

The Male Medical Student Problem

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A major part of an undergraduate's training in obstetrics and gynaecology is learning to conduct pelvic examinations under supervision. Most Canadian curricula provide initial training with the use of plastic or inert pelvic models, and the luckier undergraduates also receive instruction from professional teaching associates who allow the students to examine them and provide subjective feedback.¹ The students then graduate to performing pelvic examinations in clinical settings under supervision. Clinicians negotiate consent with patients to permit medical students to carry out pelvic examinations with "hands on" supervision.² Given that pelvic examinations performed by students are of necessity more time-consuming than those performed by the clinician alone, the problem for organizers of undergraduate education used to be persuading clinicians to accept medical students into their offices. Now it's not so much trying to place medical students, but to place male medical students. Clinicians have consciously or unconsciously come to recognize that less negotiation for consent to involve a student will be needed if the student is female. The lone male medical student standing uncomfortably outside the examining room while his gynaecology mentor attends to the patient within is one of the saddest sights in medical education.

In this issue, Jennifer Racz and colleagues report their findings from a survey of the attitudes of clinic patients and high-school students to having medical students of either gender involved in conducting breast or pelvic examinations. The observation that young women with minimal experience of undergoing these examinations were less accepting of having male students involved than were older women with more experience is perhaps what we might expect, but it is discouraging for educators and male students nonetheless. What is not known is whether the reluctance of younger women to have male students involved in their examinations can be modified at all. As Dr Racz and colleagues point out, the potential consequences for male

students of this reluctance are that they gain less experience in performing intimate examinations and develop an aversion to pursuing careers that involve performing these examinations, particularly obstetrics and gynaecology. Carried to extremes, the potential consequences include the perceptions inside and outside the profession that these examinations should be performed only by female clinicians and that obstetrics and gynaecology is a specialty for female practitioners only. The pool of candidates for residency training in obstetrics and gynaecology is shallow enough already; shrinking it to female candidates only would make it a puddle rather than a pool.

But before we despair for the spurned student, we must remember the first of Dr Robert Lambert's Six Rules Doctors Need to Know: the patient doesn't want to be there in the first place.³ With a philosophy of "patients come first," we can't insist that patients accept whatever attendant a hospital or clinic comes up with. It would be insensitive and hypocritical to insist that medical care providers are generic and interchangeable. If we recognize that a patient is going to feel least uncomfortable when examined by a female clinician (or male, for that matter), then as far as possible this preference for a specific gender should be met. The difficulty comes with determining what is a blatantly discriminatory request. If a patient requests a clinician of a specific gender, we have become used to trying to accommodate the request; should we do the same if the patient requests a clinician of a specific ethnicity, or colour?

Young women's perceptions of intimacy and trust are formed by numerous influences, and health care providers are privy to few of these. The media are strong cultural influences—by and large, very much stronger than encounters with care providers—and Kincheloe has documented the stereotyping in women's magazines of obstetrician-gynaecologists as female.⁴ This perception appears to carry on in some young women entering medical school, with the potential to have a profound effect on the career choices of their male classmates, because these choices are made in the third year of undergraduate training. This is clearly counterproductive, and the perception and bias should be reversed—but it will take time.

The conclusion drawn by Dr Racz and colleagues, that concerns about the gender of the clinician reduce progressively as a woman's experience with intimate examinations grows, reflects that of related studies.^{5,6} It is reassuring to read that the women in this study felt that the qualities of availability, competence, sensitivity and skill were all more important than the gender of the clinician performing the examination. So the bottom line must be this: in all our dealings with patients, whether we are male or female (add witticism here), we must emphasise these very qualities, but especially competence and sensitivity. If a male medical student is present, we must take the time to emphasise his value and potential importance. The corollary is that the first encounter between a young woman and a male clinician for an intimate examination must be especially unhurried, sensitive and reassuring. She doesn't want to be there. But if you get

it right, then when it really matters she will not be burdened by gender restrictions in who provides her care.

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