Let’s not talk about sex: unexpected tensions in teaching women’s health.

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Let’s not talk about sex

Unexpected tensions in teaching women’s health

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The story

As clinical educators, our vocation for medicine is deeply enmeshed with our research and educational practice. In general, we have found this to add credibility and depth to our teaching of medical students. Here, though, we describe our surprise at encountering tension and pushback upon introducing something important from our clinical world to medical education. We reflect on how this situation evolved, how we resolved it, and what we have learned from it, in the hope of informing others who may find themselves in similar positions.

Working as experienced female general practitioners (GPs) in the United Kingdom, we have long been aware of challenges around diagnosis and management of women’s health conditions. This area of medicine reflects a cultural normalization of pejorative attitudes towards ‘women’s problems’, leading to well-documented health inequalities [1]. Historically, this has been perpetuated by patriarchal attitudes within society, and subsequently within gynaecology [2–4]. Even within our modern society, certain aspects of female sexual and reproductive health remain open to stigma and even ridicule [5, 6]. Clinically, this translates to ‘hard’ outcomes in terms of delayed diagnoses and significant morbidity [7, 8]. We have observed this in action in our clinical practice, and have explored it within our academic scholarship [9, 10]. As researchers, we are critical scholars in that we seek to question taken for granted assumptions, and are committed to following a social justice agenda. Additionally, this form of advocacy for patients is a central tenet of family medicine [11], and therefore finds a natural home within general practice curricula.

We wanted to incorporate these insights into our undergraduate medical program, specifically by introducing the concept of feminism in approaching women’s health in primary care. Our specific context is within a UK institution, where the GP teaching program takes place predominantly in year four of a five-year medical curriculum. Traditionally, women’s health teaching has only been directly taught during specialist obstetrics and gynaecology modules in a secondary care setting. This offers students a primarily disease-focused model. We developed and introduced a session, billed ‘Women’s health in primary care’, within the GP teaching program. In this 90-minute session, which we facilitated, we introduced a patient-focused, primary care oriented approach encompassing common gynaecological disorders, mental health issues and public health interventions. In framing the session, we explored common inequalities and stigma associated with the healthcare of women. In doing so, we made explicit and subsequently challenged traditional patriarchal discourses relative to menstruation, sex, bleeding, childbirth and menopause. We encouraged students to think around why women’s health has been repressed historically. We then explored conditions including polycystic ovarian syndrome, endometriosis, and pelvic inflammatory disease using patient narratives as exemplars and stimuli for small group work.

Surprising outcomes

Over the course of one academic year, we delivered this session 12 times to approximately 270 students. Our intention was to spark interest and even debate amongst the students. Our first major surprise was the valency of reaction to the teaching. This was strongly polarized. Good
feedback, both formal and informal (including on social me-
dia) tended towards excellent. Students who engaged with
the materials and concepts reported positive learning expe-
riences which helped them to ‘think outside the box’. On
the other hand, during several of the sessions we experi-
enced far more resistance from small subgroups of students
than we are typically used to, as experienced teachers on
a popular and well-received course. This resistance typi-
cally manifested as non-engagement with tasks and group
discussions, sometimes associated with negative body lan-
guage such as folded arms and eyes raised to the ceiling.
While we made efforts to engage all members of the group,
we did not compel students to participate.

Our fourth year students are usually only too willing to
engage with our teaching. Some, however, appeared puz-
zled, even lost for words in the face of these new challenges.
During lectures, these students often seemed to have diffi-
culty postulating why and how women’s health might be
affected by sociocultural or historical influences. At times,
they simply appeared to us to be bored and detached, re-
gardless of how engaged their peers might be. Getting them
to consider roots of the word ‘hysterectomy’ (meaning hys-
teria) did not serve as the spark that we had hoped it would
to provoke discussion. Explaining ‘how to be a feminist
doctor’, in the broadest terms of patient-centredness and
advocating for all underserved groups, evoked strong re-
sponses, bordering on incredulity. Some students reported
feeling uncomfortable in the face of open discussion around
sex, sexual health and behaviour, and contraceptive options.
We had not anticipated so much discomfort around frank
discussion of sex.

Lessons learned

As experienced clinicians, our first duty is to our patients,
and our role is to best serve patients’ needs and address
health inequalities. It is therefore, in our view, essential
that we help doctors-in-training to understand structural in-
fluences on health and illness, yet we received feedback
that some students found ‘politics’ in medicine uncomfortable.
Having undertaken significant soul-searching, including
lengthy discussion with our tolerant academic peers, we
remain confident that it is our duty to introduce students to
primary care medicine, and primary care medicine is inex-
tricably political [12]. We were, perhaps, somewhat naïve
in our expectation that these tenets would be universally embraced.

Having extensively explored the rationale for introduc-
ing the teaching in the first place, and found it sound and
secure within a demonstrable evidence base, the next chal-
lenge was to examine the manner of its delivery. Familiar
with a more didactic teaching approach, often with a heavy
focus on scientific content (in keeping with Foucault’s ‘cli-
cical gaze’ [13]) not all medical students may find the shift to
primary care comfortable. We think that we underestimated
how challenging it might be for students steeped in hos-
pital medicine to encounter the different epistemology of
primary care [14], and its emphasis on relational, dialogic
and person-centred medical practice [15]. That prejudice
and stigma should be reified in health outcomes is not sur-
prising to established GPs, but is potentially overwhelming
for a junior trainee more attuned to the relative certainty of
hospital practice [16]. Indeed, it was our (anecdotal) observa-
tion that, as the year went on and subsequent cohorts of
students had accrued more diverse clinical experience, we
encountered far greater openness to discussion of such con-
cepts. We recognize that for many students any deviation
(real or perceived) from teaching aligned with more familiar
biomedical content presents a potential challenge. Indeed,
perhaps we challenged not just their knowledge base, but
more profoundly their identity as fledgling clinicians.

Moving from this deconstruction of the problem towards
possible solutions, as behoves our GP roots, we decided that
engaging resistant students in dialogue was a good place
to start. This year, we have introduced a multi-pronged ap-
proach, in an attempt to bring students with us as we follow
certain lines of logic. We now introduce the session with
the disclaimer that we realize frank discussion of sexual and
gynaecological health may cause students to consider their
own moral position on such issues. We differentiate be-
tween our personal moral status, and our professional obli-
gation to engage with patients without judgement. In this
line, we refer students to General Medical Council (GMC)
guidance on conscientious objection [17], and actively en-
courage questions and commentary as we go along. We
have slightly softened the language we use around femi-
nism and inequality, without diluting the content, and offer
more examples from our clinical practice. We find that stu-
dents are highly responsive to our own clinical experiences
and love to hear these real-life narratives.

Beyond this single lecture, we have expanded on other
aspects of general practice teaching, to introduce philos-
ophy of care and epistemology earlier. This allows students
to ‘follow the breadcrumbs’ throughout the course of the
GP program. Advocating for person-centred care as a cen-
tral tenet of the primary care paradigm runs as a theme
through several teaching sessions, involving different fac-
ulty, which means that students are no longer ‘coming cold’
to a session which is radically different from the majority
of their previous teaching.

Our surprise at encountering resistance led us to reflect
on why and how we had introduced potentially challenging
concepts. Our own reactions as educators to polarized feed-
back were another surprise—a minority of negative com-
ments outweighed the positive, and led to that sinking feel-

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...ing of failure. We realized that the responses to our session had taken on a personal significance for us both, cutting as it did across our multiple roles as educators, doctors, patients, and of course simply women.

**Moral of the story**

Reflexivity as clinical teachers is, as with clinical practice, vitally important to optimize our work as educators. Ultimately, though, perhaps the most important lesson is that change is inherently difficult. Radical challenge to the status quo will perhaps inevitably be met with resistance; not everyone will ‘come with you’. Yet like many of our fellow educators, we have tended to pay greater attention to our negative feedback than the largely very positive response which we also encountered. Do we simply need to learn that, after all due reflection and adjustments have been made, sometimes it is about sticking to our well-argued, evidence-based guns?

In today’s healthcare world, helping students to a critical appreciation of their role as practitioners can only be of benefit to their patients. We share this anecdote then, with a somewhat wry smile, in the hope that at least some of our colleagues will recognize this experience and take heart that, in the long run, it is all worth it.

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