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TALES OUT OF MEDICAL SCHOOL

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Research has shown that although boys and girls may sit in the same classrooms with the same teachers, they receive much different educations: "From grade school through graduate school Female students are more likely to be invisible members of classrooms" (Sadker and Sadker, *Failing at Fairness: How America's Schools Cheat Girls*, 1994). In this 1992 walk down memory lane, Adriane Fugh-Berman illustrates the nature of the invisibility and what happens when the "girls" try to change things.

With the growth of the women's health movement and the influx of women into medical schools, there has been abundant talk of a new enlightenment among physicians. Last summer, many Americans were shocked when Frances Conley, a neurosurgeon on the faculty of Stanford University's medical school, resigned her position, citing "pervasive sexism." Conley's is a particularly elite and male-dominated subspecialty, but her story is not an isolated one. I graduated from the Georgetown University School of Medicine in 1988, and while medical training is a sexist process anywhere, Georgetown built disrespect for women into its curriculum.

A Jesuit school, most recently in the news as the alma mater of William Kennedy Smith, Georgetown has an overwhelmingly white, male and conservative faculty. At a time when women made up one-third of all medical students in the United States, and as many as one-half at some schools, my class was 73 percent male and more than 90 percent white.

The prevailing attitude toward women was demonstrated on the first day of classes by my anatomy instructor, who remarked that our elderly cadaver "must have been a Playboy bunny" before instructing us to cut off her large breasts and toss them into the thirty-gallon trash can marked "cadaver waste." Barely hours into our training, we were already being taught that there was nothing to be learned from examining breasts. Given the fact that one out of nine American women will develop breast cancer in her lifetime, to treat breasts as extraneous tissue seemed an appalling waste of an educational opportunity, as well as a not-so-subtle message about the relative importance of body parts. How many of my classmates now in practice, I wonder, regularly examine the breasts of their female patients?

My classmates learned their lesson of disrespect well. Later in the year one carved a tick-tack-toe on a female cadaver and challenged others to play. Another gave a languorous sigh after dissecting female genitalia, as if he had just had sex. "Guess I should have a cigarette now," he said.

Ghoulish humor is often regarded as a means by which med students overcome fear and anxiety. But it serves a darker purpose as well: Depersonalizing our cadaver was good preparation for depersonalizing our patients later. Further on in my training an ophthalmologist would yell at me when I hesitated to place a small instrument meant to measure eye

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pressure on a fellow student's cornea because I was afraid it would hurt. "You have to learn to treat patients as lab animals," he snarled at me.

On the first day of an emergency medicine rotation in our senior year, students were asked who had had experience in placing a central line (an intravenous line placed into a major vein under the clavicle or in the neck). Most of the male students raised their hands. None of the women did. For me, it was graphic proof of inequity in teaching; the men had had the procedure taught to them, but the women had not. Teaching rounds were often, for women, a spectator sport. One friend told me how she craned her neck to watch a physician teach a minor surgical procedure to a male student; when they were done the physician handed her his dirty gloves to discard. I have seen a male attending physician demonstrate an exam on a patient and then wade through several female medical students to drag forth a male in order to teach it to him. This sort of discrimination was common and quite unconscious: The women just didn't register as medical students to some of the doctors. Female students, for their part, tended (like male ones) to gloss over issues that might divert attention, energy or focus from the all-important goal of getting through their training. "Oh, they're just of the old school," a female classmate remarked to me, as if being ignored by our teachers was really rather charming, like having one's hand kissed.

A woman resident was giving a radiology presentation and I felt mesmerized. Why did I feel so connected and involved? It suddenly occurred to me that the female physician was regularly meeting my eyes; most of the male residents and attendings made eye contact with only the men.

"Why are women's brains smaller than men's?" asked a surgeon of a group of male medical students in the doctors' lounge (I was in the room as well, but was apparently invisible). "Because they're missing logic!" Guffaws all around.

Such instances of casual sexism are hardly unique to Georgetown, or indeed to medical schools. But at Georgetown female students also had to contend with outright discrimination of a sort most Americans probably think no longer exists in education. There was one course women were not allowed to take. The elective in sexually transmitted diseases required an interview with the head of the urology department, who was teaching the course. Those applicants with the appropriate genitalia competed for invitations to join the course (a computer was supposed to assign us electives, which we had ranked in order of preference, but that process had been circumvented for this course). Three women who requested an interview were told that the predominantly gay male clinic where the elective was held did not allow women to work there. This was news to the clinic's executive director, who stated that women were employed in all capacities.

The women who wanted to take the course repeatedly tried to meet with the urologist, but he did not return our phone calls. (I had not applied for the course, but became involved as an advocate for the women who wanted to take it.) We figured out his schedule, waylaid him in the hall and insisted that a meeting be set up.

At this meeting, clinic representatives disclosed that a survey had been circulated years before to the clientele in order to ascertain whether women workers would be accepted; 95 percent of the clients voted to welcome women. They were also asked whether it was acceptable to have medical students working at the clinic; more than 90 percent approved. We were then told that these results could not be construed to indicate that clients did not mind women medical students; the clients would naturally have assumed that "medical student" meant "male medical student." Even if that were true, we asked, if 90 percent of clients did not mind medical students and 95 percent did not mind women, couldn't a reasonable person assume that female medical students would be

acceptable? No, we were informed. Another study would have to be done.

We raised formal objections to the school. Meanwhile, however, the entire elective process had been postponed by the dispute, and the blame for the delay and confusion was placed on us. The hardest part of the struggle, indeed, was dealing with the indifference of most of our classmates—out of 206, maybe a dozen actively supported us—and with the intense anger of the ten men who had been promised places in the course.

"Just because you can't take this course," one of the men said to me, "why do you want to ruin it for the rest of us?" It seemed incredible to me that I had to argue that women should be allowed to take the same courses as men. The second or third time someone asked me the same question, I suggested that if women were not allowed to participate in the same curriculum as men, then in the interest of fairness we should get a 50 percent break on our $22,500 annual tuition. My colleague thought that highly unreasonable.

Eventually someone in administration realized that not only were we going to sue the school for discrimination but that we had an open-and-shut case. The elective in sexually transmitted diseases was canceled, and from its ashes arose a new course, taught by the same man, titled "Introduction to Urology." Two women were admitted. When the urologist invited students to take turns working with him in his office, he scheduled the two female students for the same day—one on which only women patients were to be seen (a nifty feat in a urology practice).

The same professor who so valiantly tried to prevent women from learning anything unseemly about sexually transmitted diseases was also in charge of the required course in human sexuality (or, as I liked to call it, heman sexuality). Only two of the eleven lectures focused on women; of the two lectures on homosexuality, neither mentioned lesbians. The psychiatrist who co-taught the class treated us to one lecture that amounted to an apology for rape: Aggression, even hostility, is normal in sexual relations between a man and a woman, he said, and inhibition of aggression in men can lead to impotence.

We were taught that women do not need orgasms for a satisfactory sex life, although men, of course, do; and that inability to reach orgasm is only a problem for women with "unrealistic expectations." I had heard that particular lecture before in the backseat of a car during high school. The urologist told us of couples who came to him for sex counseling because the woman was not having orgasms; he would reassure them that this is normal and the couple would be relieved. (I would gamble that the female half of the couple was anything but relieved.) We learned that oral sex is primarily a homosexual practice, and that sexual dysfunction in women is often caused by "working." In the women-as-idiots department, we learned that when impotent men are implanted with permanently rigid penile prostheses, four out of five wives can't tell that their husbands have had the surgery.

When dealing with sexually transmitted diseases in which both partners must be treated, we were advised to vary our notification strategy according to marital status. If the patient is a single man, the doctor should write the diagnosis down on a prescription for his partner to bring to her doctor. If the patient is a married man, however, the doctor should contact the wife's gynecologist and arrange to have her treated without knowledge of what she is being treated for. How to notify the male partner of a female patient, married or single, was never revealed.

To be fair, women were not the only subjects of outmoded concepts of sexuality. We also received anachronistic information about men. Premature ejaculation, defined as fewer than ten thrusts(!), was to be treated by having the man think about something unpleasant, or by having the woman painfully squeeze, prick or pinch the penis. Aversive therapies such as these have long been discredited.

Misinformation about sexuality and women's health peppered almost every course (I can't recall any egregious wrongs in biochemistry). Although vasectomy and abortion are among the safest of all surgical procedures, in our lectures vasectomy was presented as fraught with long-term complications and abortion was never mentioned without the words "peritonitis" and "death" in the same sentence. These distortions represented Georgetown's Catholic bent at its worst. (We were not allowed to perform, or even watch, abortion procedures in our affiliated hospitals.) On a lighter note, one obstetrician assisting us in the anatomy lab told us that women shouldn't lift heavy weights because their pelvic organs will fall out between their legs.

In our second year, several women in our class started a women's group, which held potlucks and offered presentations and performances: A former midwife talked about her profession, a student demonstrated belly dancing, another discussed dance therapy and one sang selections from *A Chorus Line.* This heavy radical feminist activity created great hostility among our male classmates. Announcements of our meetings were defaced and women in the group began receiving threatening calls at home from someone who claimed to be watching the listener and who would then accurately describe what she was wearing. One woman received obscene notes in her school mailbox, including one that contained a rape threat. I received insulting cards in typed envelopes at my home address; my mother received similar cards at hers.

We took the matter to the dean of student affairs, who told us it was "probably a dental student" and suggested we buy loud whistles to blow into the phone when we received unwanted calls. We demanded that the school attempt to find the perpetrator and expel him. We were told that the school would not expel the student but that counseling would be advised.

The women's group spread the word that we were collecting our own information on possible suspects and that any information on bizarre, aggressive, antisocial or misogynous behavior among the male medical students should be reported to our designated representative. She was inundated with a list of classmates who fit the bill. Finally, angered at the school's indifference, we solicited the help of a prominent woman faculty member. Although she shamed the dean into installing a hidden camera across from the school mailboxes to monitor unusual behavior, no one was ever apprehended.

Georgetown University School of Medicine churns out about 200 physicians a year. Some become good doctors despite their training, but many will pass on the misinformation and demeaning attitudes handed down to them. It is a shame that Georgetown chooses to perpetuate stereotypes and reinforce prejudices rather than help students acquire the up-to-date information and sensitivity that are vital in dealing with AIDS, breast cancer, teen pregnancy and other contemporary epidemics. Female medical students go through an ordeal, but at least it ends with graduation. It is the patients who ultimately suffer the effects of sexist medical education.