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Gender norms in the development of the medical *habitus* in the years of medical schooling and residency

Pautas de género en el desarrollo del *habitus* médico: los años de formación en la escuela de medicina y la residencia médica

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ABSTRACT This article documents the gender abuse that Mexican medical students face. The concept of medical socialization is analyzed, with emphasis on the problem of the mistreatment of medical students. The theoretical framework articulates ideas from Foucault and Goffman with the nodal points of Bourdieu using a gender focus. Numerous examples are employed to show that the formal program of study also contains a hidden curriculum which serves to reproduce gender hierarchies. Women face numerous types of socially induced discouragement in choosing and completing their course of study, particularly in certain specialties. Discrimination is present in affectivized as well as in authoritarian interactions. They face sexual harassment in the classroom and in their years of specialization, and are constantly constructed as subordinated subjects. The importance of these findings in the constitution of a medical *habitus* is discussed.
KEY WORDS Hierarchy, Social; Socialization; Coercion; Medical Sociology; Physicians, Women.

RESUMEN Se documenta el maltrato de género que enfrentan los estudiantes de medicina en México. Se analiza el concepto de socialización médica, con énfasis en el problema del maltrato a las y los estudiantes de medicina. En el marco teórico se articulan conceptos de Foucault y Goffman, con los conceptos nodales de Bourdieu bajo un enfoque de género. Se ilustra mediante diversos ejemplos la manera en que el espacio de aprendizaje del currículum formal lo es también de reproducción de las jerarquías de género, a través del currículum oculto. Las mujeres enfrentan diversas formas de desmotivación socialmente inducida para optar y mantenerse en la carrera de medicina, particularmente en algunas de sus especialidades. La discriminación se presenta igual bajo interacciones afectivizadas que bajo formas muy autoritarias. Enfrentan acoso sexual en clase y en los años de especialización, y no dejan de ser construidas como sujetos subordinados. Al final se discute la importancia de estos hallazgos en la constitución del *habitus* médico.
PALABRAS CLAVES Jerarquía Social; Socialización; Coerción; Sociología Médica; Médicos Mujeres.

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INTRODUCTION

The purpose of this article is to document, in the case of Mexico, one of the aspects of the mistreatment suffered by medical students during their years of medical training, in terms of discrimination and gender-based aggression. We hold that it is fundamental to study this type of patterns of interaction because they play a decisive role in the constitution of the medical *habitus* that in the future will be functional in the reproduction of the same gender structures that originated it. This hypothesis stems from a more general research project, which this article is a part of, entitled: "Professional habitus and citizenship: a sociological study about the conflicts between the medical field and the reproductive health rights in Mexico" [*Habitus professional y ciudadanía: hacia un estudio sociológico sobre los conflictos entre el campo médico y los derechos en salud reproductiva en México*], financed by the National Council of Science and Technology [*Consejo Nacional de Ciencia y Tecnología*] (project 83466-S). The goal of this project is to demonstrate the social origin of the authoritarian character of the medical *habitus* and the effects of the latter in the relationship that the health staff establishes with the female users of reproductive health services.

In the first part, the article analyzes the concept of medical socialization, with the emphasis placed on the problem of medical student abuse, and briefly reviews the most relevant Anglo-Saxon and Latin American literature on this subject. In the second part, we argue that it is necessary to articulate a few concepts from Foucault and Goffman with the nodal points from Bourdieu, using a gender approach with the aim of constructing our object of study from a sociological point of view. In the third part, we briefly introduce the methods and the field strategy followed in this study, and in the fourth part we present the findings. To achieve this goal, the school of medicine is set in the most extensive social context to which it belongs, then, the article illustrates with numerous examples the way in which the learning environment of the formal curriculum also reproduces gender hierarchies through a hidden curriculum. Finally, the article concludes by emphasizing the importance of the analysis presented and the need to continue with this type of research studies.

The problem of the socialization of medical students

The socialization[a] of medical students has been an object of scientific interest for a long time. At the end of the 50s and beginning of the 60s of the last century, this topic emerged as an object of study within the US medical sociology. Two schools with different approaches led the research on this subject: the school of Columbia,[1] and the school of Chicago.[2] The former adopted a functionalist approach, and emphasized the way in which medical students acquire the role of doctors in an attitudinal, technical and scientific way. The latter adopted a symbolic interaction perspective, and emphasized the combination of strategies, resistances and tactics developed by students to learn to survive in the medical school, as well as the stages that the self undergoes in its transformation toward achieving its medical identity. However, both approaches remained silent regarding the gender issues that these transformations imply, owing to the fact that the gender perspective had not yet emerged in the social sciences as an authorized approach, since in those years the number of women enrolled in those faculties was less than 10%.[3]

As a result of those pioneering research studies and other studies that followed, several types of learning were identified as crucial for the students in their training process. Those worth highlighting include training for "uncertainty" (where the students must get used to the difficulty of differentiating between the limitation in their knowledge of the medical science and their own personal limitations), "distant attention" training (where the students must learn to regulate their personal involvement with the patients), and the training for "dealing with errors and failure" in their practice. Common to this learning is a certain kind of cynicism that students and doctors develop toward their work, their colleagues and patients.[3,4]

In recent years, among the many inquiries raised about this subject, the ones that began to stand out are those referred to the abuse that medical students suffer, the intensive workdays

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that the residents endure, and the effect that such aspects have in their formation and practice. This happened in the United States,[5-8] as well as in Canada[9] and other European countries.[10,11] A "culture" of abuse to medical students is even addressed, stating that such culture is related to a systematic "violation of dignity" in the health services.[12-15]

In Latin America, there are also numerous studies adopting this line of thinking, which make it clear that the abuse that students suffer in medical school, as well as in their years of specialization, is a very frequent experience to be overlooked.[16-18] Like in Mexico, this abuse has been described, on the one hand, as a "tradition" within the medical education and, on the other hand, as a centrally constitutive element of the "non-formal curriculum" with a possible connection to the type of practice carried out and the type of relations that may be developed with their own colleagues.[19-23]

A branch of these research studies has emphasized the "burnout" that this type of situations represent for the health of students and residents, with the consequent risk that such effects may have on their professional performance.[24-26] Another approach, which bears greater interest for the purpose of this work, has stated that the violence that doctors suffer during their training gives rise to an authoritarian professional style, in a similar way to what is stated in the research study about child abuse.[12,27] However, the critics of this approach have highlighted that this is a limited model, in the sense that it is too psychological (and mechanical) and does not consider the multiple variations that this phenomenon presents in practice.[28]

However, surprisingly, an aspect that is relatively unexplored is the one related to the abuse based on gender inequalities. We need a sociological research study that theorizes about it in the most general framework of the power relationships within the medical profession.[29-32] In other words, we need a much more sociological model that gives account of the medical authoritarianism as a product of the social conditions related to the hidden or non-formal agenda of the years of college training, as well as of the years of residency and medical specialization. As described in other works,[33] it is in the group of interaction patterns prevailing in the medical school and the teaching hospital, as well as in the schemes of vision and division of the world promoted by mentors in their daily duty and in their interaction with students, where the keys to trace the genesis of the professional self with authoritarian tendencies are found. It is worth adopting the definition of "agenda or hidden curriculum" as the set of

> processes, pressures and constraints which fall outside of, or are embedded within, the formal curriculum and which are often unarticulated or unexplored.[34 p.197]

An essential attribute of that hidden curriculum is the centrality of hierarchies and the concomitant relations of power that are related to it,[35,36] which need to be analyzed to adopt a gender approach. In addition, the importance of these factors and the need of studying them within a theoretical framework that gives account of the relations between the structural processes of the medical "field" and the internalization made of them by way of predispositions or *habitus* has also been described by other authors in Mexico[37,38] as well as in other countries.[39]

A CONCEPTUAL FRAMEWORK[b]

Foucault showed that penitentiary,[41] psychiatric,[42] and medical[43] institutions produce "technologies of the self," which are the expression of the concrete relations of power that intervene in the body and in the mind of the individuals. Such mechanisms constitute subjects in the mold of particular learning patterns and through the development of certain practical skills and specific attitudes.[44] They are the material expression of that power that creates and produces (knowledge, speeches, and things) through social interaction, and which differentiates itself from the power that stems from the State apparatus whose main function is to repress.[45]

Goffman[46] also noticed the creative character of social interaction, which constitutes subjects. The social identity or "self" of the subjects is not an essential substance that emerges from the depths of the individual psychology, but a socially supported construction, a systematic achievement of the actors whose patterns of interaction are sociologically discernible. Consequently, it can be

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argued that, despite its apparent diametrical opposition, both authors (Foucault and Goffman) and the analytical approaches that each one promotes, may have contact points among themselves, which are complimentary and may be capitalized for the sake of the sociological analysis.[47]

For our research study, our interest lies in tracking those technologies of the self and this constitution of the subjects in the dialectics between the field and the medical *habitus*[48] in Mexico. The *medical field* is made up of a group of health organizations, institutions and actors that, located in very different positions, establish among themselves power relations oriented to maintaining, acquiring or transforming that form of specific capital that consist in the capacity of imposing the dominant schemes of the definition, perception and appreciation of the matters which are inherent to the health agenda, as well as to the (political, commercial, scientific, professional) action that derives from it. Thus, understood jointly with the health institutions as such, the industries of pharmaceutics and medical equipment, the insurance companies, and the different types of alternative medicine such as homeopathy, chiropractic medicine, and others, belong to the medical field. In a very relevant manner to this research study, the institutions that form the new medical professionals that will eventually become a part of the field, the agents that run these institutions, as well as the teachers and students of all these specializations, are part of the medical field.

Moreover, the medical *habitus* is the socially produced subjectivity, which is characteristic of the different actors of the field, expressed as generative predispositions which result from the incorporation of the objective structures of the medical field. Such predispositions are acquired by professionals – doctors, in the first place – during the years of training in the medical school and in the teaching hospitals. At the same time, such predispositions are recreated daily in their professional practice and generate most of the "reasonable" and "common sensical" behaviors possible as professionals. As in any other field, the principle of action lies in the coincidence between the medical field and the medical *habitus* that is concomitant to it, which produces a practical sense that is inherent in the field. In other words, a daily practice that is almost intuitive, spontaneous, thoughtless (due to the origin of its social determination), which allows the permanent realization of effective behavior for the purposes of the field.

In this work, we try to characterize one of the nodal aspects that arise during the years of training, namely: the set of messages, teachings, threats, recriminations, classifications, labeling, disqualifications, regulations and hierarchizations related to gender that medical students and doctors' experience or witness, and that will eventually become a part of the medical *habitus*. These are "technologies of the self" whose relevance has not been properly assessed, since they are regulated practices through which the medical field is legitimized and reproduced. Therefore, the importance of a gender approach cannot be overrated in this work. The feminist thought has documented that the knowledge that belonged exclusively to women, the knowledge of reproductive health, was gradually expropriated for the benefit of a modern institutionalism dominated by a medicine characterized by a masculinized professional identity.[32] The historic alliance between masculine science and modern medicine also implied a gender struggle, which ended displacing women and reaffirming their roles of housewives and mother-wives.[48,49] It was only gradually that women could return to the health field, this time as professionals. However, the imprint of the exclusion of women remains and, as explained below, women must try to overcome it constantly.

METHODS

The following analysis is based on 14 focus groups including students and health professionals of either sex in different stages of their training and career: students who are still at university, serving their internship and their specialization (residents) as well as specialized doctors. The groups were led by the author during 2010 and 2011. In total, there were 120 participants between doctors[c] and students, of whom 56 were men and 64 were women. Of those 120, 25 were obstetricians and gynecologists, 20 were specialized in family medicine, 43 were residents in obstetrics-gynecology, 16 were interns planning to specialize in obstetrics-gynecology, and 16 were undergraduate

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students. Similarly, of the 120 participants, 26 were from the state of Morelos, 36 from the Federal District, 28 from the state of Mexico, and 30 from the state of Nuevo León. All participants expressed in writing their consent to take part of this research. The contents of the discussions were transcribed entirely. To analyze them, we focused on the identification of the most evident examples of gender domination that the participants reported, as from which we propose an interpretation that conforms to the analytical framework proposed in this work.

GENDER DIMENSION IN MEDICAL TRAINING

Forms of socially induced discouragement

It is convenient to start this analysis by locating the problem of gender inequality and its reproduction in medical schools and teaching hospitals, and within the wider social context – also structured on the basis of masculine domination – to which these educational institutions belong. In the fourteen focus groups described above, we noticed repeatedly expressions that give account of the difficulties that many female medical students, residents and specialists must face regularly to make their way legitimately as individuals who had the freedom of choice to study medicine and stay in it.

There are many testimonies[d] that describe the recurrent messages of discouragement received – sometimes subtly and sometimes very straightforwardly – from relatives, friends of the family, or directly from their own parents. For example, a student told us that a respected friend of the family advised her to choose a career in which she does not have to earn a salary: "*go study whatever you want without getting paid*":

> Roberto: *Why did he say that to you?* Fernanda: *Well, I guess that as the woman is the one who takes care of the children at home, I mean, sometimes in Mexico it is very... there's still the male chauvinist idea that the man is who brings the money home, so it doesn't matter if the woman has a job where she earns a lot of money, as long as she still takes care of the home.* (FG, Monterrey, No. 13)

The notion that studying a degree program is ultimately irrelevant because the fundamental purpose of women is to be housewives, wives and mothers of the family, appears in numerous ways in the material collected. There are two more very illustrative testimonies about this. In the first, a student narrates what she replied to a family friend, who is now an older woman, when she asked her opinion about studying medicine:

> *She told me: "Think it through carefully, you're going to come across to a lot of insults, a lot of rudeness, a lot of bad people, from your own classmates, it's not the environment you're used to."* (Karime, FG, Monterrey, No. 13)

In the second testimony, another student narrates that she is supported by her parents when she fails an exam. However, that support comes with a subtle message of discouragement, in a constant invitation to abandon that degree program and study something that allows her to, eventually, balance family life with her job (the latter always subordinated to the former):

> *But I think that most of us are told to "get out of there." In my case, my dad is a male chauvinist pig, very close-minded, and I don't know if it happened to any of you that you came from a "physio," a "pharma" exam or whatever you want, and came home crying because you spent two weeks studying or didn't sleep for three days, and you know you failed, and then my dad comes and says: "why did you have to drop out mechatronics?" or see your mom and tell her "mom, hug me" to be told "that's because you got into that." My dad still thinks that if I get married, I will drop out of university and I won't study anymore. And I have cousins that even bet that I won't finish my studies.* (Gina, FG, Monterrey, No. 13)

These affective expressions charged with messages of discouragement are indicators of the diverse gender mandates introduced again by their own relatives. Certainly, we are not talking about a social opposition that is equally manifested throughout the country, nor that all women face it with the same intensity. It is a certain socially instilled predisposition that, for the same reason,

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sometimes remains imperceptible, and that is activated only in some cases, most of all when certain social agents in a position of authority feel compelled to exert a regulatory function.

> *One day, a relative came and told me: "medical school wasn't made for women." I replied: "jeez, what course of studies is there for women then?" and he says: "whatever you like: you can be a secretary, a housewife, a wife... a teacher."* (Margarita, FG, DF, No. 4)

It is not a countercurrent (opposing or undermining the interest of female students in becoming doctors) that derives from bad faith or from a deliberate plan to divert them from their objectives. On the contrary: these are affective expressions of vocational guidance, familiar counseling, and solidarity. That is precisely why it is important not to minimize them, because there, in affection, the medium in which they are expressed, lies the force against which those who, despite everything, are still committed to studying medicine must fight.

Forms of exclusion in the medical school

Once in the medical school, different *authorized* expressions can be heard, which are destined to "put women in their place," to establish the limits they must not trespass and, in short, to reproduce the hierarchies and the gender norms currently established in the social fabric. As in the previous case, these are manifestations expressed by means of a particular communicative capacity, which ranges from the teacher's position of authority to the subtlety of a sense of humor that is too ambiguous to attempt any type of rebuke. For example, sometimes in the classroom, women face and deal with numerous expressions of gender discrimination which construct them fundamentally as elements for ornamental, entertainment or "seduction" purposes, for service, or as clearly inferior agents that should not, (for being women), aim for the best grades. In this way, a female student who was doing an internship commented:

> *There is a subject called "communicative competence," and there is a teacher that came by and said that we would all give a lecture but if we wore skirts, we would get a ten (the highest score).* (Mónica, FG, Monterrey, No. 13)

In another focus group, a female intern described one of his teachers:

> *I mean, he was an adjunct teacher who delivered Spanish classes. He told the girls that for every inch above the knee they wore their skirts, they would get an additional point.* He meant it to be a joke but it was true. (José, FG, Monterrey, No. 12)

These are expressions of school harassment in its sexualized connotation, which rely on the position of power that the teacher holds, and that contributes, in turn, to reproduce the gender inequality of which it stems from in the first place. One student said:

> *Then the doctor told me: "Let's see, Elena, give the lecture," and I replied: "Doctor, I already gave my lecture yesterday, now it's another person's turn," and he said: "No, but stand up," and I said: "But I don't want to, doctor, I am not giving the lecture." I could have given it, but I didn't want to stand up, I was uncomfortable, and he said: "Why don't you want to stand up if we all want to see you?" and I said: "I don't want to." And that was at a cost, I had a grade average that exempted me from the final exam, but he told me: "You have to sit for it" "why doctor?" "Because I say so." I cried, I had diarrhea, I vomited, I threw a fit, I expressed my anger in all its forms but I finally sat for the ordinary exam. And I asked him: "but doctor, what was the problem?" "I take into account other considerations, I see other aspects." I got very angry and told him: "God dammit, doctor, what are those considerations? Here are my grades, I am exempted as she is." He said: "No, you have to sit for the ordinary exam."* (Elena, FG, State of Mexico, No. 11)

Apart from being the vehicle to instill submission to authority, the current hierarchies prevailing in the classroom, in a faculty which belongs to a course of studies characterized by very separate ranks such as medicine, may serve to reproduce

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the notion that women exist, essentially, to give pleasure. However, in addition, such hierarchies may also serve to perpetuate the notion that the place of women in the medical school is always secondary and subordinated. This can be communicated in different ways. One of them, as a specialist from the state of Morelos describes, is fixing arbitrarily the maximum grade a female student can obtain in class:

> *When we were about to sit for the exam, we were probably ten of the thirty students that had enrolled, and then we received these small pieces of papers and the doctor said: "Let's see, take your paper," and we arrived and he said: "I tell the female students – we were two women – if you want to sit for the exam, it's a 6 or goodbye" (that is to say, the minimum grade to pass). And I said: "But why? If we haven't started yet." He said: "Because women are not meant to be doctors." Then, my classmate and I thought "Should we sit for it? Should we expose ourselves?" And the doctor said: "it's a 6 or the extraordinary exam, as easy as that, because women are not meant to study medicine; men, on the other hand, are the best doctors, you'll see that in your profession." And then with all that situation going on, at some point, we sat for the exam, although we answered all of his questions, we got a 6, and I saw that as he questioned us, he was writing like saying: "Come on, hurry up…" I don't know much of the whereabouts of this doctor, but it left a mark on me forever; so I have to keep moving forward to prove him that we could make it.* (Dr. Salmerón, FG, Morelos, No. 3)

Exams are the occasion par excellence in which teachers can show and make use of all the power they have to reproduce gender and class hierarchies, on which their performance is based in the first place. This is also the occasion to insist on "putting women in their place," that is, to remind everyone that the role of women is, first and foremost, that of being a wife, a sexual partner or a housewife. These are occasions to discredit again those people who are trying to overcome the gender prejudices against them to become full-fledged medical professionals in their own right.

Two more testimonies illustrate this situation. The first belongs to a female specialist from Morelos that said:

> *In this faculty there was a very well-known pediatrician. We were all afraid of him because he was very strict and smart, a good doctor but a bad person. When we arrived, he said: "Let's see, tell me about such thing" and then he said: "No, I don't understand – if someone failed to answer – I don't understand, what are you doing here? Men have the responsibility to keep a house, but for the women is enough to spread their legs," and he constantly repeated that.* (Dr. González, FG, Morelos, No. 3)

The second testimony belongs to another female specialist that studied in the state of Guerrero:

> *As to experiences such as those told by these women doctors, I remember, there was a doctor with whom the best grade you could get was a 7, just for being a woman. Then if you answered more or less well, he asked you a maximum of 4 questions, if you failed at the second, he told you: "Let's see, you look like a cook, go and do that." I mean, after the aggression. I mean, you don't understand it until now, I can understand it now; at that time you didn't do anything really, and you had to put up with it because you wanted to stay there, because you had an objective to accomplish.* (Dr. Serrano, FG, Morelos, No. 3)

Many of the testimonies mentioned above coincide with the fundamental fact that these are statements from teachers that had left a mark on the students for life. These former students – now specialized doctors – have now realized the seriousness of such statements with the passing of time. This has to do with a hidden agenda that is masked, sometimes to the point of being confused to the less trained eye, as in the students' case, with the formal agenda of their own course of studies. Other testimonies address other variants of the same message, ranging from the subtlest ways, like that of the teacher that every once in a while, said that medicine was a very long course of study for women, to more openly aggressive ways,

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like the teacher who referred to female students as individuals who "should be selling vegetables at the market." In other cases, the message aims at discouraging women from pursuing a specialty. An undergraduate student told us what a teacher told them in class:

> *A woman cannot think of a specialization because she has to take care of her family, of her children and of her husband.* (Fernanda, FG, Monterrey, No. 13)

The way in which the male participants of the focus group reacted to this type of testimonies is quite revealing. Most of them confirmed to be familiar with these testimonies and provided evidence about similar situations. However, when they were asked to what extent this type of abuses and forms of discrimination are still present, most of the men answered that it is no longer happening. That answer was consistently rebutted by women, who accused them of not being aware of it because they do not have to face those situations daily. And, however, men used to admit that women harassment is still a common practice during the years of medical schooling. One of them said:

> *There is harassment on both sides, but it is more prominent in the case of women, and... during the internship, a female doctor who is pretty and has a nice body, who looks good, I mean, will always have a significant advantage over the others, I don't know why we doctors are like this. Well, we are...* [Laughing]*, it is like that, really, you are not very strict with them, but when they deserve it... you do scold them or whatever, or you spank them.* [Laughs] *There is always the case of the typical female doctor who has finished the internship and wants to pick up a doctor; she will always have more privileges than the others.* (Bruno, FG, state of Mexico, No. 8)

The way the social fabric works can be enigmatic for its own actors, and undoubtedly, that is why it operates with such efficiency. As shown in the previous testimony, sometimes things happen and take the protagonists by "*surprise*": "*I don't know why we doctors are like this.*"

Professional reproduction of gender exclusion and inequality

As expected, this teaching style is associated with the professional reproduction of gender inequalities, where it is openly proclaimed that certain medical specialties are not for women. From the testimonies collected, urology and surgery were highlighted:

> *When I was a freshman, a histology teacher asked women "what will be your specialty?" And they answered trauma, and this or that, when you are in the first year you don't really have a good idea of what you will do, then the teacher says: "Oh, that's good!" and "who will be a surgeon?" Many students raised their hands, and among them, I raised mine, and then he said: "Why do women want to study surgery? They look really like machorras [masculine]." That's how he said it in the classroom, "they look really like butch women trying to be surgeons," and of course I was offended.* (Tamara, FG, Monterrey, No. 13)

Regarding urology, women systematically stay away from this specialty, it is like a sort of aversion that gets feedback from the myth that upholds it:

> Roberto: *Why are there male gynecologists but no female urologists?*
> Antonio: *It is the myth of society, I mean, I personally would never go to a female urologist.*
> Roberto: *Imagine if women said "I would never go to a male gynecologist."*
> Erika: *Most gynecologists are men.*
> Antonio: *I think that it is more common to see a woman going to a male doctor than men going to a woman doctor.*

Then, it is not surprising to notice that all the gender differences that have been cultivated and promoted in the classroom are also observed in the health services.

> Erika: Anyway, *men keep ruling in medicine.*
> Roberto: *What do they impose?*
> Erika: *Everything: when ordering, when asking things, I mean, they do not order, they demand, things have to be done as they say,*

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that is their attitude; all of them are above the female surgeons there.

Antonio: *I believe that one of the specialties in which the ranks are really marked, well, not the ranks but the division between men and women, is surgery; for example, just a while ago I was doing my rounds in plastic surgery and I saw these two R1 , a man and a woman, doing their rounds in general surgery and you could see how there were higher demands on the woman; on the one hand, it is all right because in medicine that is how you learn as regards practice, but to tell the truth, they were very strict with her, I mean, they didn't see her as a classmate but as a worker, you could feel it, they were indeed very strict with the female doctor.* (FG, Monterrey, No. 14)

If women are systematically constructed as being inferior, as agents whose careers should be secondary to their role of "mother-wives"; if, in the classroom, they are seen, in the first place, as sexual objects (rather than students), as mentally disabled individuals just for being women; in short, if even before they start their studies, and above all, during them, in the course of their years of training, women must permanently overcome a set of social mechanisms that fence them in and establish in their environment to make them invisible, to downgrade them, to lower their status to a secondary position; is it surprising then that during their professional exercise they have constant difficulties to be treated for what they really are, either doctors or specialists?

As described at the beginning of this work, Goffman found out that the *self,* the social identity of the actors, is a phenomenon that stems from the interaction among them, far from being an essentialist attribute that shines with its own light. In medicine, this principle is confirmed with surprising vigor. It had already been anticipated by West[50] who, working with the concept of "*master status*"[51] discovered that in doctor-patient meetings with actors of either sex, men perceive a woman in front of them (regardless of the woman being a doctor or a patient), while women perceive a doctor or a patient in front of them (regardless of it is a man or a woman). This distortion in the perception – and this identity imposition – is present in every user of the health services, irrespective of their gender: the identity, the prestige that is inherent to each of them, and the credibility of the actors are mediated by gender inequalities. The years of medical training and the teaching style prevailing then are not alien to this construction.

CONCLUSION

It is of utmost importance to study the social origin and the practical effects of the gender determinations and inequalities that are evident in the daily interaction between teachers and medical students, during their undergraduate training, their internship and the years of medical specialization. Being based on gender inequality, and reproducing it, such ways of interaction are a privileged means through which the *medical habitus* is formed and that, in turn, will be functional in the reproduction of the gender structures inherent to the medical field that had originated them in the first place. Although they present themselves as mere forms of treatment, which are sometimes funny, sometimes arrogant, sometimes, even somewhat abusive – but always as conducts that only address what is *irrelevant* – these patterns of interaction are true "technologies of the self." They are a form of symbolic violence that becomes particularly functional in the medical school; therefore, they are forms of micro power directly related to the institutional gender order in full operation. That means that it is possible to conduct an archeological analysis[e] over the *self* of the doctors that are trained in that social factory, which ultimately leads to the institutional project of domination of modernity that Foucault had identified.

It is also worth insisting on the importance of conducting this research study in the training area of prospective doctors, the medical school and the teaching hospital. These are the scenarios par excellence where the reproduction of the structures of gender inequality are developed and where the power of the medical field comes from. A field that, in turn, recreates in these institutions the conditions for producing its own legitimacy. These are practices which students are well acquainted with but whose transcendence, however, is systematically unknown for them.[f]

The actions of the teachers that harass, discriminate, use and humiliate female students is

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the product of a medical *habitus* that, in turn, starts to develop in the training years and that it is reproduced in the daily exercise of the profession. A *habitus* that completely correlates with the structure of the field to which it belongs – the medical field – and that explains how naturally certain gender behaviors are spread out; a medical field that, at the same time, is part of the social order in which gender inequality is also a constitutive part. When focusing the object of study in this way, it is possible, in the first place, to understand why someone can be a medical professional, to the full extent of the word, and at the same time, incur in this type of discriminatory behavior when teaching: it is necessary to examine what medical professionalism is socially made of. Secondly, it is possible to interpret the expressions of resistance of female students against this type of aggressions, and also their adaptation strategies against those aggressions, both elements that reflect a *habitus* in formation. In the third place, it helps us to understand how naturally many students – mostly male – experience this type of behavior, as well as the apparent "bewilderment" that many of them show and for which they have no other explanation than to attribute them to "a customary habit" or to a simple "*I don't know why we men are sometimes like that*." It helps us to notice, in the fourth place, the central role that this non-formal or hidden curriculum plays in the reproduction of hierarchies in the medical profession, among which the gender-related ones are not the least important. Finally, it helps us to understand why it is so hard to promote significant changes in the way in which doctors are trained, and to transform the authoritarian style that characterizes the relation among the different ranks of the profession: if the *habitus* is the embodied social structure in the form of generative predispositions, to attack that structure is to bring into question the actors' own subjectivity.[g] Overall, the only way to change is the objectification of these phenomena, embarrassing as they may be for the medical *establishment*.

ENDNOTES

a. "Processes through which individuals acquire the values and attitudes, the interests, the skills and the knowledge – in short, the culture – of the group to which they belong, or seek to belong."(1 p. 287)

b. A previous and larger version of this conceptual proposition has been published in "Genesis and practice of the authoritarian medical habitus in Mexico."(40) Without being literally identical, this proposition is similar, since that article, as well as this one, derive from the same research project.

c. In the remainder of the text, for language economy reasons we will use the generic masculine plural, to refer to students and specialists of both gender.

d. The testimonies included in this article belong to the different focus groups (FG) conducted, which are identified in accordance with the locality where they were conducted and the corresponding number, from 1 to 14. The names of the informants have been changed to preserve their anonymity.

e. "Archeology confronts the medical discourse with several practices to discover relations that are far less 'immediate' than the expression but far more direct than those of a causality analyzed through the consciousness of the speaking subjects. It aims to show not how political practice has determined the meaning and form of the medical discourse, but how and under which denomination it takes part in emergence, insertion, and functioning conditions."(52 p.274)

f. "The sociology of education [...] lies at the foundation of a general anthropology of power and legitimacy. It leads us, in fact, to an understanding of the "mechanisms" behind the reproduction of social and mental structures that, since they are genetically and structurally linked to them, favor the ignorance of their truth and thus the acknowledgment of their legitimacy."(53 p.18-19)

g. "If it seems easier to reform social security than spelling conventions or literary history syllabuses, it is because, in defending even the most arbitrary aspect of a cultural arbitrary, the holders of a cultural capital [...] are defending not only their assets but also something like their mental integrity."(53 p.20)

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ACKNOWLEDGMENTS

The general project from which this article derives from has been financed by the National Council of Science and Technology (code 83466-S), under the title: "Professional habitus and citizenship: a sociological study about the conflicts between the medical field and the reproductive health rights in Mexico." Lucía Ortiz participated as assistant in the organization and logistic support in conducting the focus groups. Benelli Velázquez Fernández assisted in the transcription and systematization of the focus groups.

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CITATION
Castro R. Gender norms in the development of the medical habitus in the years of medical schooling and residency. Salud Colectiva. 2014;10(3):339-351.

Received: 27 Jun 2014
Accepted: 29 Aug 2014

The translation of this article is part of an inter-departmental and inter-institutional collaboration including the Undergraduate Program in Sworn Translation Studies (English < > Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús and the Health Disparities Research Laboratory at the University of Denver. This article was translated by Ezequiel Moreno and Walter Wekkesser, reviewed by María Victoria Illas and modified for publication by Anne Neuweiler under the guidance of Julia Roncoroni and prepared for publication by Antonella Del Vecchio under the guidance of Vanessa Di Cecco.