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Original Article

Teachers' view about feminization of Medical Education in Bangladesh

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Abstract

This descriptive type of cross-sectional study was driven to explore the teachers' view about feminization of medical education in Bangladesh. This study was carried out in 4 government and 4 non-government medical colleges of Bangladesh during the period of July 2019 to June 2020. From all four phases, total 104 teachers were respondents of this study to seek information regarding the factors affecting and effects of feminization of medical education in Bangladesh with a pretested self-administered questionnaire.

The study revealed that high social respect, high marriage value, parental pressure, financial security are the factors for feminization of medical education in Bangladesh. Other factor that may influence female students to get admitted in the MBBS course is female students are more studious. There are limited better alternate profession for female students. This study also revealed that empathetic to patients are more satisfied with female doctors, they like some specific subspecialty as their career choice and feminization do not hamper quality of health care. 46 (44.2%) teachers were disagreed that female doctors like to work in rural area. and 49 (47.1%) teachers were disagreed that female doctors are efficient in medical emergency management during disaster. Study recommended establishment of female friendly working environment at all levels of the hospital. Study also recommended further long term and wider scale study with more participants to observe the impact of feminization of medical education on health care delivery system in Bangladesh

Key Words: Feminization, Medical Education, Teachers' view

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Introduction:

In many countries of the world it has been observed over the past decades and intensified over the past few years that there is a consistent trend of increased participation of females in the medical profession which has been highlighted as the so called feminization of medicine. Increased number of female physicians in health workforce is outnumbering their male peers and the profession of medicine is not dominated by males as before.[1]

Females now comprise a majority or near-majority of medical students in many developed countries. In the United States of America, 48% of medical students were women in 2013–2014, up from just 7% in 1965–1966. Similar trends are observed across Canada, Australia, the United Kingdom and other European countries. Women now account for more than half of graduate trainees in several specialties.[2]

Recent research conducted in the UK reveals that women prefer part-time and flexible working arrangements especially in the early years after qualifying, and prefer some specialties over others but are under-represented in leadership positions. In the UK female doctors are well represented in the department of paediatrics, obstetrics and gynaecology, accident and emergency medicine. Female doctors' career profiles follow an M-shaped curve with a peak in the early years, a dip in the middle with a potential for a peak in later years. Women taking time off for child bearing and raising their families may partly account for this curve. The number of women in the field of surgery is subnormal and a recent review concluded that early negative experiences and lack of encouragement in medical schools could be possible reasons for the same. Gender differences in choice of specialties were also noted in a study conducted in Kenya. Male students preferred surgery while female students mainly selected paediatrics.[3]

Methods and Materials

This is a descriptive type of cross-sectional study. The study was conducted among 104 medical teachers from 4 government and 4 non-government medical colleges of Bangladesh to assess the factors affecting and effects of feminization of medical education in Bangladesh. The study has been conducted during the period of July 2019 to June 2020 using a pre-tested self-administered semi – structured questionnaire. Teachers' participation was voluntary. Confidentiality and anonymity were strictly maintained. All ethical issues were considered and necessary permission was taken from ethical committee of the Centre for Medical Education (CME) and respected medical colleges before the data collection. Medical colleges and teachers were selected conveniently. After collection, data were checked and then entered into the software of the computer for analysis. SPSS program (IBM SPSS statistics 21) was used for data analysis. Likert scale was used to measure responses.

Results

Out of 104 teacher respondents of the study, 37 (35.6%) were male and 67 (64.4%) were female. 43 (41.3%) teachers were Assistant Professor, 37 (35.6%) were lecturers, 9 (8.7%) were Associate Professor and others (Assistant registrar, Registrar, junior consultant, senior consultant) were 15 (14.4%).(Fig-1)

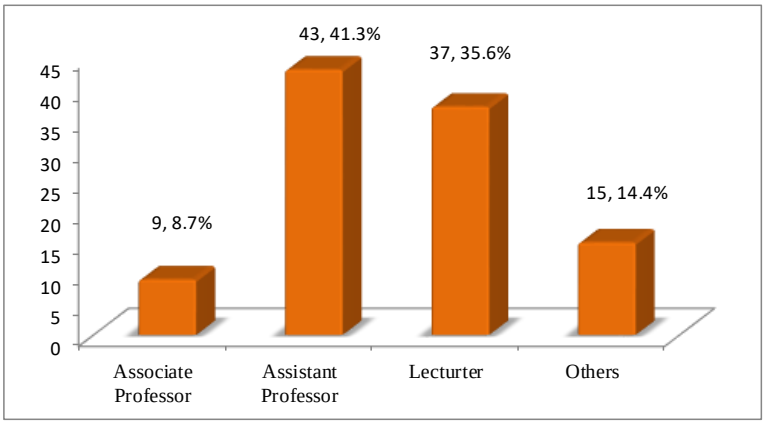

Figure 1: Distribution of teacher by their designation (n=104)

Table 1: Distribution of teachers regarding general view about causes of feminization of medical education

n=104

Factors	Level of agreement				
	SDA f (%)	**DA f(%)**	**NAND f(%)**	**A f(%)**	**SA f(%)**
High social status	7 (6.7)	31(29.8)	21(20.2)	37(35.6)	8(7.7)
High social respect	00(0.0)	17(16.3)	8(7.7)	63(60.6)	16(15.4)
High marriage value	7(6.7)	10(9.6)	19(18.3)	40(38.5)	28(26.9)
Parental pressure	1(1.0)	4(3.8)	13(12.5)	51(49.0)	35(33.7)
There are limited better alternate profession	8(7.7)	23(22.5)	8(7.7)	53(51.0)	12(11.5)
Female students are studious	1(0.9)	16(15.4)	27(26.0)	37(35.6)	23(22.1)
High opportunity to help people	0(0)	11(10.6)	17(16.3)	66(63.5)	10(9.6)
High job security	4(3.8)	22(21.2)	22(21.2)	43(41.3)	13(12.5)

Table 2: Distribution of teachers regarding general views about probable effects of feminization of medical education

n=104

Statements related to probable effects of feminization	Level of agreement				
	SDA f (%)	DA f(%)	NAND f(%)	A f(%)	SA f(%)
Patients are more satisfied with female doctors	6(5.80)	18 17.30)	20(19.20)	47(45.20)	13 (12.50)
Female doctors do not usually prefer Surgery, Orthopedics, Neurosurgery	6(6.70)	28 (26.90)	14 (13.50)	42 (40.40)	13 (12.50)
Female doctors like to work in rural area	36(34.60)	46 (44.20)	14 (13.50)	2 (1.90)	6 (5.80)
Female doctors are more efficient in medical emergency management during disaster	23 (22.15)	49 (47.10)	21 (20.20)	10 (9.60)	1 (1.00)
Female doctors can achieve leadership position easily	10 (9.60)	42 (40.40)	26 (25.00)	21 (20.20)	5 (4.80)
Feminization do not hamper quality of health care	10 (9.60)	22 (21.20)	20 (19.20)	46 (44.20)	6 (5.80)

Discussion

Internationally, there are increasing numbers of women entering medical profession. Although all countries have different health care systems and social contexts, all still show horizontal (women concentrated in certain areas of work) and vertical (women under represented at higher levels of the professions) segregation. There is much discussion and competing explanations about the implications of the increasing numbers of women in the medical profession.[4]

Regarding causes of feminization, out of 104 teachers, 37 (35.6%), 63 (60.6%) & 40 (38.5%) were agreed that medical profession has high social status, high social respect and high marriage value respectively as a cause of feminization of medical education. 53 (51.0%) and 51 (49.0%) teachers were agreed that limited better alternate profession and parental pressure also a factor for feminization of medical education. The present study showed, 66 (63.5%) and 43 (41.3%) teachers were opined that medical profession has high opportunity to help people, has high job security respectively as causes of feminization of medical education. 37 (35.6%) were agreed that present female students are studious and this is also a contributing factor for feminization of medical education (Table 1). A study done by Jane McHarg showed that students gave many reasons for applying to medical school, including a desire to help people, a desire for gainful employment, a wish to give something to mankind and a desire to save lives. However, many students reported having wanted to be a doctor, vet or hospital worker from a young age. For some, this

choice appeared to be intrinsically driven, whereas for others there were extrinsic influences, including family expectation.[5] According to Ranjana Tiwari et al reasons for choosing medical school as a carrier are parental pressure, doctor parents, influence by some doctor relatives and earning money.[6]

Regarding probable effects of feminization of medical education in Bangladesh, 47 (45.20%) teachers were agreed that patient are more satisfied with female doctors (Table 2). In a study it was found that having a female physician was associated with greater satisfaction among female patients, whereas physician's gender was not associated with male patients' satisfaction.[7]

42 (40.40%) teachers were opined that female doctors do not usually prefer surgery, orthopedics, neurosurgery. A study showed that female doctors distribute unevenly across medical specialties and are absent from traditionally male-dominated areas such as surgery, orthopaedics.[8] Another study stated that women make up 56% of the workforce in public health medicine, 50% in obstetrics/gynaecology and 42% in paediatrics. Around 25% of specialists in internal medicine and psychiatry are female, while they are significantly underrepresented in all branches of surgery.[9] 46 (44.20) teachers were strongly disagreed that female doctors like to work in rural area. A study showed that physicians generally are not well distributed in relation to the population; however, male physicians are better distributed than female physicians, since women are more likely to locate their practice in physician-rich urban areas. The most likely reasons that prompt women to choose urban locations are the social advantages and the needs of dual-career families, since about three fourths of women physicians are married to other professionals, usually physicians, whose job needs must also be accommodated.[10] Another study done by Wendy Levinson stated that women prefer to practice in urban rather than rural settings. In rural settings, female physicians may experience professional isolation, lack of privacy, and lack of work opportunities for their spouses.[11]

49 (47.10%) teachers were disagreed that female doctors are more efficient in medical emergency management during disaster. 42 (40.40%) teachers' were disagreed that female doctors can achieve leadership position easily. Women physicians belong to fewer medical organizations and associations and tend not to be in positions of power in medical institutions or associations. In a recent survey, the major reasons cited by women for not joining professional organizations were lack of time and competing obligations (for example, family), lack of opportunity, and lack of interest.[10]

46 (44.20%) teacher were stated that feminization do not hamper quality of health care. Increasing feminization of the medical profession raises a variety of issues at different levels. The principal issue pertains to relative quality of care, as this matter is not only crucial at policy

level, but also one that would concern individual patients most. There is no evidence to suggest that women differ from men in their evaluation of medical problems; however they do tend to be more interactive with patients, facilitating discussion of psychosocial issues and emotions.[9]

Conclusion:

The number and percentage of female medical workforce in Bangladesh is progressively increasing. The study emphasizing that the feminization phenomenon of medical workforce in Bangladesh requires more attention in order to assess the health system capability and readiness of meeting the needs and accommodating the females as the main care providers.

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