feelings ranging from discomfort and guilt, to pride, satisfaction and a sense of accomplishment. Contrary to Ristock's research experience, though, while she was faced with the 'need' to de-emphasize her role as an academic researcher in order to gain access to the group of feminist women that she was 'researching,' my discomfort arose when I found myself downplaying my identity as a 'feminist' in order to proceed with my research. For example, when writing to the Faculty Committee on the Use of Human Subjects in Research for approval of my research proposal and permission to gain formal access to women medical students, I felt the need to temper my language; specifically, to avoid use of the 'F-word' (feminism) altogether. My feeling was that feminist research was still seen as biased and unobjective within the conservative environment of the medical college - indeed, within the university as a whole - and therefore, in order to gain access, I would have to avoid appearing inflammatory, biased and/or unobjective. In retrospect, seeing the concern that was expressed over the fact that my "...subject selection was non-randomized (and therefore) the results could be skewed" (see Appendix F). I feel that my decision to avoid the obvious

red flag of feminist language was pragmatic. However, I still feel uncomfortable about this decision. While the feminist literature articulates the necessity of identifying one's theoretical framework in order to avoid false objectivity, there is a blatant lack of discussion centering on the difficulties one encounters and the compromises one often makes in order to do feminist research in some milieux.

Similarly, although I explained the nature of my research both verbally and in writing (up to three times for some participants - two letters soliciting participation and a letter of informed consent), and the language that I used made it clear that my research was feminist, or at the very least, unmistakably woman-centred in orientation, I still refrained from explicitly labeling myself as a feminist to the women that I interviewed. This further became more of a conscious effort on my part early on in the interview process, when I discovered that 'feminism' was not perceived favourably by many at the medical college, but, was seen as being radical, extremist and biased. Again, I felt especially uncomfortable about this conscious effort to de-emphasize my feminist orientation, although I would not and did not hesitate to identify myself and my research as such when asked by any of the participants. Yet, at the same time, I feel that this compromise was justified and pragmatic. To illustrate, I feel that I was able to get much richer and fuller sharing from women by building up a sense of trust. I endeavored to reassure each participant that there were no right answers, but rather, that I was interested solely in her perceptions and her experiences. By expressing a sincere, non-judgemental attitude and environment, I feel that I was able to show

my respect for the women. It was my perception that women who had initially suspected that I was a feminist and who had expressed a measure of hostility and defensiveness towards what they defined as feminism, seemed to become more at ease when they realized that I was not going to prejudge them or push my own views on them. To a certain extent, as well, I resolved this methodological/theoretical dilemma by keeping my own voice to a minimum during all of the interviews. That is not to say that I shunned questions about my research, but, that I endeavoured to minimize my own comments and to let the women explore their own experiences and perceptions. In fact, I usually spoke only to ask questions or to probe. While this may sound suspiciously like the traditional interviewing technique that I critiqued earlier, again, the critical distinction was that at all times I was prepared to respond to questions and to invest myself personally in the research process. Interestingly, extended discussions regarding my research perspective and the like usually came after the 'formal' interview.

I feel that it is important to include this discussion of the contradictions and struggles that I experienced during my research, in part, to continue the feminist tradition of debunking the myth of 'hygienic research.' In addition, I believe that it is equally important that feminist researchers begin to discuss openly the 'real' problems that are inherent in doing feminist research - problems that result primarily from the competing locations that women occupy as academics, activists, and more. Clearly, there are no simple solutions to resolving the tensions between 'pragmatism within patriarchal institutions' and the 'ideal feminist framework' when doing research.

In light of the absence of feminist discourse in this area, I feel that it is imperative that discussion begin. Ultimately, as in all feminist work, the goal is to continue to come together as women, to share our experiences and our expertise and, in doing so, "...to correct both the invisibility and distortion of female experience in ways relevant to ending women's unequal social position" (Lather, 1988:571).

The Organization and Analysis of Data

My research goal was two-fold: to identify common themes and also differences in experience. I transcribed the tape-recorded data from the interviews and analyzed the content qualitatively in order to document the experiences and perceptions of the women. To begin, I dated and lettered each tape in chronological order from A to U, and followed this alphabetical order when I transcribed my data. I transcribed each interview by hand into five notebooks. On paper, all interviews were identified only by the ID letter that I had previously assigned. The interviews were not transcribed verbatim, rather, I transcribed the text accurately, omitting speech nuances that did not affect the content and/or the intent of the interview (i.e., repetition of words, um's, ah's). I also devised a series of abbreviations for words that appeared frequently within the interviews. As well, since I had followed my interview guide closely during the interviews, I transcribed my own questions, probes and/or comments only when they differed in any way from my schedule (see Appendix E). Otherwise, I made a notation of the relevant question number in the appropriate location in the written transcript. In order to facilitate the process of retrieving verbatim quotations for the text of my thesis, I also the

labeled the beginning of each question and response according to the corresponding number that appeared on the tape-counter.

When I had completed the process of transcribing my data, I read over all of the transcripts five times. I read the transcripts with the intention of highlighting common themes and differences in experiences, in terms of the perceptions and consequences of sexism. I then created separate 'theme' or 'concept' lists, consisting of a heading followed by the specific relevant examples, which were identified by the interview ID letter, and the numbered location on the tape counter. Again, during this process, I reviewed the transcripts several times until I was satisfied that I had selected all of the appropriate examples from my data.

Next, I began to formulate an outline for the reporting of my findings. This outline emerged both from the focus of my interview guide, as well as from the insights and direction of the women's responses. As I began to connect general themes and organize my presentation, I again listened to the tapes and then selected the quotations that I thought would best support my emerging analysis.

It is important for me to make clear that my biases and subjectivity influenced this stage of the research process. I decided purposely to include quotations based on my assessment of strength and appropriateness of each to illustrate an aspect or issue of my analysis. Furthermore, selecting one particular quote did not preclude that other women had also voiced a similar opinion in some instances. Moreover, while I have selected the specific quotations which appear in my thesis

based on my own organizational structure, the spirit, insights and analysis of the women that I interviewed have also guided my work.

When I proposed this research, I had expected that women in their first year of medicine would have limited interaction within the faculty, with their peers and within the program itself and, consequently, many would not have given considerable thought to their overall experience. This group, I hypothesized, would provide baseline data in order to show what, if any, effect the medical school environment had on women's experiences. My following assumptions were that women in their second year would have interacted more extensively with all aspects of the academic medical training program, and thus they would be able to provide an increasingly rich and thorough account of the preclinical experience of women in medical school. Finally, women in their third and fourth years would have reached the clinical component of medical education and, consequently, they would be able to provide an additional account of their formal and informal learning experiences involving patients, their peers, and other medical practitioners on the hospital wards. I would then draw general comparisons between women's experiences during the preclinical and clinical stages of medical education. In total, the proposed study allowed for women at every stage of the four year undergraduate medical program to give voice to the diversity and commonalities of their experiences.

However, once I had completed the interviews and I began my analysis, it became apparent to me that, based on my relatively small sample size, as well as the nature of the women's responses, I was not able to make

such a direct inference from my data. My sense is that my original presupposition is logical and did, indeed, influence each woman's responses. That is, the more time each woman spent within the **latent patriarchal culture** of the medical school, the more she would experience and perceive the manifestations of this patriarchal culture. However, with the benefit of this research experience, I now realize that the relationship between each woman's number of years in medical school and her perceptions of sexism is complex and involves many factors. Based on the data that I did collect, it became apparent to me that one of the significant factors influencing the nature of the women's responses was their life experiences outside of the medical school.

Therefore, based on my interviews with 21 women, my contention is that the women's life experiences - which included their political awareness of sexism; degree of feminist consciousness; previous education; work and/or volunteer experiences; in addition to their year in medical school - created the context within which they understood, perceived and experienced sexism within the medical school environment at the University of Manitoba. To illustrate, I discovered that some women in first year described perceptions of subtle or covert sexism as significant, that some women in later stages of their training dismissed as trivial. Some women in the preclinical years also perceived more incidents of sexism and had a more pessimistic impression of medical school overall, than some women in the clinical stage. Consequently, I refocused my emphasis for analysis, and I examined the prevalence, sources and forms of perceived sexism or gender discrimination and its consequences in general, among female medical students.

Briefly, at the most general level, sexism or gender discrimination has been defined as "...behaviour, conditions, or attitudes that foster stereotypes of social roles based on sex" (Merriam-Webster, 1983:1079). While the impact of differential treatment can be positive, negative or neutral, the terms 'sexism' or 'gender discrimination' generally imply a negative impact. Sexism or gender discrimination exists on a continuum, and involves behaviours, actions, policies, procedures, interactions, and the like, that affect women adversely "...due to disparate treatment, disparate impact, or the creation of a hostile or intimidating work or learning environment" (Lenhart and Evans, 1991:78). Although such categorizations are not fixed, for purposes of definition and clarification, 'blatant sexism' is often identified as being an obvious or overt action, gesture, statement or incident of a discriminatory nature (Grant, 1988:116). Sexual harassment may be included as a form of blatant sexism, and researchers studying sexual harassment have identified a continuum of behaviours as harassment, including: "sexual remarks, jokes, teasing, questions; staring, suggestive looks and gestures; pressure for dates; deliberate touching, leaning over, caressing; pressure for sexual favours; letters, phone calls, written materials, and pictures; actual or attempted sexual assault" (Lenhart and Evans, 1991:78).

'Subtle sexism' can involve acts of commission or omission - failure to provide for the discriminated-against group some benefit or privilege accorded other groups. Again, examples involve gestures, statements, and actions which may be both conscious or unconscious in intent, and might or might not be recognized by perpetrators and targets (Grant,

1988:109,116). The focus here is on internalized perceptions of the 'proper roles' of women and men, therefore, perpetrators may feel that they are acting in a 'normal' and/or acceptable manner. Examples may include conscious or unconscious slights, or involve exploitation of women, and/or female invisibility (Lenhart and Evans, 1991:78).

Finally, 'covert sexism' is built into the fabric of 'normal,' everyday happenings within our social institutions. It can rarely be traced solely to the actions of one or a few individuals (Grant, 1988:117). It is also known as 'systemic discrimination,' and as the term implies, it is built into policy and practice of organizations. It is distinguished from deliberate differential treatment on the basis of sex, although intentional and systemic discrimination usually co-exist (Manitoba Human Rights Commission, 1992). Furthermore, the unintentional nature of certain forms of covert or systemic sexism makes it difficult for some people to appreciate its damaging effects and consequences (Lenhart and Evans, 1991:79). Therefore, while it is often difficult to make concrete distinctions between the various categories of sexism, the fundamental point to remember is that it is the perception of the consequences that the victim holds, and the reaction of the perpetrator, which are important. This final point is especially important here, since the basis of this study is women's perceptions of sexism or gender discrimination within the medical school environment.

The concept of 'boundaries' has been previously used by Gerson and Peiss to mark the social territories of gender relations, "signalling who ought to be admitted or excluded" (1985:319). These authors state that the analysis of boundaries may be useful in assessing the stability

and change in interactions between women and men. For example, boundaries within the workplace (e.g., occupational segregation) and interactional, micro-level boundaries assume increased significance in defining the subordinate position of women. For women entering nontraditional occupations, boundaries maintain women's marginal and subordinate place. Micro-level phenomena - the persistence of informal group behaviour among men (e.g., after-work socializing, the uses of male humour) - act to define insiders and outsiders, thus maintaining gender-based distinctions (Kanter cited in Gerson and Peiss, 1985:320).

Merton (1957:425) in his discussion of the maintenance of group boundaries states that there is nothing fixed or eternal about the lines separating the in-group from out-groups. As situations change, so do the lines of separation. However, once it becomes apparent that members of an out-group have too many of the in-group values, members of the in-group engage in discrimination in an attempt to control the out-group and, in doing so, return the 'natural order' (Merton, 1957:430).

The processes of negotiation and domination are also described as important and related phenomena. Here, Gerson and Peiss state that while women are not responsible for their own oppression and exploitation, at the same time they are not fully passive either. Therefore, it is important to explore the various ways that women participate in setting up, maintaining, and altering the system of gender relations. These concepts do not presume that women somehow ask for the sexism that they experience, but rather that domination and negotiation together may explain the ways that women are oppressed and either accommodate to, resist, or bargain for privileges and resources

(Gerson and Peiss, 1985:322). For example, women are now 'invited' to enter traditionally male occupations, but the consequences of the negotiation are contradictory: by insisting that women be 'male' in their job performance while retaining their 'femaleness,' the rules ensure that women will remain outsiders (Gerson and Peiss,1985:323).

One important strategy by which group boundaries are maintained is the enforcement of 'double-binds' (Eichler, 1987; Fuchs-Epstein, 1988; Unger,1988). Double-binds exist when behaviour that is practiced and emulated as virtuous by members of the in-group is regarded as inappropriate and wrong when practiced by members of the out-group (Fuchs-Epstein, 1988:151). Furthermore, not only are members of the out-group likely to be sanctioned for adopting the virtues of the in-group, but they are similarly punished when they do not. Thus, double-binds ensure that the person incurs a penalty regardless of her behaviour (Unger, 1988:132-33). When women strive for success, they are said to be adopting 'male values' and to be engaged in deviant behaviour. Yet, women who do not employ such strategies are seen as 'too feminine' to succeed (Fuchs-Epstein, 1988:151). As Unger asserts (1988:133,135):

> When women step outside of their 'proper sphere,' they become subject to contradictory categorizing, which makes them susceptible to double-binds. ...Double- binds are a subtle and destructive form of social control. They make it difficult to locate the source of conflict, and therefore may make it more likely that the source of problematic behaviour is located within the individual.

Consequently, anticipated accounts of perceived sexism have been organized according to emergent similarities and/or differences among the participants' interpretations. Such accounts may include:

incidents of perceived stress (the individual's perception of mental or physical tension, pressure and/or strain), as well as related coping mechanisms, accounts of degree of affiliation with the medical school environment, and, in conjunction, accounts of the persistence of boundaries and double-binds. Essentially, the aim is to understand better women's experiences - "the general pattern of a culture" (Spradley, 1979:185) - by identifying recurrent themes.

Problems of Research/Analysis

My commitment to minimizing the traditional power differentials of the research relationship was challenged during the data analysis. It is unavoidable that I must at some point assume the role of the person with the power to define. The act of looking at interview data, summarizing another's experience, and placing it within a context is an act of objectification. In light of the struggle and contradictions that I experienced between my locations as feminist sociologist and feminist activist, I was conscious of the inherent danger of exploitation of the research participants. My concern about respecting women's perceptions and voices and learning from women is juxtaposed with the need to ask questions, to analyze and explore, and to further our understanding about women's place within society with the goal of improvement.

The question, then, becomes how to produce an analysis which reflects critically on and attempts to interpret the experiences of women in medicine, while still representing their subjective experiences? How do I explain the experiences of others without violating their reality?

This is part of a larger problem: a critique of objectivity which asserts that there can be no neutral observer who stands outside the social relations she observes. This can easily become "...a relativism in which all explanations are subjectively grounded and therefore have equal weight. Clearly, when all accounts are equally valid, the search for 'how it actually works' becomes meaningless" (Acker, Barry and Esseveld, 1983:429).

The research perspective outlined also makes problematic the conventional ways of evaluating the products of research. For example, how should it be decided whether the research - the knowledge developed - is worthwhile? How can the findings be shown to be valid? Qualitative analysis has provided valuable insights into women's lived experiences. However, such studies are rare, in part, because they are time consuming. Also, they are considered somehow less legitimate than statistical analysis. Many social scientists would argue that 'facts' and numbers are more reliable and accurate than data collected from lengthy hours spent in conversations. This bias reflects the priority given to the collection of some kinds of data; those that are easily counted, frequently repeated, and amenable to statistical analysis (Armstrong and Armstrong,1987:69). Furthermore, "qualitative data are often dismissed as anecdotal, as unscientific, and as unrepresentative because they do not include a statistically selected sample of the target population" (Armstrong and Armstrong, 1987:75).

The first question about the development of worthwhile knowledge is answered in terms of the emancipatory goal of feminist research. Here, knowledge can be deemed worthwhile when findings contribute to the

women's movement in some way or "...make the struggles of individual women more effective or easier by helping to reveal to them the conditions of their lives" (Acker, Barry and Esseveld, 1983:431). However, it is clear that an emancipatory goal is no guarantee of an emancipatory outcome (Acker, Barry and Esseveld, 1983:431).

The second question - how to decide what is true or valid? - is a question that is common to all social science research. As stated previously, though, feminist research differs in how 'truth' is conceived. Feminist research is not interested in prediction, but rather in reanalysis and reconstruction. Thus, the focus is on the adequacy of interpretation (Acker, Barry an Esseveld, 1983:431). Validity of the research is therefore measured in terms of how fairly and accurately the results reflect the subjective experiences of the participants. This, in turn, involves the quality of the data analysis - the selection, organization and interpretation of the findings (Acker, Barry and Esseveld, 1983:431). In qualitative work, the accuracy of listening and hearing is as important as the openness of the dialogue. Clearly, while the 'problems' of qualitative research are not easily dismissed within the social science community, the strengths also speak for themselves. Qualitative interview data has the capacity to provide a fuller account of women's experiences. What follows then, is a description and analysis of my research findings.

A Further Methodological Note

In the presentation of the data I have refrained from identifying individual quotations in any manner. In essence, this decision resulted

from the tension that I experienced between my commitment to ensure complete respondent confidentiality, and the convention in qualitative research of identifying individual respondent's quotations. This identification is done in order to provide the reader with a context for interpretation and understanding of the data. These two principles of research created a methodological and ethical dilemma for me for several reasons.

First, and ultimately most fundamental to me, was the Statement of Informed Consent (see Appendix D) that all of the respondents signed, in which I guaranteed that "...any information given within the course of this interview will be held in strictest confidence and that in no way will (their) identity be revealed during any stage of the data analysis or in publication." In addition to this written document, I assured each respondent verbally that she would in no way be identified in the text of my thesis - only quotations on their own would appear in the report of the findings. Consequently, based on both my verbal and printed assurances, I resolved that ethically, I was unable to identify each quotation in any manner, be it numerically from '1 to 21,' as 'preclinical' or 'clinical,' as Med I, II, III, IV, or any combination of the above.

A related concern of mine was that my sample size was relatively small, and most of the data was extremely sensitive and had the potential to jeopardize my respondents' positions within the medical community at the University of Manitoba. An explicit commitment to the welfare of one's research participants is a fundamental principle of feminist research (Fonow and Cook, 1991:10), and the implicit caveat is

that a feminist researcher must endeavour at all times not to betray the trust freely given by her respondents (Fonow and Cook, 1991:8-9). Moreover, "a feminist has a special responsibility to anticipate whether findings can be interpreted and used in ways quite different from her own intentions" (Fonow and Cook, 1991:9). Consequently, based on these fundamental principles of feminist research, I resolved this methodological and ethical dilemma by refraining from identifying individual quotations in any manner, throughout my thesis.

However, this decision was not made without considerable introspection, discussion, and reflection. Part of the difficulty for me was that during this process, I came to the realization that the absence of identified quotations might weaken my research for some readers. That is, the resulting disadvantage is the absence of a time and/or space context within which to locate and evaluate each quotation.

Again, it is important for me to reiterate that I did not make this decision without serious consideration of such implications. Several important factors influenced this process. To begin with, after my data collection was complete, I realized that my initial assumption - that women in first year would provide the baseline data that others would supplement - was inappropriate for the organization and analysis of my research. Based on this factor, I decided that the necessity for the reader to be able to identify and compare women's quotations in each cohort was not integral to my method of reporting. The focus of my analysis is not individual voices specifically, but rather, on the individual voices of women that collectively articulate perceptions of sexism within the medical school environment.

Another related concern that surfaced for me was the issue of how to assure the reader that I had selected quotes from each and every respondent. Clearly, this is not evident from the report, and therefore, this issue is not effectively or completely resolved by the decision that I have made. I can only assure the reader that I endeavoured, at every step of my data analysis, to represent the insights and perceptions of every woman that I interviewed. However, not all women are represented equally in terms of the number of quotations from each that I have chosen to highlight.

It is again important for me to acknowledge openly my bias and subjectivity as a researcher. In many instances, more than one woman spoke about a specific incident, yet the particular quotation(s) that I selected to represent this perception reflected my own personal preferences in terms of language, style, composition, structure, and the overall strength and impact that I believed the quote carried.

Moreover, it is also important for me to state that the reporting and organization of my data is not influenced and shaped solely by my respondents' choices of words. My interviews were audio-taped and my thesis is printed and therefore, language is the only medium that I have to reflect and organize the respondents' perceptions and insights and correspondingly, my own analysis. In reality, my encounters and interviews with each woman were imbued with their insights and experiences which, in addition to language, were also conveyed through their body language, their emotions, their silences, as well as through the overall atmosphere and ambiance of the encounters. These non-verbal communications are a critical and implicit part of the verbal messages

that the women shared and consequently, guided implicitly and are reflected in my organization and analysis of the data.

I am aware that this methodological and ethical issue arose because I did not recognize and resolve this potential conflict prior to collecting my data. However, in and of itself, this has been both a difficult and a valuable learning experience which has made real for me the process of research as a lived, human and subjective experience. This experience will only serve to make my future research endeavours more sound, both ethically and methodologically. This experience is also consistent with the feminist research process of reflexivity, which is "...the tendency of feminists to reflect upon, examine critically, and explore analytically the nature of the research process..." (Fonow and Cook, 1991:2).

CHAPTER FOUR - THE RESEARCH FINDINGS

The Sample

In total, I interviewed 21 women at all stages of the four year undergraduate medical training program at the University of Manitoba. The women ranged in age from 22 to 44 years, and all were Canadian citizens. Five were women of colour (other than white), six women were living with partners, two women had children, five lived with their parents, and the remainder lived on their own, with or without roommates. Nine women stated that they had a family member who worked within the health care professions.

Medical School: The Climate

The impression that I received from the women that I interviewed was that women still feel and/or are made to feel, both subtly and overtly, like they are outsiders in a 'male profession.' Moreover, even though women enter medicine with qualifications and characteristics equal to those of men, gender stereotypes still have a prominent place within the workings of the medical school environment. While not all women identified this issue in such clearly defined terms, this message came through in many ways.

Beginning with the admissions interview, most of the women interviewed stated that the interview committee that they faced was composed mainly of established male physicians from within the Faculty of Medicine. In most cases, the committee also included one female, but she was usually identified as a fourth year student, a resident, or a

junior physician within the profession. Next, all women who participated in the study revealed that they had been asked themselves, had heard about other women who were asked, and/or had expected to be asked about their intentions to have a family, and their ensuing ability to balance domestic demands with a career in medicine. While there was some discrepancy among women on whether such a question was relevant to the admissions process, the concern that most women did express was that their response could be held against them. As one woman explained:

> I was asked whether or not I wanted kids...at the time I said 'no I didn't want to' and I believed that at the time, still, I'm not sure. I don't think it's fair to ask anyone if they want to have kids when they're not even married or going out with anyone, it's ridiculous because you can never plan that. I knew they would though, just because I heard from so many students. Now that I'm in, I don't think it's relevant to ask - before I thought it was. And it intimidates you when they do ask you that on the interview because the minute you think they're going to pry into what you want to do - if you said you want kids - then you think immediately that they wouldn't want you in - and really, that's the impression you get because you always have the impression that if you say yes you want children, they're going to think you're not as serious about medicine - that you're not going to be as good.

Another stated:

> It's hearsay around...if you admitted that you were going to have a family - the Dean of Admissions wouldn't like you - wouldn't want you to get in. If you did, you would just take the course for 5 years and then take off. That was really a concern. I don't want a family, but I wanted to make it clear that I didn't. I did make it clear. But for women who do want families and feel they can't lie about it, it's a big concern. And it's totally wrong.

Also, as several women implied, while there seems to be the realization by members of the interview committees that this line of questioning is inappropriate, it still seems to persist - to the discomfort of many women. To illustrate, one woman explained that:

> I also got - 'you don't have to answer this if you don't want to - are you planning on having children?' - admitting something, I'm going to convict myself. By not admitting, I'm going to convict myself. I convict myself either way.

Furthermore, not one woman had ever heard of a man being asked a similar question during the admissions interview. In fact, many found the very prospect to be amusing.

While such a question reflects the reality that many women in medicine opt to have families, as well as the patriarchal assumption that all women are destined to and should become mothers, the underlying message is that this is problematic for the profession. Women are aware that they are entering a profession that was created and is maintained by a system of old rules - a traditional system that evolved on the labour of men who could, if they chose to, devote endless hours to developing their skills, while their wives stayed at home and managed the family. One woman even jokingly commented that "probably most women doctors wish they had a wife." Many women referred to medicine as "the Old Boys' Club" and spoke about the strong sense of tradition that prevailed and served as the basis for such attitudes as "...this is the way we did it and we learned and we suffered and we were up for 42 hours - why can't you? If you can't cut it, what are you doing here?" For many women, it seemed that throughout medical training there were "a lot of traditions, more than necessities involved." As another woman concluded: "It's a male-dominated, paternalistic old boys' hangout, and they like it that way and they'd like to keep it that way, by and large."

As documented in the literature review - and at the University of Manitoba as well - the notion still persists that women's career commitment in medicine is weaker than that of men's. In fact, this belief is so pervasive that some women even express it themselves. As one woman explained:

> (You) have to realize a lot of women who go into medicine end up practicing for awhile and dropping out - or practicing half time - taking it easier. So if they're looking at who to bring in - they get less service for their money - for their education dollar, out of women.

Others stated that at one time or another they heard comments which suggested that "women don't make good doctors because they have kids and work part-time and are not in tune..." and ultimately that the inclusion of women "is influencing medicine towards a slacker outlook." While some women felt that such sentiments were outweighed by the positive influences they had encountered, including the positive feedback they often received from female patients, most women expressed a strong desire to see real change in the attitudes within medical training. Such change would acknowledge that medical school is "not an endurance course - not only for the toughest of the tough." This change would reflect attitudes that accept and value 'women's lifestyles' for encompassing a more balanced and realistic outlook on life, and not as reflecting less commitment to the profession. Many women agreed that such changes would not "just help women, but help everybody by making the profession a little bit more humane." However, as one woman reflected, "(I) really think society has to change - when it does, medicine will too."

Not surprisingly, then, even though women comprise close to 40 percent of all medical students at the U of M, a common theme raised by the women that I interviewed was the perceived need to make compromises in the area of career direction. While most of the women interviewed were reluctant to admit that there was a 'tracking system' in place - in other words, that women were being channeled into or away from certain

specialties - virtually every woman spoke of the conflict that they felt existed between their personal goals (which often included having children) and their career options. As one woman admitted: "family goals are definitely swaying big-time what career decisions I make."

Most women admitted to leaning towards a career in areas such as Family Medicine, Pediatrics and Obstetrics and Gynecology, and 'lifestyle' was identified as the primary reason. To illustrate, one woman explained:

> True, a lot of women go into Peds. and Family Medicine, but it may be more due to lifestyle considerations than due to ability. Because one very negative aspect of going into Surgery or Internal Medicine is the residency program which is very, very gruesome. Women are always thinking about kids, whereas men have always had women at home looking after that kind of stuff for them. One thing I wanted to say, I didn't feel pressure to go into it (Pediatrics), but it's so accepted...

Over and over, women explained that their goal of having a balanced lifestyle was incompatible with the demands of longer, more intense and inflexible residencies - typically Surgery and Internal Medicine. When I asked women how they came to realize this, they responded in various ways. Some had received direct comments from professors and clinicians such as:

> 'Well, you don't want to do that (Orthopedic Surgery)...you want to go into Family Medicine, that way you can have kids - stay home - don't have to work 120 hours/week' - and this was done in a condescending manner.

Others reported hearing statements which conveyed the message that:

> 'Well there are no female pediatric cardiologists' ...his attitude was that I couldn't do it simply because I was a woman - simply because no women have ever done it.

Or:

> 'If you want to take time off and have babies, why aren't you a nurse?' That's more or less the attitude that comes across - it's not that blatant, but it most definitely is there.

Several women also stated that they believed that certain specialties were inherently less appealing to women because of the physical or psychological nature of the area of specialization. For example, several women spoke of the perceived requirement of physical strength for Orthopedic Surgery, which tended to eliminate the pursuit of this option. Relatedly, while the field of Obstetrics and Gynecology is an acceptable specialty for both men and women, there is an underlying assumption that Urology (often focusing on the male uro-genital tract) is off-limits to women. To illustrate, one woman described her understanding of the process of choosing specialties:

> I think mostly because of the nature of the job, there are not too many female Urologists...it wasn't that people discriminated, just certain jobs are more appealing to either sex. To do Orthopedics, you have to be strong to maneuver people's limbs - it's kind of a brutal type of surgery - bone flying everywhere. I just don't think it's very appealing to a lot of women. They don't have the strength to do that sort of thing, so there's a natural avoidance of it...Obstetrics is heavily weighted, there's a higher concentration of women because of the nature of the work.

Most women spoke about the reputation that the field of surgery had for being a male-dominated, macho and paternalistic boys' club. While this may seem like fairly inflammatory language, horror stories abound describing why surgery is still perceived as a hostile environment for women. Women recounted tales about the bad hours and inflexible time commitments; the lack of maternity leave, and the lack of female change rooms; the lack of respect for, and poor treatment of, female patients; as well as the lack of female residents and surgeons to serve as role models. These are only some of the examples of the prevalent sexism and

discrimination that female surgical residents endure. Women also described surgery rotations as "a month and a half of them trying to make you cry" and as "having to work harder to be accepted." Unwelcoming messages about surgery seem to filter down through the school by osmosis:

> It's (the) old guard protecting its turf - they have to keep the myth and magic alive - that such and such a group is the only elite here. For some, only 'elite' is guys. It's an undercurrent thing and I don't know where I picked that up from, but it seems to be filtering down somehow.

As one woman summed it up:

> I know more male students that want to be surgeons than women just because they hear from women clerks that surgery was the biggest drag... surgery especially has the reputation that 'we are the workers.' Here at 6 AM, stay till 7 PM, and if you can't keep up with it, you're just not cut out for it. Definitely a very macho image - 'we're really driven' - you have to be as driven if you're planning to do this. It's not really conducive if you're planning on having children. You KNOW you're going to be really stuck if you get pregnant during residency. You KNOW that taking maternity leave means you lag behind your classmates and you will not get good appointments. Whether it's overt or covert, you know that. It's definitely harder to be a woman in it than a man.

Another explained:

> Let's say that I would want surgery, I think I would be kind of scared. All you ever see is a bunch of male residents. I'd be one woman with a bunch of men. I think this would freak out almost any female. I think if there were 3 or 4 other male residents and me, then I would feel the deficiency right off the bat, because the field is mostly males. I think that's bad, there should be more encouragement because more than half the world is females and a lot of females are getting operations...I don't think there is a lot of encouragement either way, but males might just feel a security blanket underlying - 'I'll go into surgery, guys always go into it.' I'd feel unconfident even applying. It's hard to get in. Do I feel I even have a fair chance?

Consequently, at the University of Manitoba, most women are still 'choosing' to go into traditional female fields. Women reported that

the demand for female Family Practitioners, as well as the perceived benefits - such as more flexible residencies and work opportunities, maternity leave and on-site daycare, and an overall less hostile environment - were definitely assets that these specialties had to offer.

However, the impression that I received from most women was that the perceived curtailment of their career options was not taken lightly nor without regret and disappointment, even frustration and anger. "There's always a niggling feeling of cop-out when you read that there's only one female General Surgeon in Manitoba - that seems a terrible shame." Another woman explained:

> I know I'm pretty good with my hands, but again, the scheduling would bother me and again, the people I'd have to work with. But you've got to penetrate those fields somehow. And another thing would be is that I wouldn't want to 'traditionalize' myself and go into something like Family Medicine and Pediatrics and those things that are female-dominated.

It appears that women face a catch-22 situation: while they recognize the need to make inroads into male-dominated specialties, they also recognize the need to learn and work in a tolerable environment, and most were not willing to endure the pitfalls of being token women. As one woman summarized:

> Men become Surgeons and Internists. I think a lot of it is because of the time commitment. When you're a surgical resident, you spend ALL of your time at the hospital for 5 years...Internal Medicine is the same. You MUST, in order to be successful, completely give yourself up to it. And men can have families and children and still do that and women really can't. It's very male-dominated, it's very paternalistic. Maybe that is another reason that it's not attractive to women. Do you want to spend your time with these guys. Although, if you really wanted to be a Surgeon, I don't think that that would dissuade you. I'm sure there are women that do, although I don't know any women surgical residents.

Some reactions were even stronger. Although some women joked to me that "Family Medicine is where women go and Pediatrics, cause we know about kids and babies - Obs-Gyny is where women go because that's natural, our hormones will just tell us what we're supposed to do," others made the connection between such underlying attitudes, and the lack of control and lack of respect that women encounter. A definite system of hierarchy exists within medicine which ranks everything from medical students and hospital staff, to fields of specialization (Merton et al., 1957; Becker et al., 1961; Shapiro, 1978). While the male-dominated surgical specialties are seen as home to the 'cream of the crop,' traditionally female specialties rank lower. Although most women downplayed prestige and money as motivating factors in their medical careers, without doubt, these qualities are valued in society and, at some level, cannot be dismissed as insignificant. As one woman complained with some sarcasm:

> (Such fields are) allowable for women...of course, being the nurturing type and stuff, we should be around children and homemaking, wives, mothers...and Family Medicine because it takes so little training and off they go. So...(I) feel like going into Surgery or something just to prove them wrong because there's only one surgical resident at St. B. that's a woman - ONE and just to be the other one, I'll do it too. And I won't do it because I don't like the lifestyle, but I don't want to go into Peds just because it's so expected. To be dismissed so easily... even though I'd bore myself to tears doing that (cardiovascular surgery) I'd hate it - not challenging - I almost want to do it just so I can get the respect.

Finally, in some cases, women expressed anger and frustration at having to make compromises that their male peers, who were sometimes their partners, were not faced with.

> (It's) hard to explain to my boyfriend - we're going to have a child someday, but you're not going to care as much as I do. You don't seem to understand. You're still making these

> decisions as if I didn't exist because that's what you're used to doing...In terms of my boyfriend and myself, why is his life his own? Why am I always having to make all these compromises, not just for my own well-being, but for everybody, and it's annoying. Because there's nothing that I can do to make others compromise for a change, or even realize that there are compromises to be made. That would be a step too!...Compromises, I'm aware have to happen, and at this point I'm still angry that they have to. Anger has been my basic feeling for the past little while as I become more and more aware of the compromises to be made. It's overwhelming how angry you get, and can't see a way out...I want to say, 'I want to be a surgeon, but can't I set my own hours?' Things are totally beyond your control. Why can't I have more control of my own life?

Another stated:

> My boyfriend who's relatively aware of these things says 'but I want to be an orthopedic surgeon.' I say, 'but what if your wife does too?' 'Well, it's difficult...' and that's after I went digging, 'what about the woman you're going to marry?' I know lots of men that wouldn't even consider that, they'd just go on. And that doesn't mean that they don't do Family Practice, but they don't really consider that.

This same woman stressed that:

> I really think it should change. I really think the image of doctors as the God should just stop. We have to say 'look, I want to take 6 months, 8 months, a year off to raise children. Don't penalize me for it - don't set me back because of it. It's going to take me a few months to get back into the swing of things'...Family Practice is great. You can get another doctor to come in and do a locum, just as much as you can afford. But in a specialty, you definitely lose an edge - patients, time in O.R., on the wards - and that hurts you career-wise. If you're a researcher and you're gone for 2 years, good luck!

Female Role Models

> I have yet to see a female surgeon - but I know they exist (laughs)... I would like to be a surgeon, it would be very interesting...

Overwhelmingly, the women that I interviewed stated that there were not enough women teaching in medical school. Most women reported that

only between 5 and 20 percent of their instructors had been female. All respondents were extremely enthusiastic about having more women occupy positions within the medical school hierarchy - from Lecturers and Preceptors to Department Heads and Deans. Some women stated that, to them, it made no difference whether they encountered a female or male instructor since "they're probably going to say the same thing either way." Other women agreed but, at the same time, questioned the absence of women instructors in medical school.

> Sometimes I wonder why, but it doesn't really make a difference to me personally who's teaching it, as long as they're teaching what they're supposed to be teaching. But sometimes I wonder why there's so few women. With women making up so much more professional faculties these days, you wonder why there isn't more in the teaching. In my med. class this year, I'd say we're around 1/3 - only 1/3 women - maybe a little more than 1/3. And it's not proportionate to the teaching staff or the number of women doctors that there are out there. It doesn't seem proportionate, but it doesn't really bother me.

However, most women agreed that women were important role models who provided females with a sense of belonging and comradery. As explained by one women:

> I think it would make a difference to me if there were more women, yeah. I think I would feel much more included. I would feel more excited about learning a lot of stuff. It would be exciting to me if more women were teaching more pertinent topics...I think if there were more women overall, I would feel more included.

Several women commented that the women they encountered tended to be exceptional teachers, extremely supportive and encouraging, and sensitive to students' needs. The women also reported that female professors were very approachable, and served as much needed sources of information regarding what it was like to be a woman in medicine. As one woman explained:

> I would like to see more women preceptors because it's nice to have someone to identify with and that's the bottom line...When I was on surgery - Neurosurgery - there was a female resident. The only one in Manitoba and one of a handful in Canada. I really wanted to talk to her. Why had she chosen this specialty? Neurosurgery is known to be hectic. I wanted to know if she still wanted to have a family or whether she thought it was still viable - but those kinds of issues you just don't discuss with men. I want to know how she felt it went and that's why it would be nice to talk to some women surgeons at this stage of the game. I want to know what their lives are like. Have they made sacrifices? Was it worth it?

Just as women lauded the benefits of having more women visible in the medical college, they also described the effects of the lack of female role models. The message that several women conveyed was that, by and large, the physician is still seen as male, even in their own eyes. One woman reported that it was "strange to see a woman come in the room, to tell the truth" and another stated that "(I) find I just assume that the preceptor is going to be male generally because most are." Another woman stated that

> often when a woman comes to the front of the class, people make the assumption - oh, she must be a dietician or a physiotherapist, or whatever else - or, she can't be a doctor, or we won't listen. Really, women instructors have to work extremely hard to grab the classes' attention.

Yet another woman observed that the "description of a bad female lecturer might be a little worse than (that of a) bad male lecturer. Females are criticized a little more... ." Finally, one woman expressed the concern that her male colleagues might not learn to value and respect women, or feel comfortable taking orders from female interns because of the lack of female authority figures. Moreover, she wondered whether she and her female peers would garner the same respect as males, once they got into the system. Another admitted that "...a strange

thing happened when I actually did get a female lecturer in medicine - once in a blue moon - I didn't take them as seriously as I took men. It was kind of disappointing when I realized...how much that influenced me."

Finally, some women also made the connection between the lack of female academics and the dearth of women in positions of authority within medical school. The message here was clear: if there are few women in the power structure, the likelihood of change is a lot less promising. One woman summed up the significance of the situation for herself:

> I think it (more women) would make my experience a lot more positive because...at least I'd know that if I so choose to become an academic doctor, it would just send me the message that there's less barriers, because that's what I thought when I was in undergrad and didn't see any female profs. I thought, there must be something that stops women from doing this, either it's too hard to have children, there's sexism, you're actively discouraged from doing this. That's what the message that I get from seeing so few women profs, that there are some barriers somewhere that makes it more uncomfortable for women to do this. And if there were more, I wouldn't feel that and would be more likely to consider it.

Another women declared simply that:

> We don't have female role models...maybe one out of one hundred. What does that say to the women in class? To the Old Boys' Network? And how hard must women have to work in order to get teaching positions as part of the medical faculty? I can't even imagine...We have to be concerned that I have to count on the fingers of one hand the number of female teachers that I've had all through the program.

Relatedly, some women felt that the unequal number of women and men admitted to medical school was not problematic, and to illustrate this, they expressed sentiments such as:

> I think our class is 60 percent male and 40 percent female - you can't ask for perfect all the time...It doesn't make me particularly upset. I think the general population, because

> there are fewer women doctors, they'd probably be the ones who'd want more women. But as medical students, it doesn't make a difference as long as there is a certain percentage. If it was 80/20 or 90/10, then I think I'd start to worry.

And:

> I don't think that it makes any difference. If it was 10/90, then it would make a huge difference. But 40/60 is sort of balanced. If it was a noticeable imbalance, it would make a difference, sure.

Some women further stated that gender should not, in any way, figure into the criteria for admission to medical school, and that students should be admitted on merit alone.

However, other women made the connection between the imbalance of females and males in medical school, and the ingrained inequities in the ideology and structure of the institution. To illustrate, one woman revealed that to many people, a ratio of 60 percent men to 40 percent women equals 50/50, "at least, it was as 50/50 as it was going to get." Another woman elaborated on the imbalance in an interesting manner:

> Really, it should just be 50/50, of course, some years lower or higher, but it's never higher, never over 50 percent (women). People say, 'oh, it's close to 50 percent,' but it's never above it, there's never that occasional peak. It just seems to me in talking to doctors - male doctors that I had for clinical skills last year said if you became a Family Physician and you're a woman, you could hang up a shingle, and in 6 months you would have a full practice. So obviously, there's a big demand for them. So...if male doctors are taking 3 years to fill up a practice, maybe there's too many men in medicine...

Not surprisingly, most women found organizations such as the Federation of Medical Women of Canada to be vital links to women in medicine, as well as a source of support and community: "The women I talked to there were very interesting and dynamic - it was just really interesting to talk to women who are actually practicing medicine in

whatever field they've chosen - it gives you an idea what it could be like." Interestingly, one woman spoke of the negative reaction that a few of her male peers gave an announcement of one of this organization's upcoming meetings. She felt that it was really disconcerting that some men would have so little sensitivity to the need for such an organization. She added, "the entire medical organization is for medical men, that's why we need something for medical women."

Sexism In Medical School

In a 1983 article on women in medicine which appeared in the magazine "Mother Jones," David Osborne wrote (1983:22):

> Ten years ago, the profession was notorious for its sexism: the men's club atmosphere of the hospital, the constant barbs aimed at the few women who dared compete, the Playboy centerfolds slipped into lecture slides. Today, men simply cannot get away with that sort of behavior.

Ten years ago the sentiment was that blatant sexism within medical school was no longer tolerable. What are women reporting about their experiences today? The following is a discussion of the examples of perceived sexism that the women I interviewed spoke about. These examples were experienced, witnessed, and/or had become part of the student culture in medicine. It is also important to point out that while not every one of the examples were identified by all the women interviewed, each example was perceived as problematic by one or more women in the sample.

One message seems to be, as alluded to earlier, that there is a distinct 'maleness' to the medical school environment. To some women, this aspect was subtle, yet pervasive. One woman attempted to explain her perception in the following way:

> It just felt really isolating. So much of medicine - the concepts - are male somehow. Like you don't really talk about the human aspect of things...you don't talk about illnesses in women's language, if you know what I mean...And I started to notice that - I don't know if I can explain it to you - sort of, the language used in notes is very static, very fixed - square (laughs). I don't have the words to describe it, and when I think how would I describe it myself, it's a lot more flowing, more descriptive kind of language. I started noticing that because I thought how would I describe this particular illness? Very, very different...So in that way, I'm probably reading too much into it, but I wonder if I've developed almost a male way of thinking? Because I learned in that language for so long, it would take me a number of years to unlearn that particular way of thinking about it.

She later added:

> I even made the comment to my mom and sister in first year that 'I feel like I'm growing balls.' You have to be so directed, so driven, which I always think of as a male type of world. I'm working so hard, so motivated, directed, focused, I feel like I'm becoming male.

Women also spoke of the 'natural' use of the generic 'he' in many contexts. While to some women this was seen as a non-issue, one particular example provided a sobering image:

> Things like when they wrote up cases for tutorials, the doctors were always male. Even now when I read a case history, if it's a female doctor, it blows my mind. I find out later that all along I was thinking of this person as male and they refer to something that indicates that she's female. I think (laughs) that's impossible. We don't have women doctors. [But you're going to be one.] I know! It's contradictory, that's what I'm saying, but no matter how it happens, when someone refers to the doctor, I immediately bring out a male picture.

Several women also related an incident where an information package on exam stress put out by Psychological Services for medical students addressed the medical student population in a gender specific manner throughout. As one woman articulated:

> Another example is the guy in charge of psych services for medical students puts up a little thing for first and second years, an exam stress thing..but it's always written to male students - always, 'you may feel stress because you don't want

> to disappoint your girlfriend or wife.' We were thinking, what about boyfriends or husbands, or why can't you say that in a gender neutral kind of way? 'You don't want to disappoint important people in your life.' It's specifically written 'he, he, he,' and referring to female partners. Some women do have female partners, but that's obviously not what they're thinking when writing this. There are lots of examples of using male pronouns, gender specific kind of stuff.

Several women agreed that the male body was often the norm in anatomy diagrams and texts, as well as being the implied norm within the context of lectures and tutorials. As one woman explained:

> Just little things that people say don't matter but do. If a patient comes to you, HE has presented with this. Why not just say the patient? People say I'm splitting hairs, but it makes a big difference. If a man comes in with abdominal pains, or a woman, I'm going to be thinking of two completely different systems. No, they definitely do tend to use the male as 'the normal.'

Yet another woman concurred that:

> Oh yeah, always pictures would be male. It's subliminal. When you're learning clinical skills, all the videos of how to do it are of men, except for the breast exam. Males are even used for the chest exam. Consequently, most men don't know what to do with those things in front of a woman's chest when they're trying to listen (laughs). They're embarrassed, they've never seen how it's done.

And another woman stated:

> The pronoun used was always 'he,' including in gynecology. They wouldn't say 'he,' but would say 'man.' They would say 'the menstrual cycle in man.' That's funny to me, although I guess these people would say 'man' is humankind - but, I can't say that without laughing. And nobody seems to notice that.

Many women also stated that women's health issues were often tacked on at the end, condensed into one token lecture slot, and often seen as non-core. According to some of the women interviewed, this marginalization and devaluation of women's health appeared in many forms, ranging from learning that the majority of medical research

refers to the "35 year old, 70 kilogram male (which) does not take into account women's unique endocrine situations," but is often universally generalized, through to the value-laden clinical skills and diagnostic frameworks that students are taught. An example that illustrates this point particularly well was related by one woman:

> Basically, I don't think anyone was sensitive to people as people. We're not appropriately taught how to do a breast exam. I happen to teach this, it's one of the things I do - I've done for 4 years - I teach medical students how to do 'gyny' exams. I know how to do a good breast exam, and how to judge when a poor breast exam is done. It's an important exam to teach, but it's not really taught except in the small program I'm involved in, once in third year and once in fourth year...In second year, we were officially taught how to do a breast exam. My group was taught it by an old surgeon - male - who taught it to us on a rubber breast, which felt nothing like my breast, or any breast I've ever felt, and I've examined many. And it was a joke...almost obscene to be taught on this rubber breast. In my small group, jokes were made. First of all, we're not taught how to do the exam appropriately on a rubber breast, it didn't feel right, and also, the whole idea that there was that part of the body that was so filled with all connotations of whatever in your head that we have to use a rubber model. We don't use a rubber model on an abdomen exam or anything else, and God knows, they never even teach the genital exam. We don't have genitals. We were taught this exam on a rubber breast and then we went up to the wards to do a real breast exam and I was elected to do the breast exam...and I did the breast exam the way I always do, and he actually apologized to this woman. He said, 'these students - that was probably the most thorough breast exam you'll ever have and my goodness, you certainly don't need that.' He just kind of 'poo-pooed' the whole thing as if to say, this isn't an important part of your exam. And I felt, what's he saying to her about breasts - to us students - never mind to me - but to everybody else who's supposed to be a physician, who's supposed to know the importance of these exams. What's he saying about breasts?

Further to breast examinations, yet another woman commented on the lack of respect that was shown to a woman within a similar context:

> The breast exam was finished...and he (doctor) had turned away, except her top was left down. And just a little thing like that that he just didn't even notice. And as we left I turned to her and said, 'let me put that up for you,' because she didn't know what we wanted to do next...Whether he would have done that with a testicle/penis exam - something like that, I have no idea...

This same woman added that she had entered medicine,

> with the knowledge that breast cancer doesn't get as much research as other types of cancer that tend to affect males more. That lupus, which is a disorder that primarily affects women isn't getting the attention that other immunological problems are getting - either not gender-based, or based on men.

Finally, another woman commented that, in terms of "...many women's issues, especially to do with reproductive rights...we heard some things that I thought were so immoral to present to doctors - who should be impartial, but I know won't be."

Women also reported encountering inappropriate and insensitive phraseology such as 'the bleeding uterus' and 'curetted a woman.' As one woman responded, "we asked him (the lecturer) when we would ever see a tutorial called 'the pussing penis,' and he said that he didn't think that would be coming up." Another woman stated that:

> I was conscious because I was pregnant last year - another text that we use currently referred to a pregnant uterus as something like a 'tumorous mass.' It made it sound just horrible - very bizarre descriptions of female anatomy - really inappropriate. And the male anatomy is simply the norm, that's true.

Relatedly, many women spoke about one senior professor in particular who used non-clinical language to describe female body parts. Several women stated that they were offended, and found it an inappropriate double-standard that, within a lecture setting, male genitalia was referred to as the penis, while women's breasts were called 'tits.' Women also spoke about a couple of professors who were notorious for "addressing everything in sexual innuendo...(they) tell dirty jokes as an intro to their lecture." As one woman elaborated:

> One prof in particular apparently has been making dirty jokes for 30 years, and the first class we had, he didn't say anything directly, but comments made about breastfeeding and

> menstruation were questionable - I always wondered. The first lecture I just didn't get a good feeling from it - wondered if something was going on here. Then the next lecture, it was blatantly sexist jokes, I can't remember exactly, but I remember that I left half way through the class, I said that I was never going to one of his lectures again. And the next lecture that I didn't attend - but I have a friend who was in class. (He) started out with the joke: 'what's the difference between a 3 ring circus and a chorus line? One is a cunning array of stunts' and then he just left it, meaning the other is a stunning array of cunts. This was made in the third lecture in a room full of people.

Similarly, some women found it offensive that issues dealing with breasts and genitalia were often sexualized by both professors and colleagues alike. To illustrate, one woman related this incident which took place in the anatomy lab:

> I said, 'now when I'm looking for the vas defferens, which is the tube that you cut during a vasectomy, where do I go?' And I was asking a male doctor, I mean, we were dissecting a male genitalia...He says, 'Well, you palpate the spermatic cord...you've probably done that, haven't you?', like meaning on a live person. I just looked at him 'Are you serious?' and just walked away. It was just so nudge, nudge, wink, wink, hey honey.

As well, one woman stated that:

> Apparently the cervix feels like the tip of the nose, and some jokes are made about that among doctors and people doing pelvic exams - and suggestions that women find it pleasurable. I feel like saying, 'yeah, nothing is more pleasurable than having my butt slid down to the end of a table with my knees up, with a complete stranger - it's not a fun thing. They make it something sexual, when it isn't sexual at all. It's no more sexual than a rectal exam - both are completely uncomfortable and completely disquieting for the person having them done. You'd be hard-pressed to find a woman that goes to the gynecologist in the city just for fun. Definitely jokes of that vain, quite often.

Also, as one woman revealed, "...even having lectures on STDs and stuff, and professors saying PID is a disease of promiscuous women." And another elaborated on this same issue:

> Whether it's a comment from a gynecologist telling us that women with PID should automatically be considered

> promiscuous...the act of judging is certainly not the place of physicians...her partner may have 10,000 partners, and to judge her, to call her promiscuous - to use that word. If you use it in your own mind, that's one thing, but to use it in front of 80 impressionable young doctors-to-be who believe everything you say - I thought, it just felt wrong.

One woman also spoke about an exam question,

> about blood pressure and the erect penis, and the different things that affect it...and one of the list was 'vaginal compression,' which has nothing to do with blood pressure and the erect penis - nothing. So I got very angry and came really very close to just handing in the test paper and saying, 'if this is the type of question I can expect, I've had it.' Then I said, no, no I can't do that because then I'll fail. So I wrote out this little speech - 'I'm tired of medical school humour and if I'm going to be associated with you, I'd rather just quit because I have no desire to be associated with this faculty if this is the image you have.' I guess I wasn't alone because...(someone) stuck it up on the bulletin board, circled it and put 'bravo!' on top of it.

Another woman stated about some male classmates that:

> Their whole attitude towards breasts and gyny exams - they have to relate something sexual to me, so that I know they really know what they're doing, but it has to be based on their sexuality. It's so stupid, so immature, so unright. I'm always appalled when I see it (during a breast exam)... 'Yeah, I examine my girlfriend's breasts all the time.'

And another woman revealed that while talking to some of her male classmates about specialty choice, one commented that, "well, I'm not going into gynecology - I couldn't stand to look at another one of those when I came home."

Women also described the many ways that they were made to feel marginal and less or differently valued. Women were called 'girls' or mistaken for nurses - and they pointed out that even senior nurses in their 50s were called 'girls' by male clerks and residents in their 20s.* Some women reported feeling invisible or being ignored by male

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* It is reflective of the deeply ingrained hierarchical and counterproductive ordering of health care professionals, which is perpetuated especially by the medical profession, that women medical

professors and preceptors. As one woman revealed:

> There was a very specific situation I found very, very intolerable. I remember last year...(a patient) had some kind of abdominal problem and the surgeon was supposed to come see him. He came charging in and had an awful bedside manner...started pressing on the patient and talked all the while to (male partner on rotation), and I started to be more and more uncomfortable because it started to be less and less coincidental that he was just focusing on (male partner). So I asked a question, not because I wanted to know anything, but because I wanted to be focused on - because I wanted him to realize I was there too. He looked at me, saw me, then turned back to (male partner) and answered (him). I stood there and I was humiliated...I didn't feel like he was punishing me, but I felt like I'd done something wrong. Then he walked out of the room with his arm around (male partner) and I just trailed behind - so I felt really, really bad about that. And then on the way out the door, he elbowed (male partner) and said, 'it must be nice to have girls in your class, we never had that.' And here I was right behind him and I could hear every word.

Conversely, some women felt that they were judged more harshly than their male peers. Many felt that they had to work harder than their male classmates just to be seen as equally competent. To illustrate, one woman recalled that:

> The most striking example that got me most upset was this 60 year old plus hepatologist. We were learning about the liver in a tutorial - 10 or 12 of us. I had prepared fairly well, I knew answers, but any time I'd try to open my mouth, he'd cut me off: 'no, no, that's not right. Don't use that term this way, you're saying it wrong.' He wasn't interested that I knew the basic idea of what was going on, and it wasn't like everyone wanted to answer - there were long silences. So finally I decided to answer again, and basically he gave me a hard time. This happened 2 or 3 times in the tutorial and then I avoided saying anything even though I knew the answers...And I noticed that he did that to other girls as well. He asked a question and one girl answered, it was a short answer, but basically right. So, he sighs, goes to the board and draws out an elaborate thing, basically what she said. And any of the guys who would speak, he would let them finish. He would say 'yeah, right' or 'not quite right,' - if girls opened their mouths, he gave them a really hard time, really different.

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students would find the label 'nurse' to be derogatory.

As another woman concluded: "women must look competent, men just look incompetent for themselves, but when women fumble, they sort of give all other female students a bad name."

Women articulated a variety of ways in which they were treated differently and inappropriately by male professors, clinicians, colleagues, and patients. These included being judged on the basis of their appearance, being called a "skirt," or being leered at as they walked through the hospital wards. Women heard patronizing comments such as, "it's so nice to have a pretty girl here," and witnessed and experienced inappropriate touching, such as "bum pinching," as well as sexual advances - which occurred within both clinical and instructional settings. To illustrate, one woman revealed that, in her opinion, one particular professor "...took advantage of the kind of questions and contact that he had with, I would say, female students in that environment, to touch women...I was certainly aware that this was going on and was making people uncomfortable." Another woman stated that a female colleague,

> went in to examine a patient and she took a history and he had told her that he had external genitalia problems, so she did a thorough exam on the external genitalia, and she went back to his chart and he had cardiovascular problems. He didn't even have anything wrong with him there. Stuff like that is uncomfortable.

As well, she continued that she, herself, was made extremely uncomfortable by a particular encounter with a patient:

> I was examining this 40 year old guy who had 3 heart attacks, so I had to examine his chest. So, I asked him to take off his shirt and he had numerous tatoos. And he had this tatoo of a woman receiving cunnilingus from a snake on his chest...I didn't show it, I did what I had to do and I got the hell out of there, but boy was I uncomfortable.

Another woman related an incident involving "one man in the class that nobody likes." She explained:

> The lecturer was talking about situations where a very forceful rape can stimulate ovulation in women because of the trauma to the body - all kinds of hormones are released, all kinds of pathways are turned on and women will ovulate. And this person made the comment that it would be a very good BSc Med. project - a summer research project that is taken on. And he said it and he laughed out loud, and there was silence throughout the entire theatre and the lecturer had nothing to say, and then said something like, 'that was an inappropriate comment' - tried to brush it off...He honestly thought he was making a joke...and now on the wards, they're having a lot of problems with him - he calls the nurses 'girlies.'

This marginalization was expressed as well, through more subtle incidents, such as:

> Subliminal messaging...just in terms of, say there are 8 people working with a physician, when it comes to doing things like putting the robe back on the patient, usually it's a woman singled out to do things like that...just kind of a different treatment. And then if you're talking about the different cranial nerves emerging from the brain stem, usually there's total eye contact with the male people in the group, it's very subliminal.

Another woman lamented the demise of the 'safe walk' program at a hospital where she's a clerk.

Many women mentioned crude, misogynist and offensive humour that surfaced in many places, including the lectures of established male professors and, of course, during 'Beer and Skits.' While some women described 'Beer and Skits' as an appropriate forum for crude jokes which "nobody takes seriously," where "anything goes," and/or while "extremely sexist," not "degrading to women in general, because it is not meant in that way," clearly, others were not as convinced. To many women, 'Beer and Skits' with its occasional displays of pornography and crude sexual humour, simply reflected the sexist attitudes that were all too common

within the profession. Women revealed that females were often stereotyped within skits as "housewives or hookers," and one woman explained that:

> It was interesting that...the positions women would take in different skits, this was quite overt, it wasn't just me who noticed...guys would have the main roles - the women would have the short little skirts, the 'cutesy' back-up singing positions - they wouldn't have equal kinds of positions...and these are women and men who are supposed to be equals in the same class...to dress like that - to always act as handmaidens to male doctors, it makes you wonder what kind of role they're going to take in the hospital...and I think that a lot of them don't see that by behaving like that, that's the kind of position that they may be seen to set themselves into.

One woman remarked:

> I was amazed to see what people chose to laugh at - women chose to laugh at...I drink, I laugh, I joke, I dance, but one thing put on by the class that won, something called 'The Slut of Medical School' - I couldn't believe it. And women did it, women participated just the same as men in the class. I just thought it was sick...some others found it offensive too, not just me.

Yet another woman explained:

> This is medicine's big social night and this is what we do - why? There are so many things that we could do that are funny about medicine, why pick this? Well, that's what 'Beer and Skits' is, a night where everybody gets together and uses the words 'penis' and 'vagina' as much as possible. It's so pathetic - so highschoolish...and just as bad towards the men, but it's definitely got a tilt towards being anti- woman, definitely. Yet a lot of people don't perceive it as that. A lot of women think I'm just being uptight.

Furthermore, while, it is 'comforting' to know that as a result of one particular class that hired a female stripper to help them with their skit a couple of years ago, strippers have been offically banned from 'Beer and Skits,' some women feel that such measures are not enough. One woman made the connection between the inherent sexual harassment evident in a genre of skits featuring "women in skimpy outfits and men as whistling construction workers," and the spectrum of everyday

violence in women's lives. She explained: "now with the news about women's issues - rape trials on TV. Hey, these attitudes have to be stopped. Just walking down streets and women getting attacked. I started thinking, I have a responsibility too." One woman commented ironically about 'Beer and Skits':

> It started out as something really crude, something the boys did, but I think it's changing a lot. But for some reason, the judges don't think any other stuff is funny, but really react to woman-type humour... Now that it's changing, they can't get anyone to come out, now that's it's getting less crude.

Finally, almost ten years after Osborne's optimistic proclamation that blatant sexism was no longer tolerated in medical schools, several women described a recent incident where a pornographic centerfold made its way into a set of lecture slides, to the amusement of many people in attendance. This one incident, more than any other example of sexism that was related to me, was described by most women, whether they experienced it personally or not, as being a profoundly painful and disturbing reminder of the ongoing discrimination that they still faced in medical school. Furthermore, this experience was painful for women on many levels. To begin with, many women found the reaction of the professor in attendance to be totally inappropriate. A pornographic slide was secretly slipped into the slide carousel by a male student and, as one woman described the incident, while the professor "initially appeared startled," he then "started describing in great detail the size of her breasts and what he'd like to do with them, which is completely inappropriate for a lecture in any kind of educational forum." Several women described being shocked, stunned, and disoriented by the experience. As another woman commented that,

> there was lots of laughing in the lecture hall and I was appalled and shocked that the whole thing had kind of just been let to happen. Nobody made a comment at the time to kind of, give representation to how I was feeling, and I knew that I was not alone in this sensation. But nothing actually happened at the time to state that this was offensive - what was happening here - the laughter and the mockery of this sex symbol. So, I think that later on that evening when I spoke about this at home and kind of began to collect my thoughts together at how I felt about that - and then my anger at having not done anything myself - that was a fairly profound event, I guess... I would say that what the situation did was it made evident to me not only the nature of this lecturer - and he was compromised in my view from then on in - but it also made me aware that there were people in my class that did not share my view of what had happened there. And that made me sad.

Although a formal letter of protest was written requesting an apology from the lecturer, several women stated that they were disappointed at the lack of support that those who complained received. As well, many women were shocked by the intensity of the anger projected, mainly by male classmates, who thought that the women were overreacting. As one woman explained:

> I found that a very trying, traumatic experience. I still look back on that - it's amazing to me. It's hard to get people you care about to understand that feeling...It's hard to separate their reaction to the actual incident and their reaction to the women who reacted. That was also hard to separate. Why are you reacting so strongly against people who just have an opinion? They were just angry because they didn't feel the professor owed anybody an apology because it was just a joke...it eventually died down. I just can't forget (it). For a long time - I knew the guy who put the slide in - I had a hard time feeling any kind of respect for him.

Clearly, though, just as important as the examples of sexism that women spoke about were the reactions such instances got from those within the medical school. Women spoke of male peers and professors who were supportive and understanding. To illustrate, one male professor receptively altered his lecture notes to read 'uterine bleeding' and

'curetted a cervix.' But as many women pointed out, this was not always the case. In one instance, complaints about offensive jokes and inappropriate terminology were trivialized by faculty, administration and students alike. Reactions to the complaints were described as defensive and dismissive. For example, in response to several women's complaints about the sexist and misogynist humour of another professor, women gave various descriptions of how the event was trivialized and dismissed by members of both the faculty and the administration. As one woman explained, referring to the professor in question: "...he said that if...the women in class were SO insecure, then they're not suitable as physicians because they're going to run across certain comments that are JOKES in real life, and they're not going to make it." Another woman stated that:

> Next class, which I went to just to see if he would change started off with, 'well, I've gotten a letter and was told about some complaints. Well, I've gotten complaints for the last 5 years. I don't always keep it clean and sometimes I don't like to.' So, obviously he's not taking seriously the fact that he's offending a great many people in class, and NOT just women.

Several women who spoke about this incident also revealed that they had heard that: (1) the Dean was reluctant to discipline a doctor who had been "here for awhile," and who was already 'upset' by the formal complaint that was lodged; (2) the professor rationalized his jokes as a "way of breaking (students) into the world...because (they're) so immature (that they) need these jokes to bring (them) out of (their) immaturity"; (3) the professor used the Hippocratic Oath to suggest that students "are supposed to respect (their) teachers," and that the women who complained weren't respecting him; (4) the professor stated that as a result of students complaining, he was going to boycott 'Beer and

Skits,' and finally; (5) the professor concluded that he would "come and teach the lectures, but from (then) on, he (wouldn't) add jokes...(just) go from the notes, and it sure would be boring."

Finally, as one woman reflected:

> there's definitely still some sexist profs out there and the fact that nothing is done to silence them sends the message that it's not that important. It doesn't really matter. Even if it's offending you and making you uncomfortable, it's your problem, you should get over it because it doesn't bother us...it was only one person, admittedly, but it sends a pretty strong message.

And the message is strong. Several women said that they wouldn't feel comfortable objecting publicly to blatant sexism or harassment because they didn't want to be labeled as troublemakers. As one woman explained:

> There is a certain population of women who would like to object, but don't because they don't feel comfortable about it. I do hear it when we just sort of talk in front of the bulletin boards or in the bathroom. They kind of agree, but they don't feel comfortable out loud.

And another woman suggested that "usually it doesn't get you very far either if you complain." Others mentioned that due to work overload, they didn't have the time to notice or to make an issue over the subtle and not so subtle inequities that existed. Another woman voiced another frequently stated opinion. She stated, "I'm so used to laughing along with jokes like that, I didn't find it insulting." Relatedly, one woman commented that in general, she noticed that females were much more hesitant to challenge or to speak out, in any context.

What appears to be most disquieting is that several women admitted that they would be reluctant to make a visible complaint, or to sign

their name to a formal complaint, because they were afraid of the ramifications. As one woman revealed: "I guess I'm pretty reluctant to bring stuff up to that level. I try to work it out through myself...I think a lot of women end up getting nailed because they go that route - they get people angry. Whether they do or they don't, you still get labelled." And as another woman explained:

> That's a big issue for women right now. Because I'm in a very touchy point in my education - if I was an intern and already graduated, it's a slightly different situation, but now, I would more than likely jeopardize my situation. It would be more harmful to me than to the person I was accusing, more than likely. And I would have a really hard time deciding whether it was worth it, unless it was so overwhelmingly awful...Because even if you are right, are justified, there's a stigma attached to complaining.

Even among their peers, many women stated that when they spoke out against sexism they were told that they were overreacting, they were too sensitive or that they couldn't take a joke. Their complaints were trivialized and dismissed, and they were personally labelled as being "uptight" or as "bitches." Many women recognized the inherent hypocrisy in situations similar to the following, as described by one woman:

> If we made a point of raising concerns, a portion of the class saw us as being bitchy or complainers. But, when males did the same in our class, we NEVER heard a complaint like that, and we often talked about this last year - why people would think this way of us or other girls that spoke out. It always seemed that if we had vocal abilities to speak out, that somehow we were bigmouths - but men were expected to speak out and that was acceptable.

Moreover, according to several women, the ultimate insult and method of silencing women these days is to be labelled as feminists and, therefore, as lesbians. In fact, several women that I interviewed emphasized that they were NOT feminists, even though, in my perception,

they went on to articulate extremely in-depth, 'feminist' analyses of the discrimination that they encountered in medicine. To many women on the medical campus, feminism is seen as dangerously radical and extremist - a forum for the propagation of man-hating and male-bashing. Furthermore, feminism was often linked to lesbianism, which also highlights the issue of homophobia within the culture of medical school and, indeed, within society in general. As one woman stated:

> There now seems to be a backlash against the whole feminist thing... A lot of women I know (have a) 'feminist fear' - (they're) quick to distance themselves from that just in case there's negative ramifications...Somebody said 'oh, well I wouldn't consider myself a feminist.' I said, 'oh, why not?' 'Well, no, just, I'm not.' The image of the bra burner was definitely what she was referring to.

And as another woman reflected:

> There are so many issues you could explore. What about gay women here? This would be the WORST place - how difficult - you can't even begin to imagine...Some of the comments...just so scary to me, because I feel strongly that these are attitudes that shouldn't be held, or should be kept in your own little suitcase - keep them inside your office door, and don't ever let anyone in your office. And yet, these people have attitudes and opinions, and have no experience to base these opinions on. They have opinions because they are privileged young people, and are taught all their lives to have opinions they think are well-respected. There are people in class who are very affected by these things and can't speak up because of the situation here. 'Radical, lesbian, feminist' - that's exactly the words, exactly the words used to silence women.

Not surprisingly, several women spoke of the isolation they felt at being attacked for voicing their opinions. Some began to question whether indeed they had overreacted, and many expressed genuine confusion and frustration about what to do. As one woman explained:

> It gets back to the fact - how do you react? Getting on edge every time someone makes a comment? I'm at the point where I can't decide how to react. Should I get up in arms regardless of how innocent this remark is intended to be, just to make a point, or should I just laugh, and take it for what it was intended to be? Supposedly?

Still others admitted that they had simply given up speaking out against perceived discrimination.

> I definitely get the feeling from a lot of men in class, like when we're talking about 'Beer and Skits' or about doctors making offensive jokes, they go 'oh lighten up - what's the big deal? - what's the problem? - there's nothing here, you're creating problems.' They're definitely not willing to see that. Like even if it's not a problem, if I say something that offends someone, I'll make an effort, whether I think it's valid or not, I will make an effort not to say that in front of them again, because you have to have respect for other peoples' feelings and emotions. I just don't feel that they respect what you say, they think it's garbage and fiction.

And, several women expressed that the most painful part was seeing their female colleagues not support each other. However, as one woman explained, using a telling example:

> Over and over again, the people that told the smutty jokes were the endocrinologists, the gynecologists, the people that make their money off of women - telling jokes about women that were purely offensive, and if you were to change the punchline from being 'woman' to being 'black' or even animal - 'dog' or 'horse'...people would be up in arms, they would not put up with it. But because the butt of the joke is a woman, everyone, including women laughed. And it breaks my heart to see women laugh like that, but I guess they laugh for the reasons they've laughed for years, because you're nervous about it and you don't want your colleagues to think you're a prude.

Several women further commented that they felt that a big part of the problem was that there was no visible sense of community or network of support among women in medical school. As one woman explained:

> We don't talk about this stuff, that's part of missing the sisterhood... (I) felt like I went into (a) kind of situation where it was a man's world and there was nothing to bring women together. And there was no sense of sisterhood or support for each other , and a lot of underlying competition.

This same woman went on to reveal that: "(I) really wanted more of an active women's group on campus, but when I asked around, there weren't very many other women in my class interested in doing that - was no real

excitement there whenever I mentioned the idea, so I didn't really follow it up."

The women that I interviewed often expressed interest in knowing what their male colleagues saw and thought about the issue of sexism within medical school. Moreover, many women shared their hope for building a support network for students, where all issues of concern could be discussed in an open forum. As one woman explained: "I'm interested in what other women see because, like I said, we don't talk about it. This kind of stuff doesn't exist in medicine, whether it happens or not, because people don't take notice or talk about it." Another woman stated:

> There's no network of support, you just have to find somebody, or have tremendous support outside, and there's no time to have a tremendous network of support outside...There was nothing to build on here...If we could say out loud that we're having some trouble, if we could somehow legitimize it. If I could say to you 'this is a nightmare, how are you finding it? Anything we could do?'...I wish all the women I met here could somehow find each other.

Yet, despite the incidents of sexism and discrimination that they related to me, many women also expressed optimism that medical school was becoming a more hospitable environment for women. Some stated that while change was inevitable, "it's a matter of how long it takes," and expressed the tentative hope that, "I just hope that by the time I get to be someplace, I will not find it to be really grueling." There was also the sense that while some improvements had taken place, more tangible and lasting change would still occur in the future. To illustrate this point, one woman stated:

> As the older doctors are retiring, the younger men are moving up. I think in 20 years it will be very different. I think over the 4 years that I've been here there have been some

> changes, but it will be longterm and will take until all these guys have died...And until the men that have lived with women who are their equals and have learned that women are just as effective as men, it'll take that long to change. So it'll be a long time because these 60/70 year old guys are still teaching the residents who are 20/30 years old and they kind of like it - they kind of bond - and then they teach their juniors. And it'll be their juniors that aren't really going to buy into it as much, so that it won't be propagated throughout the system. When there are more women as the Chiefs, the preceptors - again, it'll change. Now, there are a minority of women in positions of authority.

Another woman echoed:

> I honestly don't think a sexist attitude can survive, especially when there are so many women around here. There are too many women medical students to keep that attitude viable, and 10 years from now, there will be a lot more female doctors. I think it's going to change with women in power.

Other women were even more optimistic, and felt very positive about the changes that they perceived had already taken place. As one woman commented: "I really see change in the medical profession as a whole. As more women get into the system - get pregnant and have families - allowances have to be made for them. As a result, more allowances are made for everybody. I think medicine is more reasonable." Another woman concluded that: "I'm optimistic about this whole thing...I've always had every opportunity available to me and have always been encouraged."

However, there were also many women who clearly did not share such optimism, and their descriptions of their experiences within medical school ranged from disappointment to profound pain. What follows are several comments which reveal the diversity of the pessimism that women voiced when describing their overall impressions of medical school. To begin, as one woman explained, "I did a lot of research before I came in

and when I've run into stuff, I kind of expected that it'd be there, to some degree. Although, it still surprises me, in terms of sexism, the things that haven't changed." Another commented that:

> It's one of the undercurrent things, I guess for now - the sexism part seems to be not obvious, not overt, I think because we're just numbers, bodies in lectures. But the impression I get is that it's going to get worse, especially as we get to fourth year...and worse when we pick our specialty. When trying to get into a specialty - it's the Old Boys' School, the old guard protecting their turf...

The impact that perceived sexism and discrimination had on women was also described as profound, and shows clearly just how devastating and debilitating such experiences can be for some women. As one woman explained:

> It's been a real lack or loss of idealism...I mean, everyday in first year I felt like I'd been boxed around a bit. They really try to mold you, and maybe I'm a little melodramatic about that they were trying to break my spirit. I thought they were all fascists, so I think it may be a little bit easier for other women...I think men are able to tolerate some of what goes on a little bit better. There's not so much directed at them, it wouldn't be as draining.

Several women also described the profound sense of marginalization and isolation that they felt within medical school.

> I don't fit in per se, but I never really did...Second term was just awful...third term was just worse - really offensive profs. I said really, if this is the attitude, do I really want to struggle through this? Because it was to me, a struggle - walking into a classroom and wondering, is this person going to be a jerk? Worrying about getting offended, trying to keep my temper, not standing up and screaming at them. Sometimes I wonder if I picked the right profession...

Another woman explained that:

> I wanted to quit every minute of my first year - every minute I thought 'this is not the place for me.' I never felt so isolated, so different, and made to feel crummy for being different. Qualities that I had thought were good were not appreciated - I was being, in fact, shit on. I wanted to quit all the time...I was in such pain, I really was isolated...really had few people here who knew anything about

> the things I was feeling...First year I wouldn't have wished on anybody, I felt it was a nightmare.

Several women also described the sense of despair and defeat that they felt, as well as their perceived helplessness to challenge or change the system. As one woman explained:

> Basically...those kinds of smutty remarks would be made in small groups, in tutorials, or in large groups. And those were the things that I found the hardest to deal with because there was nothing I could do except either to walk out, or to not laugh and look around me - I felt there was nothing I could do...There were thousands of things that happened...every class would give you something new to pull your hair out over...

As this same woman concluded:

> I did go home and cry. I didn't want to participate, but I thought I could change it. Well, that's just bullshit. There's no way I can change it. Based on the skits that we saw from other years and our own classmates, based on role models - teachers, profs, medical doctors standing in front of class and telling us jokes that were not funny, that were offensive. Attitudes that I found abhorrent. Jumping up and down in a class many times in a day to try to point out or speak out against this, which is what I thought my mission would be. I'll fail medical school, but I'll make some impact. No, you don't make any impact, except you wear yourself out...So many times I would speak out...I don't know if they groaned or not, it was my impression they groaned...And everyday, there wasn't a day that went by that there wasn't something to make me go home and cry.

Furthermore, some women hypothesized that change had to be initiated from within the system, as exemplified by this statement:

> There needs to be more women in medical school, more women as physicians...The only way it'll change is for women to have more control over teaching, over the whole system. If we're not happy with it, we should try and change it, and we should be active in making those changes and the way to do that is to become involved. And the only way you can change the system REALLY is from the inside. It's fine for all kinds of outside people, like Medical Sociologists, to stand there and say, 'we've done these stats and this is what's wrong,' but the profession will not change from the outside - it's a closed system.

While others countered that:

> In terms of personal experience, it's SO subtle, really subtle - so hard for me to come up with specific examples. But, all the lecturers are men, for one thing. There are some women, but they sort of slide in and out and don't really have any place in the whole running of the school. The people who really make decisions about what happens, the ones you see around a lot, aren't women. That's subtle, but it takes its toll. I think our class is about 1/2 and 1/2, but it felt like there's a whole bunch of men and women are kind of dotted - really isolated, separated.

And:

> I don't think things are changing, I don't really think things are changing. Women are there, but we all act like men. We all think like men by the time we're done. Most of us are going to go off, even if we have a spark of interest in this stuff, like I do. I'm not going to go and teach in medical school, I'm going to be with my family. Until we get more women in academic participation - in teaching, designing, running of programs, writing of literature, writing of case summaries, writing of textbooks - until that language infiltrates...it's not going to change. Language is so important, we read all day and all night long...And it's so elusive in terms of how do you change things into women's language? But until that changes, I don't think we will change medicine.

And finally, one woman concluded that she was pessimistic that the system would ever create real change for itself because, in her experience, it worked on so many different, yet interrelated levels to perpetuate itself, from the selection of students through to the form and content of the dissemination of knowledge, skills and ideology. As she explained:

> I think that it's who the role models are and how we're teaching, not what we're teaching, it's how it's presented. I don't think we need another class on menopause - (there is) an attempt to bring lay people from the community in, to tell their story. Yet, most medical students think of this as 'non-core,' non-significant, not worth listening to. Somehow if this is presented by people medical students think of as powerful - if it's presented as good, then maybe their attitudes will change. I think how it's presented is so important...As I came through - I know who I am, I'm stable, (but) it's like being in the Marines the way they train you here. On the one hand, you're the cream of the crop - brilliant, on the other hand, you're shit on, to build

> character. I thought this won't work on me because I'm a formed person already, I won't change easily... but...you know, in a past life I was a woman, and now I'm a medical student. It really shook me...I can't see how they're training anyone to be proud of who they are or even what they can do. It just seems that they're retraining the same kind of doctors they always had... I'm not so impressed on how some of us approach people...I look around and I'm not so impressed with many of us here...When you look at through the prototypes of people accepted here, they do well on the MCAT, well on grades - basically, although they've taken away the science requirements, you really need those science courses in order to get in. They're looking for people who do well in marks - very academically oriented - I think all that's a mistake...Here they say they don't seek people straight out of the Bachelor of Science degree, but that's who we have - that's who we're seeing. We're seeing people who still live at home, who've never been anywhere else but their parents' homes and who study all the time. They've never experienced any kind of life...Sometimes I look at people...and think, they're not ready...I don't have a wonderful, optimistic attitude.

To summarize, then, the preceding discussion is a description of the tape-recorded, transcribed interview data provided by the 21 female students from all four levels of the undergraduate medical training program at the University of Manitoba. The interview touched on all aspects of the medical school experience, beginning with the admissions interview, through to structured learning settings, course content and materials, as well as interactions with professors and peers, including more informal and social activities related to medical school. Students were asked if they, themselves, had experienced differential treatment based on gender, and if they had observed similar treatment of classmates and/or faculty. The form of the questions allowed students to report both favourable and unfavourable treatment. All women were encouraged to elaborate on their answers and to raise issues not directly related to the specific questions on the interview schedule. As stated earlier, while not every woman shared all of the views

presented here, all experiences and perceptions of sexism and gender discrimination were found to be significant by one or more of the women. What follows then, is an analysis of the research findings.

CHAPTER FIVE - ANALYSIS OF THE RESEARCH FINDINGS

It is apparent from the previous discussion that even though women now constitute almost 40 percent of all medical students in Manitoba, medicine is still a male-oriented profession on many levels and, consequently, women are still discriminated against and/or treated differently throughout their training. The internal climate of the University of Manitoba medical school is such that the 21 women that I interviewed all described experiences and effects of sexism, and perceived that gender discrimination still persisted on the campus. Furthermore, these experiences reflected all of the forms of sexism that have been identified by researchers, ranging from subtle sexism, double-binds, and systemic discrimination, through to more overt and blatant examples of sexism and discrimination, many of which fell within the realm of sexual harassment.

At the University of Manitoba, it is clear that one of the predominant ways that the culture of medicine is still organized, is according to the general principle of differentiation and privilege based upon gender. Furthermore, this underlying patriarchal ideology, that is, the **latent patriarchal culture** of medicine, is critical to the maintenance of women's discrimination within the profession as reflected in their experiences during training. As I stated previously, characteristic of patriarchal institutions and structures is a system of hierarchical ordering and control, wherein there exists a 'natural' division of labour by sex. My research has provided empirical evidence to support the theoretical construct of **latent patriarchal culture** that I developed in my chapter on theory.

As revealed throughout the interview data, women at the University of Manitoba, are still defined, both implicitly and explicitly, in a stereotypical manner, which results in the curtailment of their options within training and practice. As I argued in the presentation of the theoretical framework of this thesis, there exists a continuation of the pervasive social identification of woman as 'mother' - as naturally supportive, nurturing and self-sacrificing - and therefore, ultimately, as 'the other.' Indeed, this 'gendered consciousness' becomes 'naturalized.' It is internalized by both women and men, and as a result, it continues to be legitimized, maintained and reproduced within the institutions of society, including the profession of medicine. Moreover, this process reinforces ideology and policy which serves to keep most women restricted, devalued, marginalized and/or exhausted within the medical profession and, as a result, without the power and ability to control and/or change the patriarchal agenda of medicine. Therefore, even though the numbers of women in medicine are increasing steadily, women's ability to balance a career in medicine with their 'natural' duties of motherhood and, relatedly, their commitment to the profession, are still questioned. This questioning is evident at every stage, from the admissions interview, through academic and hospital interactions with professors and clinicians, to the specialty selection process. As I have shown in the literature review on women in medicine, woman as m(other) and therefore, not thoroughly as physician, is a pervasive underlying theme at all stages of a medical career. Thus, the link that I presented in the theory section, between social structure and gendered subjectivity as "...two different but inseparable and constantly interacting levels of reality" (Fox, 1988:176) which are

responsible for the creation and maintentance of patriarchal ideology, is made evident. The 'natural' division of labour by sex that is characteristic of patriarchal institutions is both explicit and implicit in the structure of medicine and in medical school, and reflected this is reflected in the data.

The culture of medicine is based on a 'masculine' model wherein all of women's choices, actions and accomplishments are compared to men's and, then, at some level, devalued as 'the other.' As I argued in my theory presentation, women's paid, public work tends to be devalued and/or undervalued when compared to men's work. Within the politics of gender, 'male' is the norm - the standard that, inherently, women can never live up to. Furthermore, women have learned to police themselves in many ways as a result of the long process of socialization within a patriarchal society. Women have learned to be quiet, to question their own authority and/or to second-guess themselves, and not to take risks or to challenge the status quo. In essence, women have learned to silence themselves. Women have also learned that there are great pressures that come with being 'token' women, and/or women within non-traditional fields. There are pressures to be exemplary, to deliver always and, moreover, pressure to perform not just as an individual, but rather, to represent all of 'womankind' (University of Western Ontario, 1991). Because women in the public sphere carry this heavy burden, it is inevitable that at some level (public, private or both), they are guaranteed to fail to live up to society's patriarchal standards (Simms, 1991).

Feminist analysis has revealed that success and its trappings are incompatible with the expectations placed upon women. First, the intensive drive and competitiveness that are often necessary for and expected during advancement are at odds with the typically 'feminine/motherly' behaviour encouraged in women. Furthermore, the double standard exists that even when women do engage in typically masculine tactics for advancement, they are criticized and ostracized, and labelled cold, unfeeling and unnatural, as these behaviours are disconcerting coming from a woman (Namenwirth, 1984:23). Within patriarchal institutions, success and prestige are unequivocally admired when attained by men but are often problematic for women, who find attaining and holding onto success in conflict with the notions of what a woman should be and do (Namenwirth, 1984:20).

As the result of the ideology of motherhood, there is enormous societal pressure for women to have children, but comparatively little institutional and/or ideological support for women who want to remain in the public sphere at the same time. Consequently, within medicine, women encounter both structural barriers and a lack of institutional supports when they attempt to balance their desire to have children with their professional goals. Since males create and dominate the institution of medicine and, indeed, personify the image of 'physician,' it is difficult for women to find appropriate mentors and role models to assist them in their progress through the system. Ultimately, it is also difficult for women to be envisioned as truly equal and suitable colleagues if and when they 'choose' different career paths and lifestyles. This perception was reflected many times over in the experiences of the women who I interviewed.

Throughout the interviews, numerous examples of discrimination surfaced which revolved around the expectation that motherhood was the natural, desired and ultimate goal for all 'normal' women - combined with the lack of institutional supports (i.e. pregnancy leave, daycare) and, as well, professional discrimination against women because of their reproductive capacity. This inherent contradiction - the double-bind, whereby women were both defined by and discriminated against because of their reproductive capacity - was reflected in women's perceptions of the admissions interview, the gender-tracking system towards and within specialities, the absence of female role models, the lack of mentors, and, more generally, the unequal expectations for women and men, and the sexist and/or exclusive behaviours, incidents and understandings - all which have been discussed in detail in the preceding chapter.

Moreover, all of these aspects of the **latent patriarchal culture** of the medical school were significant in shaping the experiences of female medical students. Women described feelings of frustration and anger, helplessness and resignation, as well as isolation, alienation and a sense of marginalization. What I found to be especially disturbing was the backlash against the women who attempted to challenge or to protest against what appeared to be blatantly sexist and offensive behaviour and/or incidents. Clearly, any anger expressed by women - especially those who were labelled as feminists or those who were perceived to be focusing too long on women's issues - was interpreted as an overly emotional, exaggerated, and unfairly personal response to men. Through this reaction, the political was personalized - issues were individualized and, therefore, diffused. Obviously, then, even though

women are now allowed to enter, are ostensibly even 'welcomed' into medical school, it is on the unstated condition that they do not challenge or attempt to change the status quo. Women are welcomed as long as they keep their place, do not want to get too far, and don't take up too much space (University of Western Ontario,1991). As I argued in my theoretical discussion, the medical profession continues to sanction its recruits for violating the cultural norms of the profession. And, as stated previously, since a fundamental principle of patriarchal ideology is the implicit definition of woman as mother in the private sphere, women in medical school are indeed violating a norm of the **latent patriarchal culture.** Therefore, gender inequalities in medicine are pervasive because they are ingrained within the 'normal' workings of social institutions and maintained by everyday assumptions about appropriate work and roles for women and men in and out of the home. To reiterate my theoretical contention, **latent patriarchal culture** is created and maintained through the interaction between social structure and gendered subjectivity (Fox, 1988:176). Moreover, while the actual norms and roles which constitute the public and private domains (social structure) have changed with time, the underlying patriarchal ideology (gendered consciousness) which necessitates the concept of difference has remained intact (Muszynski, 1989:69). Consequently, the cycle of exclusion and oppression continues.

I also found it interesting that while most women that I interviewed had a very clear sense of the **latent patriarchal culture** of medical school and, correspondingly, had very astute and well-developed analyses of their oppression within the system, all but a few women denied

vehemently that they were feminists. While it is outside the scope of this research to investigate the 'backlash against feminism,' it is important to state that this reaction is not uncommon among young women today, and is part of a larger backlash within society. As Kamen reports (Kamen cited in Jones, 1992:59):

> The 'F word' carries such a powerful stigma that although many young women voice strong support of women's rights, they 'shun' feminism...turned off by supposedly offensive and extreme oldtime 'manbashers,' many twentysomethings share a vision of a 'kinder, gentler individualistic philosophy.' They don't want to 'turn off' men by voicing displeasing assertions.

And as Gibbs states (Gibbs, 1992:42):

> The question remains of why so many American women with firsthand experience of discrimination still refuse to call themselves feminists. There is something in the label that a lot of women, especially young ones, reject even as they acknowledge how much the movement increased the opportunities available to them. Younger women 'think of feminists as women who burn bras and don't shave their legs...the Amazons of the 60s. The facts have no relation to it, but it's become conventional wisdom.'

What is clear is that to challenge patriarchal biases and assumptions within medicine is to risk being ostracized, marginalized, devalued and silenced. However, feminists have pointed out that the alternative is equally damaging to women. To the extent that women accept and work from the assumptions of a male perspective, they are alienated from their own personal experiences. "They speak a language, use theories and select methods in which they are excluded or ignored" (Smith cited in Roberts, 1981:78). Furthermore, women are forced to absorb and regenerate the misogyny of their discipline. Obviously, this constant discrimination, analogous to "being crushed by a ton of feathers" (University of Western Ontario, 1991), has to have a cumulative negative

effect on women. Whether women choose to challenge or work within the **latent patriarchal culture** of medicine, they are excluded and/or oppressed in either instance.

However, in addition to the backlash against feminism, women in medicine also face the powerful forces of professional socialization. Research still shows that "women physicians more nearly resemble men physicians in professional attributes than they do other women in the population" (Eisenberg, 1983:534; Dornbush et al., 1991; Osborne, 1983). While some studies report that female physicians are perceived more favourably by patients, and seem better able to communicate sensitivity and caring to patients (Linn et al., 1984:966; Arnold et al., 1988:729), research also confirms that female and male doctors and male MDs have comparable diagnostic and therapeutic skills, as well as comparable knowledge bases (Arnold et al., 1988:729). Furthermore, while studies have shown that women start medical school with more humanistic views, "...the conservative effect of medical socialization on both male and female students attenuates these differences" (Arnold et al., 1988:729). To illustrate, a U.S. study of 773 first and third year students and recent medical graduates revealed that while female first year students tended to give more importance to the human, social and preventative dimensions of patient care than their male counterparts, few, if any, gender differences were found among medical school graduates (Maheux et al., 1988:73-75).

When the medical school environment is examined from yet another angle, these results are not at all surprising. First of all, the socializing aspects of medical school are extremely powerful in shaping

students' attitudes and priorities over the 3-4 year undergraduate medical program. Medical school curriculum still focuses on short-term memorization and regurgitation of 'facts' originating almost exclusively from within the basic and medical sciences. Moreover, the emphasis in this learning process is on 'what,' rather than on 'how' or 'why' and, as a result, what is blatantly excluded is general problem solving skills and the humanistic aspects of general and preventative health care (Clawson, 1990:86). Medical training takes place in a highly competitive and individualistic environment - a unique atmosphere which is further "...associated with a lack of support for activities or behaviours that might threaten the authority, independence and financial potential of the physician" (Dornbush et al., 1991:151). Without doubt, one of the overriding factors is that professional socialization is a homogenizing process: students become more alike as they progress through medical school (Shapiro, 1978). Consequently, 'class loyalties' become stronger than gender loyalties with regard to social issues within health care and medical practice (Dornbush et al., 1991:152; Navarro, 1976,1978). Because of the hierarchical, competitive and overwhelming nature of the medical school educational experience, most students do not think to - or want to - question what they are taught. Therefore, most students (both female and male) tend to adapt to abnormality - to accept, normalize and incorporate sexism and gender discrimination into their developing framework regarding the theory and practice of medicine.

In addition, the "fine mesh of the admissions sieve" (Eisenberg, 1989:1544) ensures that women enter medicine with qualifications and

characteristics equal to those of men. The group of women (and men) who are admitted to medicine are a very select group of intelligent and high-achieving individuals. Yet, much of the current criticism of the medical school process highlights that "the selection and education process has encouraged only science- and high technology-oriented individuals to enter medicine, even though social and behavioral factors are the basis of a majority of today's medical problems" (Clawson, 1990:85). Most medical schools require several years of premedical education, the rationale being that the individual should be broadly educated in arts and sciences before embarking upon medical studies. However, the reality of the situation is that, in Canada, 15 out of 16 medical schools require one or more second or third year University level science courses, while only 8 schools require one entry level course in the humanities or the social sciences (the University of Manitoba falls into both of these categories) (ACMC, 1991:135). Furthermore, 11 out of 16 schools, including the University of Manitoba, require the Medical College Admission Test (MCAT), which is composed of 6 sections, 5 of which are math and sciences-oriented, while the sixth focuses on reading skills (ACMC, 1991:135). Obviously, such scientifically focused admission requirements, in the context of today's keen competition for diminishing spaces, does not encourage a broad educational and theoretical base. Therefore, the vast majority of women entering medicine are trained in the same scientific assumptions and, as a result, hold similar values as their male counterparts.

As well, the long-term, rigorous training schedule still prevents many students from considering medicine. To illustrate, a recent U.S.

study revealed that 'financial concerns' were among the top three reasons listed by students who considered medicine, but decided against it (Colquitt, 1991:273). Similarly, many of the women that I interviewed made comments to the effect of: "even just being here costs far more than most can manage - or some. Some do very well...We have to pay for exams, there are things we have to pay for that I had no idea we would have to pay for. For some people this is a real struggle, for others, Daddy always helped out."

A study of Canadian adolescent girls also indicates that the socio-economic background of family is still an important factor in mediating future career aspirations. Girls from wealthier, more educated families were more likely to consider non-traditional professions, especially medicine and law (Baker, 1985). Similarly, most of the women who I interviewed had the impression that many of their classmates had family members who were also members of the medical profession. The women's perception was that it was "really quite rare" to be in medicine without such an important influence. As one woman stated:

> I bring up often the fact that socio-economically, so many people in the class are children of doctors - children of professionals. So few people are from working class backgrounds...I think some people think it's a fair representation of society and I disagree. I think it's very skewed towards the wealthier. You're looking at 8 years of training, at least 7, where you only get summers to work. If you don't have Mom and Dad at least helping a little bit - with paying rent or helping with tuition - you're looking at a massive loan...

Again, this is an important consideration, since people from the same socio-economic status tend to hold similar values to begin with, which will be further homogenized during medical training. Thus, this subtle

aspect of the admissions process also works to ensure that all medical students resemble each other (Shapiro, 1978). Consequently, even though sexism is prevalent at every stage of the medical education process, women are not immune to the overriding influences of professionalization. Again, for many women in medicine, 'class loyalties' prevail. However, it can also be argued that to separate sexism from classism is somewhat of an artificial distinction. As I presented in my discussion of the theory of **latent patriarchal culture,** patriarchy is characterized by a system of hierarchical ordering and control (Beechey, 1979:77). Therefore, issues of 'class loyalty' are implicitly linked to, and interrelated with, issues of gender relations.

Obviously, then, more women in medicine is not the answer if they are trained to think about medicine and medical practice in the same authoritarian, hierarchical, paternalistic, sexist and destructive (to those who fall outside of or challenge its cultural norms) framework that exists today. Indeed, while admitting more women to medicine may eventually strengthen medical practice, it is questionable whether or not the patriarchal assumptions within academic medicine can be altered significantly solely by adding more women. On the other hand, suggesting that women remain outside of the medical profession is neither a viable nor a reasonable solution. As Eisenberg, a female physician and a critic of the system, writes (1983:534):

> If medicine is to become more humane, admitting more women into the profession will not be enough. The task will be to cultivate the humane qualities in all health professionals by making career paths, and the reward structure that reinforces them, consonant with that goal...

She adds in a later article (1989:1544):

> Women, in themselves, are not likely to alter the perceived shortcomings of medical practice. For that to take place, it will be necessary to modify admission criteria, to broaden the narrow focus of medical education, and to change the reward systems which govern medical practice for both women and men.

Indeed, as research shows, women are not powerful within the medical profession, and therefore, it is both unrealistic and ironic that we should look to women to be the initiators of fundamental philosophical and material change.

Clearly, there is no simple solution to this issue. The crux of the predicament is that medicine can be a very destructive enterprise, especially to women, but it is also a very powerful, and seemingly permanent institution within society. However, as many have stated, that is not to say that it must remain in its present form. Therefore, it is vital that, when analyzing the problems and the discrimination that women face in the medical system, the underlying ideology of the institutional structures and the organization of work be recognized as significant factors in circumscribing women's opportunities and experiences. The constant influences and effects of the **latent patriarchal culture** of medicine must always be recognized and documented. Women's experiences within the institution of medicine - the enduring and damaging stereotypes, the formal and informal barriers, and the collective and individual discrimination - are products of a patriarchal society which are used to oppress women systematically and systemically. The challenge, then, is to continue the feminist critique of the medical profession and current medical training and practice and, in doing so, to create the political awareness, the will, the demand, and the climate for change from within, as well as from outside of medicine.

CHAPTER SIX - CONCLUSION

This research was an attempt to add experiential interview data to the body of literature on women in medicine. In part, this is in response to the feminist critique of research in the (social) sciences which exposes the myth of objectivity and neutrality within traditional (social) science, and insists that women must be placed at the centre of scientific inquiry, as active agents in the gathering of knowledge (Stacey and Thorne, 1985:303). Feminism tries to uncover the political presuppositions that have masqueraded as objectivity, and the social and economic biases that have masqueraded as neutrality (University of Western Ontario,1991). While the number of quantitative studies on women in medicine is increasing, this study was unique in that it provided a forum for women's voices to be heard. Consequently, it was an opportunity to construct a more complete description, and to broaden the understandings about the institution of medicine, as well as women's perceptions of their place within today's medical system. Moreover, this research had as its fundamental aim, the ideological goal of feminist scholarship within the social sciences: "...to correct both the invisibility and distortion of female experience in ways relevant to ending women's unequal social position" (Lather, 1988:571).

The in-depth interview data that I gathered supported my theoretical contention that the Faculty of Medicine at the University of Manitoba, is strongly characterized by a **latent patriarchal culture,** which, in turn, influences every aspect of the medical school experience. Consequently, this study offers two major contributions to the fields of Health Sociology and Women's Studies. First, it is evident from the

supporting literature that the study findings are not isolated conceptually. This research is among a growing number of studies which report that "the same themes - social isolation due to an 'Old Boys Network,' preoccupation with sex status, differential role demands, and inappropriate role models," keep resurfacing in research on women in medicine (Coombs and Hovanessian, 1988:21). Consequently, as stated previously, the enduring and damaging stereotypes, the formal and informal barriers, and the collective and individual discrimination experienced by women in medicine must be recognized as products of a patriarchal society which are used to oppress women systematically and systemically. The findings of this research are important because they represent the opinions and experiences of some women in medical school today. The women interviewed have raised many serious issues and concerns that cannot be easily dismissed.

Secondly, this research makes a valuable theoretical contribution because I have linked explicitly the theoretical concept of **latent culture,** developed by Becker, Geer, Hughes and Strauss in 1961, with the concept of **patriarchy,** which has been developed more recently in the feminist literature (Beechey, 1979; Eisenstein, 1984; Fox, 1988; Muszynski, 1989). Through this research I have introduced, investigated and documented the political expressions of patriarchy within the culture of medical school. In essence, I have highlighted the inherent patriarchal dimensions of a theoretical construct - latent culture - that was previously conceptualized as apolitical. In making the connections between **patriarchy** and **latent culture,** I have made the implicit explicit. The creation of the concept **latent patriarchal**

culture represents an attempt to politicize latent culture - to substantiate the feminist adage that "the personal is political."

That said, it is essential that the limitations of this study be acknowledged. This research is a small-scale exploratory study, and because of the limited size of the sample as well as the fact that the women were not randomly assigned to participate but, rather, self-selected into the study, the generalizability of the findings is correspondingly limited. However, based on the data collected from this study, important issues have been highlighted, questions can be revised and, in addition, new questions can be formulated and applied in a future research project. One recommendation for further research in this area is to expand the geographical parameters of this study. That is, it is my contention that a large-scale, qualitative study investigating women's perceptions of the persistence and consequences of sexism in all 16 Canadian medical schools is an important and necessary step in documenting and highlighting the pervasiveness of **latent patriarchal culture,** and in continuing to make explicit the connections between the personal and the political. A larger study would also allow examination of theoretical issues such as how women's perceptions are affected and influenced by their year in medical school in relation to their outside life experiences. Moreover, a large-scale study would allow the researcher to explore, pre-empt and, therefore, reconcile the tensions between methodological and ethical issues (i.e., identification of individual quotations in the research report). Therefore, by providing a time and space context for women's experiences in future research, women's individual voices will indeed be heard.

Relatedly, another area for future research is the investigation of the many ways that patriarchal culture manifests itself within the medical school environment - particularly in the form of homophobia, and in the backlash against feminism. In sum, it is critical that future research in the area of women in medical school continue to investigate, identify and analyze the various dimensions and mechanisms of **latent patriarchal culture.** To restate Beechey's assertion (1979:80),

> the forms of patriarchy which exist in particular social institutions have to be investigated...we are wrong to assume that domination assumes the same form in all social formations and in all kinds of social institutions within a society.

It is also important to state that this study falls into the domain of woman-centred research. This strategy is premised on the understanding that women have been excluded from consideration, and progress will not result from simply adding them to otherwise unchanged ways of doing science. "The starting point is, therefore, the position of women, and the goal is to reach a better understanding of the particularities of the female condition" (Eichler, 1987:25).

It is my hope that through the dissemination of these findings this study can be a vehicle to promote meaningful discussion among women and men, both separately and together, and ultimately, to help facilitate change. For meaningful dialogue to occur, it is critical that discussion move away from 'intentions,' and instead focus on the 'effects' of the latent patriarchal culture within medical school (University of Western Ontario, 1991). It must be recognized that sexism is built into the system at all levels, and consequently, that it is everyone's responsibility to create and carry out permanent and

far-reaching systemic change. Furthermore, it is necessary that men, who continue, collectively, to hold the power within the institution of medicine, state publicly that sexism and/or gender discrimination is a problem that needs to be addressed in a serious and immediate manner (University of Western Ontario, 1991). While the institution might see its responsibility as being fulfilled now that women are in the doors, and indeed, represent close to 50 percent of the Canadian medical school population, the problem remains that when women "...want to think differently, do different kinds of research, teach differently, say different things, express different interests, challenge the process - that's not as welcome" (University of Western Ontario, 1991). It is my hope that this study will be a catalyst in instituting the many changes that are necessary, based on the women's perceptions of sexism within their training programs, including: gender inclusive and specific language within all curriculum materials and learning situations; immediate increases in the number of females teaching in medical school; immediate increases in the number of institutional supports for women (and men) such as more daycare spaces, female changing rooms, fair maternity leave policy and flexible residencies; and, institutional acknowledgement and sanctioning of all forms of sexism and gender discrimination - reflected in, and enforced by, realistic and workable policy. In light of research which reports that students' adaptation to the medical school environment is important as it directly relates to learning and professional performance (Vitaliano, 1989:1327), it would seem timely that such discussion and initiation of change begin now.

In 1892, Harriet Foxton Clarke became the first woman graduate from the Manitoba Medical College (Hacker, 1974:145). One hundred years later, the question that must be asked is 'how much has really changed for women in medical school at the U of M, and elsewhere'? While change of this magnitude is rarely easy or without tension, it is time to begin the process which will result in women finally and truly becoming welcomed, valued and equal members of the medical profession. Ultimately, this can only be positive for the profession and society, as a whole. As Dr. Glenda Simms, current president of the Canadian Advisory Council on the Status of Women declared (Simms, 1991):

> I'm talking about changing the rules. Changing the rules does not mean lowering the standards - because isn't that what we say? Are we going to have the same standards? Well, let me tell you, that standard needs to be improved. I'm talking about improving the standard!

In conclusion, this study represents a unique theoretical and substantive contribution to medical, sociological and feminist literature, and also to the field of health research. This study was a first attempt at providing Manitoba data to document women medical students' subjective experiences in today's medical school environment. This study has documented the presence of the **latent patriarchal culture** of medicine at the University of Manitoba, and elaborated on how the medical school experience affects female students' lives, as well as their ability to develop the professional identity of 'physician.'

BIBLIOGRAPHY

Acker, J., K. Barry and J. Esseveld
1983 "Objectivity and Truth: Problems in Doing Feminist Research," in Women's Studies International Forum. Vol.6, pp.423-435.

Adamson, N., L. Briskin and M. McPhail
1988 Feminist Organizing for Change. Toronto: Oxford University Press.

Altekruse, J. and S.McDermott
1988 "Contemporary Concerns of Women in Medicine," in Feminism Within the Science and Health Care Professions: Overcoming Resistance. S. V. Rosser (ed.), Oxford; New York: Permagon Press, pp.65-88.

Archer, L., R. Keever, R. Gordon, R. Archer
1991 "The Relationship Between Residents' Characteristics, Their Stress Experiences, and Their Psychosocial Adjustment at One Medical School," in Academic Medicine. Vol.66, No.5, pp.301-303.

Armstrong, P. and H. Armstrong
1987 "Beyond Numbers: Problems with Quantitative Data," in Women and Men: Interdisciplinary Readings on Gender. G. Hofmann Nemiroff (ed.), Toronto: Fitzhenry & Whiteside, pp.54-79.

Armstrong, P. and H. Armstrong
1990 Theorizing Women's Work. Toronto: Garamond Press.

Arnold, R., S. Martin and R. Parker
1988 "Taking Care of Patients - Does It Matter Whether the Physician is a Woman?," in The Western Journal of Medicine. Vol.149, No.6, pp.729-733.

Association of Canadian Medical Colleges
1991 Canadian Medical Education Statistics. Vol. 13.

Association of Canadian Medical Colleges
1988 Admission Requirements To Canadian Faculties of Medicine and Their Selection Policies.

Babbie, E.
1989 The Practice of Social Research. (5th edition) Belmont: Wadsworth Publishing Company.

Backstrom, C. and G. Hursh-Cesar
1981 Survey Research. New York: John Wiley & Sons.

Baker, M.
1985 What Will Tomorrow Bring?: A Study of the Aspirations of Adolescent Women. Ottawa: Canadian Advisory Council on the Status of Women.

Becker, H.S., B. Geer, E.C Hughes and A.L. Strauss
1961 Boys in White. Chicago: University of Chicago Press.

Beechey, V.
1979 "On Patriarchy," in Feminist Review. Vol.3, pp.66-83.

Benston, M.
1982 "Feminism and the Critique of Scientific Method," in Feminism in Canada: From Pressure to Politics. Montreal: Black Rose Books.

Bickel, J.
1989 "Maternity Leave Policies for Residents: An Overview of Issues and Problems," in Academic Medicine. Vol.64, No.9, pp.498-501.

Brown, S. and R. Klein
1982 "Woman Power in the Medical Hierarchy," in The Journal of the American Medical Association (JAMWA). Vol.37, No.3, pp.155-164.

Bunch, C.
1987 Passionate Politics: Feminist Theory in Action. New York: St. Martins Press.

Burnley, C. and G. Burkett
1986 "Specialization: Are Women in Surgery Different?," in JAMWA. Vol.41, No.5, pp.144-151.

Calkins, E., L. Willoughby and L. Arnold
1987 "Gender and Psychosocial Factors Associated With Specialty Choice," in JAMWA. Vol.42, No.6, pp.170-172.

Calkins, E., L. Willoughby and L. Arnold
1992 "Women Medical Students' Ratings of the Required Surgery Clerkship: Implications for Career Choice," in JAMWA. Vol.47, No.2, pp.58-60.

Canadian Press
1992 "School Sexism Upsets Educator; Separate Classes Suggested," in Winnipeg Free Press. April 12, p.A2.

Cartwright, L.K.
1987 "Role Montage: Life Patterns of Professional Women," in JAMWA. Vol.42, No.5, pp.142-148.

Caucus for Women
1992 "Facts About Women at the University of Manitoba - 1990/91."

Clawson, D.,
1990 "The Education of the Physician," in Academic Medicine. Vol.65, No.2, pp.84-88.

Cohen, M., C. Woodward, and B. Ferrier
1988 "Factors Influencing Career Development: Do Men and Women Differ?," in JAMWA. Vol.43, No.5, pp.142-154.

Colquitt, W. and C. Killian
1991 "Students Who Consider Medicine But Decide Against It," in Academic Medicine. Vol.66, No.5, pp.273-278.

Conrad, P. and J. Schneider
1986 "Professionalization, Monopoly, and the Structure of Medical Practice," in The Sociology of Health and Illness: Critical Perspectives. P. Conrad and R. Kern (eds.), New York: St. Martin's Press, pp.127-133

Coombs, R. and H. Hovanessian
1988 "Stress in the Role Constellation of Female Resident Physicians," in JAMWA. Vol.43, No.1, pp.21-27.

Daum, D.
1979 "The Data: Women in Medicine," in JAMWA. Vol.40, No.2, pp.175-199.

De la Cour, L. and R. Shienen
1990 "The Ontario Medical College for Women 1883-1906: Lessons from GenderSeparatism in Medical Education," in Despite the Odds: Essays on Canadian Women and Science. M. Gosztonyi Ainley (ed.), Montreal: Vehicule Press.

Deliman, T. and J. Smolowe
1982 Holistic Medicine. Reston, Virginia: Reston Publishing Co., Inc.

Dial, T., J. Bickel and A. Lewicki
1989 "Sex Differences in Rank Attainment Among Radiology and Internal Medicine Faculty," in Academic Medicine. Vol., No., pp.198-202.

Dickstein, L. and J. Stephenson
1987 "A National Survey of Women Physicians in Administrative Roles," in JAMWA. Vol.42, No.4, pp.108-111.

Dickstein, L.
1990 "Female Physicians in the 1980s: Personal and Family Attitudes and Values," in JAMWA. Vol.45, No.4, pp.122-126.

Donoghue, G.
1988 "Eliminating Salary Inequities for Women and Minorities in Medical Academia," in JAMWA. Vol.43, No.1, pp.28-29.

Dornbush, R., S. Richman, P. Singer and E. Brownstein
1991 "Medical School, Psychosocial Attitudes, and Gender," in JAMWA. Vol.46, No.5, pp.150-152.

Dralle, P., D. Daum, D. Hein and R. Elston
1987 "Sex Role Stereotypes in Freshman Medical Students' Perceptions of Self and Physicians," in JAMWA. Vol.42, No.3, pp.75-80.

DuBois, B.
1983 "Passionate Scholarship: Notes on Values, Knowing and Method in Feminist Social Science," in Theories of Women's Studies. Bowles, G. and R. Duelli-Klein (eds.), London: Routledge and Kegan Paul, pp.105-115.

Eichler, M.
1987 "The Relationship Between Sexist, Non-Sexist, Woman-Centred and Feminist Research in the Social Sciences," in Women and Men: Interdisciplinary Readings on Gender. G. Hofmann Nemiroff (ed.), Toronto: Fitzhenry & Whiteside, pp.21-53.

Eisenberg, C.
1983 "Women as Physicians," in Journal of Medical Education. Vol.58, pp.534-541.

Eisenberg, C.
1989 "Medicine is No Longer a Man's Profession," in The New England Journal of Medicine. Vol.321, No.22, pp.1542-1544.

Eisenstein, Z.
1984 Feminism and Sexual Equality. New York: Monthly Review Press.

Elliot, D. and D. Girard
1986 "Gender and the Emotional Impact of Internship," in JAMWA. Vol.41, No.2, pp.54-56.

Fee, E.
1981 "Is Feminism a Threat to Scientific Objectivity?," in International Journal of Women's Studies. Vol.4, pp.378-392.

Fee, E.
1986 "Critiques of Modern Science: The Relationship of Feminist to Other Radical Epistemologies," in Feminist Approaches to Science. R. Bleier (ed.), New York: Permagon Press, pp.42-56.

Fiorentine, R.
1987 "Men, Women, and the Premed Persistence Gap: A Normative Alternatives Approach," in American Journal of Sociology. Vol.92, No.5, pp.1118-1139.

Fonow, M. and J. Cook
1991 "Back to the Future: A Look at the Second Wave of Feminist Epistemology and Methodology," in Beyond Methodology: Feminist Scholarship as Lived Research. M. Fonow and J. Cook (eds.), Bloomington: Indiana University Press, pp.1-15.

Fox, B.
1988 "Conceptualizing Patriarchy," in Canadian Review of Sociology and Anthropology. Vol.25, No.2 pp.163-182.

Fox Keller, E.
1982 "Feminism and Science," in Signs. Vol.7, pp.589-602.

Fox Keller, E.
1985 Reflections on Gender and Science. New Haven: Yale University Press.

Fuchs-Epstein, C.
1981 "Women in Sociological Analysis: New Scholarship Versus Old Paradigms," in A Feminist Perspective in the Academy. E. Langland and W. Gove (eds.), Chicago: University of Chicago Press.

Gerson, J. and K. Peiss
1985 "Boundaries, Negotiation, Consciousness: Reconceptualizing Gender Relations," in Social Problems. Vol.32, No.4, pp.317-331.

Gibbs, N.
1992 "The War Against Feminism," in Time March 9, pp.38-47.

Glaser, B. and A. Strauss
1967 The Discovery of Grounded Theory: Strategies for Qualitative Research. Chicago: Aldine Publishing Company.

Goode, W.
1957 "Community Within a Community: The Professionals," in American Sociological Review. Vol.22, pp.195-200.

Grant, L.
1988 "The Gender Climate of Medical School: Perspectives of Women and Men Students," in JAMWA. Vol.43, No.4, pp.109-119.

Hacker, C.
1974 The Indomitable Lady Doctors. Toronto: Clarke Irwin.

Hammond, J.
1981 "Social Support Groups, Women's Programs, and Research on Gender Differences: The Bad Press for Women in Medical Education Literature," in JAMWA. Vol.36, No.5, pp.162-165.

Hapchyn, C. and I. Gold
1990 "Training Issues for a Female Psychiatric Residency," in JAMWA. Vol.32, No.2, pp.43-46.

Harding, S.
1989 "How the Women's Movement Benefits Science: Two Views," in Women's Studies International Forum. Vol.12, No.3, pp.271-283.

Harris, M. and M. Conley-Muth
1981 "Sex Role Stereotypes and Medical Specialty Choice," in JAMWA. Vol.36, No.8, pp.245-252.

Harrison, M.
1990 "Woman as Other: The Premise of Medicine," in JAMWA. Vol.45, No.6, pp.225-226.

Harward, D., C. Lyons, C. Porter and R. Hunter
1981 "A Comparison of the Performance of Male and Female Medical Students and Residents," in Journal of Medical Education. Vol.56, pp.853-855.

Hartsock, N.
1979 "Feminist Theory and the Development of Revolutionary Strategy," in Capitalist Patriarchy and the Case for Socialist Feminism. Z. Eisenstein (ed.), New York: Monthly Review Press, pp.56-77.

Heins, M., S. Smock, L. Martindale, J. Jacobs and M. Stein
1977 "Comparison of the Productivity of Women and Men Physicians," in Journal of the American Medical Association. Vol.237, No.23, pp.2514-2517.

Hofmann Nemiroff, G. (ed.)
1987 Women and Men: Interdisciplinary Readings on Gender. Montreal: Fitzhenry & Whiteside Limited.

Hunter College Women's Studies Collective
1983 Women's Realities, Women's Choices. New York: Oxford University Press.

Hyde, J.
1985 Half the Human Experience. Lexington, Mass.: D.C. Heath and Company.

Institutional Analysis
1991 "Statistics." University of Manitoba.

Janus, C. and S. Janus
1987 "Career Adjustment of Women Radiologists," in JAMWA. Vol.42, No.2, pp.54-56.

Johnson, C., B. Johnson and B. Liese
1991 "Dual-Doctor Marriages: The British Experience," in JAMWA. Vol.46, No.5, pp.155-163.

Jones, A.
1992 "Books: Backlash and Beyond," in Ms. Vol.11, No.4, pp.58-60.

Kettner, A.
1988 "Female Family-Practice Graduates at the University of Manitoba: Career Patterns and Perceptions," in Canadian Family Physician. Vol.34, pp.831-837.

Kinesis
1988 "Notes." June, pp.20-25.

Kohman, L. and J. Hoefer
1991 "The Formation and Function of Women's Groups Within Specialty Societies," in JAMWA. Vol.46, No.3, pp.91-94.

Labour Canada
1986 When I Grow Up... Career Expectations and Aspirations of Canadian Schoolchildren. Ottawa: Minister of Supply and Services.

Lather, P.
1988 "Feminist Perspectives on Empowering Research Methodologies," in Women's Studies International Forum. Vol.11, pp.569-581.

Lenhart, S., F. Klein, P. Falcao, E. Phelan and K. Smith
1991 "Gender Bias Against and Sexual Harassment of AMWA Members in Massachusetts," in JAMWA. Vol.46, No.4, pp.121-125.

Linn, L., D. Cope and B. Leake
1984 "The Effect of Gender and Training of Residents on Satisfaction Ratings by Patients," in Journal of Medical Education. Vol.59, pp.964-966.

Longino, H.
1989 "Feminist Critiques of Rationality: Critiques of Science or Philosophy of Science?," in Women's Studies International Forum. Vol.12, No.3, pp.261-269.

Lorber, J.
1975 "Women and Medical Sociology: Invisible Professionals and Ubiquitous Patients," in Another Voice. M. Millman and R.M. Kanter (eds.), New York: Anchor Press, pp.75-105.

Lorber, J.
1981 "The Limits of Sponsorship for Women Physicians," in JAMWA. Vol.36, No.11, pp.329-338.

Lorber, J.
1984 Women Physicians. New York: Tavistock Publications.

Lorber, J.
1986 "Sisterhood is Synergistic," in JAMWA. Vol.41, No.4, pp.116-119.

Lorber, J.
1987 "A Welcome to a Crowded Field: Where Will the New Women Physicians Fit In?," in JAMWA. Vol.42, No.5, pp.149-152.

Lorber, J.
1990 "Can Women Physicians Ever Be Equal in the American Medical Profession?," in Current Research in Occupations and Professions. J. Levy and G. Marx (eds.), New York: JAI Press, pp.1-36.

Mackie, M.
1983 Exploring Gender Relations. Toronto: Butterworths.

MacKinnon, C.
1987 Feminism Unmodified: Discourses on Life and Law. Cambridge: Harvard University Press

Maheux, B., F. Dufort and F. Beland
1988 "Professional and Sociopolitical Attitudes of Medical Students: Gender Differences Reconsidered," in JAMWA. Vol.43, No.3, pp.73-75.

Major, B.
1987 "Women and Entitlement," in Women and Therapy. Vol.6, No.3, pp.3-19.

Manitoba Human Rights Commission
1992 "Public Presentation on Systemic Discrimination," at The University of Manitoba.

Marquart, J., K. Franco and B. Carroll
1990 "The Influence of Applicants' Gender on Medical School Interviews," in Academic Medicine. Vol.65, No.6, pp.410-411.

Martin, C. and J. Woodring
1986 "Attitudes Toward Women in Radiology," in JAMWA. Vol.41, No.2, pp.50-53.

Martin, C., J. Jones and M. Bird
1988 "Support Systems for Women in Medicine," in JAMWA. Vol.43, No.3, pp.77-83.

Martin, S., R. Arnold and R. Parker
1988 "Gender and Medical Socialization," in Journal of Health and Social Behavior. Vol.29, pp.333-343.

McDonough, R. and R. Harrison
1978 "Patriarchy and Relations of Production," in Feminism and Materialism: Women and Modes of Production. A. Kuhn and A. Wolpe (eds.), London; Boston: Routledge and Kegan Paul, pp.11-42.

Merriam-Webster
1983 Webster's Ninth New Collegiate Dictionary. Springfield, Mass.: Merriam-Webster Inc. pp.11-42.

Mies, M.
1983 "Towards a Methodology for Feminist Research," in Theories of Women's Studies. G. Bowles and R. Duelli-Klein (eds.), London: Routledge and Kegan Paul, pp.83-113.

Merton, R. K.
1957 Social Theory and Social Structure Glencoe, Illinois: Free Press.

Merton, R. K., P. Kendall and G. Reader (eds.)
1957 The Student Physician. Cambridge, Mass.: Harvard University Press.

Muszynski, A.
1989 "What is Patriarchy?," in Socialist Studies. Vol.5, pp.65-86.

Nachmias D. and C. Nachmias
1987 Research Methods in the Social Sciences. New York: St. Martin's Press.

Nadelson, C.
1992 "Advancing Through the Medical Hierarchy," in JAMWA. Vol.46, No.3, pp.95-99.

Namenwirth, M.
1984 "Science Seen Through a Feminist Prism," in Feminist Approaches to Science. R. Bleier (ed.), pp.18-41, New York: Permagon Press.

Navarro, V.
1976 Medicine Under Capitalism. London: Robertson.

Navarro, V.
1978 Class Struggle, the State and Medicine. New York: Prodist.

Nebraska Feminist Collective (NFC)
1983 "A Feminist Ethic for Social Science Research," in Women's Studies International Forum. Vol.6, No.5, pp.535-543.

Oakley, A.
1981 "Interviewing Women: A Contradiction in Terms," in Doing Feminist Research. H. Roberts (ed.), pp.30-61, Routledge and Kegan Paul.

Opinion
1986 "Why Would A Girl Go Into Surgery?," in JAMWA. Vol.41, No.2, pp.58-60.

Osborn, E., V. Ernster and J. Martin
1992 "Women's Attitudes Towards Careers in Academic Medicine at the University of California, San Fransisco," in Academic Medicine. Vol.67, No.1, pp.59-62.

Osborne, D.
1983 "My Wife, the Doctor," in Mother Jones. pp.18-44.

Parkerson, G., W. Broadhead and C. Tse
1990 "The Health Status and Life Satisfaction of First-Year Medical Students," in Academic Medicine. Vol.65, No.9, pp.586-588.

Phelan, E.
1991 "A Survey of Maternity Leave Policies in Boston Area Hospitals," in JAMWA. Vol.46, No.2, pp.55-58.

Poirier, S.
1986 "Role Stress in Medical Education: A Literary Perspective," in JAMWA. Vol.41, No.3, pp.82-86.

Ramos S. and C. Feiner
1989 "Women Surgeons: A National Survey," in JAMWA. Vol.44, No.1, pp.21-25.

Ribbens, J.
1989 "Interviewing - An 'Unnatural Situation'?," in Women's Studies International Forum. Vol.12, No.6, pp.579-592.

Ristock, J.
1989 "Feminist Social Service Collectives in Canada: A Viable Force or a Contradiction," PhD Dissertation: OISE, University of Toronto.

Roberts, H.
1981 "Some of the Boys Won't Play Anymore: The Impact of Feminism on Sociology," in Men's Studies Modified: The Impact of Feminism on the Academic Disciplines. D. Spender (ed.), pp.237-248. Oxford: Permagon Press. Vol.42, No.1, pp.15-18.

Robinson, L., S. Edelman and K. Goist
1987 "Sex Role Stereotyping: Reactions of Women Anesthesiologists," in JAMWA. Vol.42, No.1, pp.15-18.

Rose, H.
1986 "Beyond Masculinist Realities: A Feminist Epistemology for the Sciences," in Feminist Approaches to Science. R. Bleier (ed.), pp.57-76. New York: Permagon Press.

Rosenthal, P. and J. Eaton
1982 "Women MD's in America: 100 Years of Progress and Backlash," in JAMWA. Vol.37, No.3, pp.129-133.

Sayres, M., G. Wyshak, G. Denterlein, R. Apfel, E. Shore and D. Federman
1986 "Pregnancy During Residency," in The New England Journal of Medicine. Vol.314, No.7, pp.418-423.

Scadron, A.
1984 "AMWA's Experiment in Planned Change. A Report on the Women in Medical Academia Project," in JAMWA. Vol.35, No.3, pp.299-301.

Schermerhorn, G., J. Colliver, S. Verhulst and E. Schmidt
1986 "Factors that Influence Career Patterns of Women Physicians," in JAMWA. Vol.41, No.3, pp.74-78.

Schneider, S. and A. Soto
1989 "Sexist Language: Should We Be Concerned?," in JAMWA. Vol.44, No.3, pp.80-83.

Scully, D. and P. Bart
1978 "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textbooks," in The Cultural Crisis of Modern Medicine. J. Ehrenreich (ed.), New York: Monthly Review Press, pp.212-226.

Shapiro, M.
1978 Getting Doctored. Kitchener: Between the Lines.

Silver, M.
1991 "Gender Differences in Career Development Among Psychiatrist-Administrators," in JAMWA. Vol.46, No.1, pp.19-22.

Simms, G.
1991 "Comments," in The Chilly Climate for Women in Colleges and Universities. (Video), University of Western Ontario. Executive Producers: Western's Caucus on Women's Issues and the President's Standing Committee for Employment Equity.

Sinal, S., P. Weavil and M. Camp
1988 "Survey of Women Physicians on Issues Relating to Pregnancy During a Medical Career," in Journal of Medical Education. Vol.63, pp.531-538.

Sleightholm, S.
1991 "Women Make the Grade in McMaster's First-Year Medical Class," in Hospital News S.W. Ontario and Hamilton, May, 1991, p.4.

Spiegel, D., R. Smolen and K. Hopfensperger
1987 "Interpersonal Stress in Medical Education: Correlates for Men and Women Students," in JAMWA. Vol.42, No.1, pp.19-21.

Spradley, J.
1979 The Ethnographic Interview. New York: Holt, Rinehart and Winston.

Stacey, J.
1988 "Can There Be a Feminist Ethnography?," in Women's Studies International Forum. Vol.11, pp.21-27.

Stacey, J. and B. Thorne
1985 "The Missing Feminist Revolution in Sociology," in Social Problems. Vol.32, No.4, pp.301-316.

Stanley, L. and S. Wise
1983 "'Back into the Personal' or: Our Attempt to Construct 'Feminist Research'," in Theories of Women's Studies. G. Bowles and R. Duelli-Klein (eds.), London: Routledge and Kegan Paul, pp.192-209.

Strong-Boag, V.
1981 "Canada's Women Doctors: Feminism Constrained," in Medicine in Canadian Society. S.E.D. Shortt (ed.), Montreal: McGill-Queen's University Press, pp.207-235.

Unger, R.
1983 "Through the Looking Glass: No Wonderland Yet! (The Reciprocal Relationship Between Methodology and Models of Reality)," in Psychology of Women Quarterly. Vol.80, No.3, pp.9-32.

University of Western Ontario
1991 "The Chilly Climate for Women in Colleges and Universities," (video) Executive Producers: Western's Caucus on Women's Issues and the President's Standing Committee for Employment Equity.

Vitaliano, P., R. Maiuro, E. Mitchell and J. Russo
1989 "Perceived Stress in Medical School: Resistors, Persistors, Adaptors and Maladaptors," in Social Science and Medicine. Vol.28, No.12, pp.1321-1329.

Wallis, L., H. Gilder and H. Thaler
1981 "Advancement of Men and Women in Medical Academia," in Journal of the American Medical Association. Vol.246, pp.2350-2353.

Walsh, M. Roth
1977 Doctors Wanted, No Women Need Apply. New Haven: Yale University Press.

Walsh, M. Roth
1984 "Feminist Showplace" in Women and Health in America. J.W. Leavitt (ed.), Madison Wisconsin: The University of Wisconsin Press, pp.392-405.

Westkott, M.
1979 "Feminist Criticism of the Social Sciences," in Harvard Educational Review. Vol.49, pp.422-430.

Wheeler, R., L. Candib and M. Martin
1990 "Part-time Doctors: Reduced Working Hours for Primary Care Physicians," in JAMWA. Vol.45, No.2, pp.47-54.

Whiting, B. and J. Bickel
1990 "AAMC Data Report: Women on Faculties of U.S. Medical Schools, 1979-1989," in Academic Medicine. Vol.65, No.24, pp.277-278.

Wilson, J.S.
1986 Women, the Family and the Economy. (2nd ed.), Toronto: McGraw-Hill Ryerson.

Witt, P., D. Derouen, F. Kamel, P. Kelleher, M. McCarthy, M. Namenwirth, L. Sabatini and M. Voytovich
1989 "The October 29th Group: Defining a Feminist Science," in Women's Studies International Forum. Vol.12, No.3, pp.253-259.

Woodward, C. and L. Chambers
1986 Guide to Questionnaire Construction and Question Writing. Ottawa: Canadian Public Health Association.

APPENDIX A

UNIVERSITY OF MANITOBA
FACULTY COMMITTEE ON THE USE OF HUMAN SUBJECTS IN RESEARCH

NAME: Ms. Jo-Anne Kirk

OUR REFERENCE: E91:22

DATE: April 23, 1991

YOUR PROJECT ENTITLED:

Women in Medical School: An Experiential Account of the Persistence of Sexism and its Consequences.

HAS BEEN APPROVED BY THE COMMITTEE AT THEIR MEETING OF:

April 22, 1991

COMMITTEE PROVISOS OR LIMITATIONS:

Approved as per your letter dated April 22, 1991.

You will be asked at intervals for a status report. Any significant changes of the protocol should be reported to the Chairman for the Committee's consideration, in advance of implementation of such changes.

**This is for the ethics of human use only. For the logistics of performing the study, approval should be sought from the relevant institution, if required.

Sincerely yours,

J. P. Maclean, M.D.,
Chairman,
Faculty Committee on the Use of
Human Subjects in Research.

JPM/ll

TELEPHONE ENQUIRIES:
788-6255 - Lorraine Lester

APPENDIX B

THE UNIVERSITY OF MANITOBA DEPARTMENT OF SOCIOLOGY Winnipeg, Manitoba Canada R3T 2N2

October 3, 1991

Dear Medical Student:

As a student in medicine today, you may be interested in the following information:

In 1989-90, women comprised 44 percent of the total enrollment in Canadian faculties of medicine, compared with 7 percent in 1957-58, and 17.8 percent in 1970-71. Between 1985-89, women also earned 41 percent of the M.D.'s at all Canadian universities, compared with 4.9 percent from 1940-44, and 11.3 percent from 1965-69. At the University of Manitoba, there were 34 first year women in a class of 85 students, as of December 1, 1990. Today, women comprise 38.8 percent of the total enrollment in the undergraduate medical training program at the U of M.

These statistics show that women are now better represented in medical schools and in the profession than in the past. Yet, the question arises as to whether these numbers actually represent a positive and progressive change in the medical profession's attitude towards women as students, as physicians and as professionals.

My name is Jo-Anne Kirk and I am a graduate student in the Department of Sociology at the University of Manitoba. I am interested in women's experiences in medical school and am presently doing research in this area. In particular, I am interested in interviewing female medical students about their experiences at the U of M Faculty of Medicine.

If you are interested in speaking with me, please contact me at 772 1709 before Friday, October 18, and I will arrange an interview appointment at your convenience. Any questions that you may have about this interview or my research can be directed to myself, my advisor Dr. Karen Grant at 474 9831, or Dr. Pat Mirwaldt, Assistant Dean of Medical Student Affairs, at 788 6495.

I am sure that you will find the interview very interesting as it involves several topics of relevance to your experiences in medical school. I would also like to assure you at this time that your responses on this interview will be kept strictly confidential.

Your participation in this study is of vital importance and would be greatly appreciated. I am looking forward to speaking with you.

Sincerely,

Jo-Anne Kirk

APPENDIX C

THE UNIVERSITY OF MANITOBA DEPARTMENT OF SOCIOLOGY Winnipeg, Manitoba
Canada R3T 2N2

November 15, 1991

Dear Female Medical Student:

At the beginning of October, you received a letter in your mailbox briefly describing my M.A. thesis research (Sociology, U of M) on women in medicine. My research focuses on whether the increased number of women in medical schools and in practice, represents a positive and progressive change in the medical profession's attitude towards women as students, as physicians and as professionals.

This is a reminder that I am still very interested in interviewing female undergraduate medical students about your experiences at the University of Manitoba Faculty of Medicine.

If you are interested in speaking with me, please contact me as soon as possible, at 772 1709. I am able to schedule an interview at your convenience until Tuesday, December 10, 1991. Once again, I would like to assure you that all of your responses on this interview will be kept strictly confidential.

If you have any questions about this interview or about my research in general, you can contact me at 772 1709, my advisor Dr. Karen Grant at 474 9831, or Dr. Patricia Mirwaldt, Assistant Dean of Medical Student Affairs, at 788 6495.

I would also like to take this opportunity to warmly thank all of the women who have already participated in my research. Your time, as well as your thoughtful and insightful responses are greatly appreciated.

Sincerely,

Jo-Anne Kirk

APPENDIX D

THE UNIVERSITY OF MANITOBA DEPARTMENT OF SOCIOLOGY Winnipeg, Manitoba Canada R3T 2N2

STATEMENT OF INFORMED CONSENT

WOMEN IN MEDICAL SCHOOL: AN EXPERIENTIAL ACCOUNT OF THE PERSISTENCE OF SEXISM AND ITS CONSEQUENCES

The purpose of this research is to explore the experiences of women in medical school at the University of Manitoba. In particular, the study aims are to identify the effects of the medical school environment in terms of women medical students' perceptions of the persistence of sexism within their training programs, and its consequences. This information will be gathered by way of an individual tape-recorded interview with the researcher, lasting approximately 1-2 hours.

I understand that I can refuse to answer any or all questions without prejudice.

I understand that any information given within the course of this interview will be held in strictest confidence and that in no way will my identity be revealed during any stage of the data analysis or in publication.

I understand that my participation in this study is completely voluntary and that I am free to withdraw at any time without prejudice.

I understand that if I have any questions I can conduct the researcher, Jo-Anne Kirk at 474-9260, or the research supervisor, Dr. Karen Grant at 474-9831.

Having read and understood the nature of this research and my participation in it, my signature below signifies my willingness to participate.

_____ _____

Date Signature

_____ _____

Date Witness

APPENDIX E

General Interview Guide

To begin, I will assure the respondent of the confidentiality of her responses and of all information divulged during all stages of the research. I will also attempt to make her as comfortable and at ease as possible.

At the time of the first interview with each respondent, she will already have a general understanding of the nature of the research as the result of previous contact (either telephone or in-person) with (1) myself and/or (2) other women in medicine who already have been interviewed. However, before the actual interview begins, I will again take the time to explain the research intentions. At this time, the nature of the interview (e.g. two-way interaction) will be explained, and I will answer any questions each woman has regarding the research, my work in general, and the interview itself. I will also encourage the respondent to ask as many questions as she likes throughout the interview. Finally, I will also emphasize that I am interested in both positive and negative experiences and incidents, in reference to herself, as well as in relation to other women in medical school. What follows is a general interview guide.

INTERVIEW SCHEDULE

(1) To begin with, I'd like you to define 'sexism' for me. That is, take a few minutes and tell me what 'sexism' or 'gender discrimination' means to you.

Now, with that definition in mind, I'd like to explore your experiences both leading up to and involving medical school. Please remember that there aren't any right or wrong answers - I'm interested in your perceptions and opinions. I'd like to hear about both the positive and negative experiences that you've had yourself, as well as anything else that you feel is important to add to the discussion.

(2) I'm going to ask you to remember back to when you first started thinking about becoming a doctor. When was this? What made you decide to go into medicine? Were there any people in particular who encouraged or discouraged you to pursue this goal? Whom? and what were their reasons? How did they encourage/discourage you to pursue this goal?

(3) With regard to your educational and/or academic experiences prior to being admitted to medical school, does anything particularly positive or negative stand out? Did you receive any encouragement or discouragement in terms of your academic/career goals? (Expand)

(4) Can you tell me about your admissions interview for medical school? How did it go? Do you remember anything particularly positive or negative about the experience? What did you like or dislike about the interview?

Did you have any sense of being treated differently from men or other women? If so, how? Who was on the interview committee?

(If applicable) Did the men and women on the panel seem to ask different kinds of questions? If so, how? When you found out that you had been admitted to medical school, what were the reactions of the significant people in your life? Suppose that you were not accepted into medical school, did you have alternative career goals in mind? If so, what was your plan?

(5) Now I'd like to focus on your preclinical years, still keeping in mind your definition of sexism. In terms of lecture and lab situations, have you experienced, witnessed, or heard about anything that you feel is relevant to relate?
In terms of course material and lecture formats - do you feel that issues relevant to women's bodies and health are being adequately addressed? Is the male body often the norm?
What about the use of humour during lectures/labs? Have you ever felt uncomfortable because you are female? Please explain.
Have you noticed any patterns of silencing in the classroom? (explain if necessary - Which students are asked questions, who is not? Have any questions, or anyone been ignored? picked on? If a student [female, male or in general] openly challenged a professor, what has been the reaction? Or, is this unlikely to happen?)

(6) In reference to the teaching faculty, approximately how many women have you had as instructors/lecturers? Do you feel that there are enough women teaching in medical school? Does this make any difference to you? Why or why not?

(6 - Continued)

In terms of the other students in medicine (both in your year and in general), do you feel that there is a good balance between the number of women and men? Does this make a difference to you? If so, how?

(7) (If Applicable) I'd like to now focus on your clinical experiences. Again, thinking back to your definition of sexism/gender discrimination, does anything in particular come to mind? You may want to consider the same types of instances that I referred to in your preclinical years. (i.e. lecture material, humour, during rounds, etc.)

Any comments on interactions involving a) staff physicians; b) nurses; c) patients; d) your peers?

Can you tell me about your residency interviews? (refer back to probes in #4)

(8) Have you ever participated in extra-curricular activities such as study groups, voluntary associations among medical students, 'Beer and Skits'?

Are there, or have there been any situations where you've felt uncomfortable or particularly satisfied because you are female? Have you witnessed or heard about such instances for others? Can you comment on any differences and/or similarities that you perceive as existing between yourself and other female and/or male medical students?

(9) Are there any formal bodies or mechanisms for dealing with students' complaints and/or problems in medical school? For problems dealing specifically with sexism/gender discrimination? Have you used or would you use this option? Why or why not? Are there any informal groups or mechanisms for dealing with students' complaints/problems?
Have you or would you take this route? Why or why not? Elaborate.

(10) In your opinion, what qualities do you possess that would make you a good doctor? How and why?

Now that you've spent some time discussing your experiences in and out of medical school, I'd like to switch the focus slightly and ask you to think about your personal goals and aspirations. However, before we move on, is there anything else you'd like to ask, or add to what we've just discussed?

(11) What are your career aspirations? How, if at all, have they changed over the time you've been in medical school?
Have you been encouraged or discouraged in any of your career decisions and/or goals? By whom? How did this make you feel?
Do you know of anyone else this has happened to? Elaborate.

(12) What is your overall impression of medical school? How, if at all, have your thoughts and feelings about medical school changed since you've been there? Do you feel that you belong or fit in? Do you feel, or have you ever felt otherwise? Please elaborate.

PROBES: Have you ever thought seriously about quitting medical school, or had thoughts or feelings of having chosen the wrong profession?

Have you ever felt that medical school controls your life?

Have you ever felt a sense of isolation or marginality? When? Why?

(13) What are your goals and aspirations outside of medicine, in terms of family or anything else that is important to you?

(14) Have you ever been in a situation where you've felt that your personal goals and academic and/or career goals have come into conflict? How have you dealt with this(these) situation(s)? Do you feel that you've had to compromise either your career or personal goals? If yes, when, and how so?

(15) Finally, is there anything else that you would like to add or expand upon? Do you have any questions?

(16) In closing, I'd like to ask you a couple more brief questions:

a) What is your age?

b) How would you describe your ethnic identity?

c) Are any other of your family members involved in the healthcare professions? Whom? What position occupied?

d) What is your current living arrangement?

e) Do you have any children? If so, what are their ages?

THANK YOU FOR TAKING THE TIME TO DO THIS INTERVIEW.

APPENDIX F

THE UNIVERSITY OF MANITOBA

FACULTY OF MEDICINE
Office of the Dean

753 McDermot Avenue
Winnipeg, Manitoba
Canada R3E 0W3

(204) 788-6557

January 22, 1991

Ms. Jo-Anne Kirk
Dept. of Sociology
Isbister Building
University of Manitoba

Dear Ms. Kirk:

Re: E91:22 "Women in Medical School: An Experiential Account of the Persistence of Sexism and its Consequences.

The Committee was concerned that if your subject selection was non randomized the results could be skewed. As soon as the questionnaire has been developed a copy should be sent to the ethics office. There should be a place for a witness on the consent form.

Please respond to these comments and an approval form should follow.

Yours sincerely,

THE UNIVERSITY OF MANITOBA

J. P. Maclean, M.D.
Chairman,
Faculty Committee on the Use of
Human Subjects in Research.

JPM/11

ADDENDUM

Preface to My Departmental Thesis Presentation - August 24, 1992

Before I begin my presentation, I would just like to take a few minutes to address something that is very important to me, as a feminist and a feminist researcher.

One of the guiding principles of feminist research is to engage in research with women and to share the resulting knowledge with women (and men) in attempt to eliminate the oppressions of our society - sexism, racism, classism, ageism, homophobia, able-bodiedism, etc. - I think that it is indicative of how systemic and pervasive and insidious the manifestations of patriarchy are within our (patriarchal) institutions, that we are gathered together today for an event that is labelled a 'defense.' Today, I am to demonstrate that my research is/was valid and real according to the standards and guidelines of social science research within academia. To paraphrase a comment from "The Chilly Climate" video - 'the presupposition is that They own it, They define it, and I must defend it' (University of Western Ontario, 1991).

And I find this underlying framework and the language that reflects this framework quite offensive. Even if I am reading too much into the hidden academic agenda, I find the word 'defense' inappropriate and unacceptable to describe this final task of my feminist research process. So, I would like to ask you all to help me by reframing this event in your minds, because I have learned that that is where change begins. It is a simple task that I am asking. I would like you to

collectively think of and label this a 'Communication' - a sharing and discussion of my MA research process and product. And through your questions, challenges, and critical insights, and my presentation, my responses, and my critical insights, hopefully we will all leave this room enriched: knowing more about one another, about my research, and about this **latent patriarchal culture** of ours.

So, without further hesitation, I will embark on my Communication.