GENDERING THE MEDICAL PROFESSION

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CERTIFICATE

This is to certify that the dissertation titled **"Gendering the Medical Profession"** submitted by **SAYENDRI PANCHADHYAYI**, bearing Reg. No. 16SSHL05, in partial fulfilment of the requirements for the Award of **Master of Philosophy in Sociology,** is a bona fide work carried out by her under my supervision and guidance which is a plagiarism free thesis.

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I, **SAYENDRI PANCHADHYAYI**, hereby declare that this dissertation entitled, **"Gendering the Medical Profession"** submitted by me under the guidance and supervision of **Dr. Pushpesh Kumar** is a bonafide research work which is also free from plagiarism. I also declare that it has not been submitted previously in part or in full to this University or any other University or Institution for the award of any degree or diploma. I, hereby declare that my dissertation can be deposited in **Shodhganga/INFLIBNET**. A report on plagiarism statistics from the University has been enclosed.

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Introduction

Studies have shown that there has been a "feminization[1]" of the medical profession[2]. However an examination into the domain of medicine and health reveals that the occupational mobility of women within the profession is concentrated in certain specialties especially for the female physicians[3]. The medical profession imports the gendered hierarchy that is prevalent in the society and medicalize the bodies of female patients through gendered construction of illness[4]. This research makes an attempt to explore the gendered hierarchy and medical imaginings of women's bodies within the medical profession and also examine the role of medical socialization (that is brought about through clinical training) to argue that medical science epitomizes masculine principles. In this light, the study integrates the contentions from selected feminist literature on science, medicine and health with the narratives of intern-doctors of Bengal National Hospital and College of Medicine[5].

[1] Feminization of the medical profession refers to the influx of female physicians in the medical profession.

[2] See Reichenbach and Brown 2004 and Lechien *et al* 2017.

[3] See Hinze 1999, Creed *et al* 2010, Bhadra 2011, Davis and Allison 2013.

[4] See Annandale 1998, Riessman 1992: 124, White 2002, Riska 2003: 60, Gabe *et al* 2004: 61 and Inhorn 2009: 13.

[5] The name of the hospital has been changed for the purpose of the study.

Situating the context

Biological sciences including medical sciences have been gendered since their inception. Bordo (1989) states that science is premised on the foundation of Cartesian objectivism which according to her is an aggressive intellectual "flight from the feminine" rather than a positive new epistemological ideal. The Cartesian re-imagining of the world is concerned with the masculine rationality. Historically, rationality, intelligence, clarity, detachment and distance were associated with the masculine and considered to be the key principles for the foundation of science (*ibid*: 456). Bordo (1989: 451) explains that this masculine is not a biological category but it is a "cognitive style" (way of thinking) and an "epistemological stance"[6]. Here, the idea of the masculine implies the detachment from the particularities of time and space, emotional life, personal idiosyncrasies and from the object itself[7].

The project of empirical science was to tame the female universe through an aggressive assault, violation of the "secrets" or the mystery associated with female biology and rationalism that was accomplished through the philosophical neutralization of the

[6] Epistemology refers to the study to knowledge, its structure, source, methods, limits, justification, validity and scope of knowledge. In other words, epistemology is largely understood to be issues concerned with the creation and dissemination of knowledge. Accessed December 1, 2017. (https://plato.stanford.edu/entries/epistemology/).

[7] Detachment from the object can be understood through the proposition of Evelyn Fox Keller (1983) who states that as men learn to distinguish themselves from the mother he also learns to distinguish between the object and the subject and also between himself and others. Because in the scientific fraternity most scientists are males this male mind set of detachment and mastery informs the methodological framework and principles of science (Cited in Judy Wajcman 1991: 7).

vivacious female energy (*ibid*: 454). Drawing from the argument of Keller, Bordo further states that "the Cartesian reconstruction of the world is a defiant gesture of independence from the female cosmos-a gesture that is at the same time compensation for a profound loss" (*ibid:* 451). Keller (1985) argues that knowledge is perspectival and partial, and manifests the interests of individual or groups who generate that knowledge (Cited in White 2002: 140).

Harding (1992 and 2005) and Wajcman (1991) have also criticised the nature of science as it embodies masculine bias. This is especially visible in the biological sciences that foster an image of women's nature as different and inferior in comparison to the men. This masculine bias is manifested both in the definition of what constitutes as scientific research problem and also the interpretations of research (Wajcman 1991: 5). Medical Science absorbs and ensconces normative structures and the andro-centric doctrines present in the society. Medical field is the exaggeration of the male and female body. Honour, shame and modesty that are interwoven in our everyday struggle for existence are imported and replicated in the medical field. Grosz (1988) opines that medical knowledge reeks of masculine bias notably in the following ways (a) firstly, it discriminates against women by juxtaposing and differentiating them from the more "positively valued images" of men (b) secondly, medicine reflects patriarchal disposition by representing the knowledge of men as logical, rational, unemotional, truthful and objective whereas the knowledge of women are represented as emotional, intuitive and hence, non-realiable (c) thirdly, medical knowledge is phallocentric[8] and therefore, women are represented in general terms (Cited in White 2002: 140-141). Wajcman (1991: 6) propounded that the radical science and health movements that started in the late 1970s in Britain and America exposed medical science as a

[8] Phallocentrism refers to ideas concerning or emphasizing the masculine viewpoint.

"repository of patriarchal values". Conceptual dichotomy is intrinsic to scientific thought---culture vs. nature, mind vs. body, reason vs. emotion, objectivity vs. subjectivity, the public realm vs. the private realm. In each of these cases the former is deemed as superior to the latter and the latter is largely associated with the feminine (*ibid*). Jordanova (1980) contended that "biomedical science intensified the cultural association of nature with passive, objectified femininity and of culture with active, objectifying masculinity (Cited in Wajcman 1991: 6)

Parsons (1954) argues that the doctors have specialist expertise on account of their theoretical knowledge about the different states, processes and functions of the human body. As a result of which they are considered as agents of social control. Hence, patients are expected to submit to the power and authority of the doctor (Cited in Gabe *et al* 2004: 164). Candib (1973) argues that doctors tend to exercise authority over their patients especially the female patients. It is because in a patriarchal society, women are believed to be incapable of understanding their own biological condition or finding ways to deal with such situations. She further states that a female patient feel uncomfortable in articulating her problems to the doctor with the fear that their problems would be dismissed or she might be chided by the doctor. In case of a male patient he can be made to feel emasculated for sharing his concerns over "minor ailments". Gabe *et al* (2004) states that compared to men more women are reported to be suffering from ailments which can be attributed to the role of the medical science in defining the notions of health and illness. Landrine and Klonoff (2001) argue that women are rendered as weak and hence, inferior without examining the structural context of gender discrimination and marginalized position of women that exacerbates her health conditions.

It was the influence of feminist movement and affirmative action during the mid-1960s in the American and European context and the increasing concern for the health of Indian women[9] in the Indian context that promoted the entry of women into the medical profession. The incorporation of women within the trope of medicine came with its own cost. Female physicians are largely concentrated in the low-paid and low-prestige specialties[10] . The growth in the number of female applicants in medical schools has not been successful in altering the occupational mobility of female physicians[11]. Thomson (1998) argues that a large number of female medical students end up as general practitioners, do not go for post-graduation or pursue psychiatry and paediatrics that are located at the bottom in the hierarchy of specialties (Cited in White 2002: 138). Iyer *et al* (1995) propounded that the history of the nursing profession reveals that women were inducted as nurses to reduce the careload of the doctors as the latter was believed to be performing more important task of intellectual labour. Feminist scholars have highlighted the feminization of the nursing profession (Connolly and Rogers 2005) and subjection of the women's body to medical gaze (Annandale 1998 and Subha Sri 2011).

Studies have shown that gendered moorings, imaginings and negotiations are inherent in the medical profession. As a result of which it seems pertinent to discuss here the concept of medical socialization which offers a deeper insight into the construction of

[9] The London School of Medicine was established in the year 1874 with the aim of addressing the health issues of Indian women. Following this trend, the Madras Presidency was established in 1875 and from 1884 onwards Calcutta Medical College (CMC) started admitting female medical students (Ray 2014: 58). It was felt that Indian patients would feel more comfortable in interacting with the native female physicians and at the same their services would be much more affordable for the common people.

[10] See Riska 1989, Hinze 1999, Reichenbach and Brown 2004, Creed *et al* 2010 and Davis and Allison 2013.

[11] See Mandelbaum 1978, Morantz 1978 and Ehrenreich and English, 1979.

the gendered self of the practitioners of the modern medical science. The term medical socialization refers to the distinct characteristics acquired by the medical students and doctors that render them a strong sense of their professional identity that is linked to values and knowledge.

Hafferty (2007: 2931) opines that medical socialization refers to the training received, the values learnt, perspectives nurtured, personality developed and the common patterns that tie the community of physicians across nations. He further states that it is an "intensive form of adult resocialization through a series of encounters ridden by tension between lay and medical norms and values, with the latter gradually (but not always smoothly) coming to be seen as 'superior' to the former" (Cited in Gabe *et al* 2004: 170).

Gabe *et al* (2004: 171) stated that till the late 1970s the studies on medical socialization were not concerned with the social indicators of gender, class, race, etc. However with the steady entry of women in the medical profession combined with the staunch feminist critique shifted the focus on the gendered experiences especially the plight of women physicians. Such an academic endeavour enabled in understanding the connection between "formal pedagogy and informal modes of influence" (*ibid*: 169) or in other words the link between "professional socialization with gender socialization" (Martin *et al* 1988). Martin *et al* (1988) in their study on gender and medical socialization found that apart from the gendered differences in terms of representation within medical organizations and in academia, the influence of gender identity is evident in the medical practice (that includes doctor-patient interaction, patient care and clinical behaviour) of doctors.

According to a report published in CNN Money (Rema Nagarajani, January 11, 2016), there is a wide gender gap in the payscale--- If 20% male doctors claim to possess a net worth between 2 million USD (United States Dollar) and 5 million USD the percentage of their female counterparts is only 12. The situation is not quite different in India--- Only 17% of allopathic doctors and 6 % of those working in the rural areas are female. This wide gender gap along with the accounts on gender laden experiences from peers triggered me undertake this study and link the discourse of biomedicine and medical socialization to reveal the gendered medical profession in the backdrop of a public teaching hospital in Kolkata named Bengal National Hospital and College of Medicine.

Objectives of the Study

1. To delineate the gendered underpinnings through an understanding of the entry of women in the 'masculine' medical profession, and the perception about male and female doctors. To contemplate on the sources and motivations behind the gendered choice of specialties.
2. To examine how the discourse of medical science and medical training become important in sustaining a culture of medical patriarchy and reductionist view? During the course of medical training what are the experiences that leads the medical students to adopt and adapt into the mould of the doctor?

Methodology

In this research I have adopted a combination of review of literature and semi-structured personal interviews with intern-doctors who are associated with Bengal National Hospital and College of Medicine. According to Reinharz (1992: 18) semi-structured personal interviewing or unstructured interviewing as a method is different from ethnography that demands a long period of participation in the field. The aim of semi-structured interview comprise of a series of open-ended questions to enable the participants to provide their views of the problem being studied and through that generate an understanding of the research problem.

Dr. Antara Das[12] a close friend, facilitated my entry into the field and sensitized me a priori regarding the field, the various social actors in the field and advised me on how to act in the hospital setting. In the light of my study her role and position can be understood as that of a key informant. In explaining the meaning of key informant, M N Marshall (1996) states that key informants are expert sources of information. "Key informants, as a result of their personal skills, or position within a society, are able to provide more information and a deeper insight into what is going on around them." Regarding key informants, Tremblay says that key informants take interest in the attitude of people around them, they observe the advancement in culture and draw inferences based on such observations (Cited in MN Marshall 1996: 92).

During the course of the interviews, the purpose and nature of the study were explained to each of the participants while obtaining their consent. The interviews always proceeded with the participants' awareness of the use of the information in the present research. From the outset, I was aware about the hierarchy and unequal power

[12] Name of the key informant along with the participants have been changed to maintain confidentiality.

relationship that I shared with my participants. It is because being a researcher I had the power to manipulate the narratives and misrepresent my participants to meet the objective of my research. To neutralize such possibilities, I decided to share my written documents (that had the interpretation of the narratives of my participants) with my participants. This was an endeavour to retain the transparency and trust that has been the foreground of this research work. In addition, this was also an attempt at co-production of knowledge with the participants and to accord them their due credit which is also the core of feminist methodology. The personal interviews were conducted in locations that made the participants feel comfortable and to dismantle the formidable atmosphere that might rise due to the notion of interviews. Some of these locations were cafe, restaurant, library of the teaching hospital (my fieldsite), park and also in the house of the key informant. The semi-structured face-to-face interviews lasted for two to three hours depending on the itinerary of the participants. Some of the key concerns of the interview was to understand the motivation to enter medical profession, which specialty they are interested to pursue, rank and position enjoyed by the physicians pursuing each of the specialty, kinds of discrimination that exist between the physicians and their patients, whether there is a propensity for women to pursue gynaecology, experience of learning in a co-educational setting, experiences with the patients that they felt have sexist connotations and their views about family and relationships.

This research has drawn from the large wealth of feminist critique on gendered nature of sciences and biomedicine (See Wajcman 1991, Annandale 1998 and Riska 2003). Regina Markell Morantz's (1978) concept of 'sex-stereotyping' Sylvia Walby's concept of 'public patriarchy' (1990), Barbra Ehrenreich and Dierdre English's concept of 'institutional sexism' (1993), Susan W. Hinze's (1999) concept of high-

prestige and low-prestige specialties and Mita Bhadra's (2011) concept of 'masculinisation' of certain specialties. I have made an attempt to dwell on these concepts and hence, kept them at the backdrop while formulating the research problem and also to comprehend the gendered nature of the medical profession and its practises.

For the chapters pertaining to gendered socialization, the concepts of Renee C. Fox (1979) and Nancy R. Angoff's (2013) notion on 'detached concern' (1979), Byron J. Good and Mary-Jo DelVechhio Good's 'medical gaze' (1989), B Subha Sri's (2010) concept of 'reductionist' view and 'medical patriarchy' and Lucy Candib's (2011) concept of 'interventionist' or 'instrumentalist' approach have been influential. I have kept these concepts at the backdrop of the study to understand the essence of medical socialization with a specific focus to gender.

The Field

My field site is Bengal National Hospital and College of Medicine which is a government funded teaching hospital. The collective factors of low-cost medical care, geographical location of the hospital and competent doctors has made this hospital favourable among a large number of people from the marginalized sections. The family members of the patients are referred as "patient-party" by the members of the medical college and hospital. Established during the colonial rule in India, this public teaching hospital is considered to be a premier institution for medical education in the state of West of Bengal. The different departments (like orthopaedics, gynaecology, surgery, etc.) are located in different buildings in the same premise. Being a public medical institution the ruling political party exerts great influence over the administrative structure of the hospital. Many of the medical students studying in this institution

belong to different districts in West Bengal, sometimes coming from remote areas to pursue their dream of becoming a doctor. For many of these students this is their first tryst with the city of Kolkata.

During my field visits in the months of April and May, 2017 one or the other intern of this study were present at the hospital site to inform me about the functioning and condition of a public teaching hospital. Their presence allowed me to enter the Minor OT (Operation Theatre) and have a first-hand experience of watching doctors perform surgical tasks in a clinical setting. The patients are brought into the emergency ward by their relatives. The OT (Operation Theatre) room reeks of stench of blood and medicine. The rubber clothes are barely washed or changed adding to the unhygienic state of affairs of public hospitals. The condition of the field site also made me realize about the squalid state of one of the most esteemed public hospitals in Kolkata. I found that in the General Emergency Ward, where patients of emergency cases are brought for treatment does not have beds. Patients are either laid on the table or on the floor by their family members. The Emergency Observation Ward where patients of emergency issues are admitted for continuous monitoring by the physicians has dilapidated walls, wrinkled bedsheets and ill-maintained floor. The squalid ER (Emergency) area where the patients are yet to be admitted is in the most unbearable condition. There is an adjoining room that stores medicine but looks like it is a site of garbage disposal. The patients persistently complain about the insufficient beds to the nurses and doctors but the lack of funding from the state government has culminated in such a situation. It creates an impression that since patients are provided subsidized health care they do not deserve dignified treatment at these hospitals.

The Surgery building which is situated at the extreme corner of the hospital premise is characterized by darkness and an uncanny silence, thus exuding an ominous feeling.

The building also consists of a mourning room. There are separate wards for male and female patients in the surgery department. Unlike the departments of general medicine and gynaecology, the surgery department have few patients. However, that doesn't indicate that the workload in the surgery department is less-the possibility of emergency cases are quite high in the surgery department as told by the interns.

In the absence of adequate beds, the male patients in the orthopaedics department have to lie on the floor against the backdrop of walls stained with blood and stench from the nearby washroom. During their round of duty, the doctors have to jump across from patients to patients in order to examine their health conditions. During night duty PGT (Post-Graduate Trainees) doctors have the option of taking rest in a separate room allotted to them. However, interns have to lie down on the trolleys that are used for transporting the patients to the hospital. No pillow or blanket is provided to the interns. According to their view, these experiences enable them to get a feel of the real world of adulthood. I also had the opportunity to visit the main canteen of the teaching hospital. I found that there is a separate room for dining for the PGTs, senior doctors and faculty members from that of the interns. The interns of the study said that this has been the norm since their tryst with the institution and they are accustomed to such an arrangement.

I decided to interview interns (not Post-Graduate Trainees or medical students or veteran doctors) as they were the ones who have recently completed their MBBS and have just entered into internship. This duality was important for comprehending the subtleties of being a newly graduated MBBS and a newly inducted intern. All the participants identified themselves as middle-class; however belong to different caste position. My key informant being a Bengali veered me towards interns who also come from the same linguistic background.

My relationship with the participants transcended the “fieldwork phase”. The participants became an extension of my larger peer group. My periodic interaction with them has culminated to a cordial exchange of knowledge between the two distinctive disciplines. I am fully aware that the degree of rapport that I share with my participants became possible due to shared age group (my participants and I are in the age group between 24 and 26), common language (my participants and I share Bengali as our mother tongue), educational credentials (I am pursuing MPhil research that is revered as it is subsumed within higher education and in case of my participants their MBBS degree accords them high-prestige in the society) and class location (my participants and I identify ourselves with the privileged middle-class identity). In addition, our shared interests in photography, food and other aspects of life enabled me to establish intense bond with the participants. Another factor is that my proximity with the key informant and the participants being part of her professional and personal social circle accelerated the pace of my fieldwork and enabled me to conduct research with negligible challenges. My participants treated me as one of their own and cooperated at every juncture of this research. Despite their demanding schedule they made sure that they were available for me and hence, took the effort of informing me about their schedule a priori so that I could arrange my itinerary. They were extremely enthusiastic, sometimes more than me, that they got a platform to express their plethora of experiences of their medical school life

However, the close proximity with the participants can pose hindrance on analysing the narratives by allowing personal bias to overpower. I have been conscious and cautious of that possibility and have attempted to keep away personal bias during the course of the study.

Overview of the study

The review of literature, replete with the scholarship of feminist scholars, medical professionals, historians and anthropologists furnishes an elaborate and concerted overview regarding the different epochs in the exclusion, inclusion, appropriation and peripheralization of women in medicine and health both in the Western and the Indian context.

There are three main chapters in the dissertation. Chapter 1 titled 'Understanding gender hierarchy: From text to context' through a survey of the existing literature (in a limited manner), delineates the entry of women into the medical profession. It is found that inclusion of female doctors in the Indian medical scene was in conformity to the notions of zenana, "*purdah"* (seclusion of women from direct interactions with men who are not of their immediate family) and cultural notions of modesty. The incorporation of women was not to provide them with employment but to cater to the zenana women thus underlining the functioning of patriarchal network. Practise of seclusion and the institution of zenana motivated the rise of women doctors in India to cater to the "*purdahnasheen*" women (See Burton 1996, Sehrawat 2013 and Ray 2014). It is paradoxical that the "*purdahnasheen"* women who were projected as a reason for laying the ground for female medical intervention were unable to exercise their agency in choosing their doctors. European, Eurasian and American doctors appropriated the career opportunities and benefits (Burton 1996 and Sehrawat 2013). The epoch of zenana medical care under the patronage of Dufferin Fund was more about disseminating gendered healthcare emerging from the intersection between caste and religious patriarchal ethos[13] rather than providing high-quality medical service. The

[13] See chapter 1 the section on 'Masculinization of medical profession: Plight and challenges of women'.

entry of female physicians in the form of Christian medical missionaries with the aim of proselytization and the rise of native female doctors within the manifold of medical service witnessed the configuration in gendered, caste, class and racial hierarchies[14]. The ideology behind the nursing profession reinforces the societal gender stereotypes of nurses representing the traits of ideal femininity and doctors embodying ideal masculinity-"combining intellect and action, abstract theory and hard-headed pragmatism" (Ehrenreich and English 1979: 40). Although native women were inducted into the medical profession as physicians and nurse their everyday experiences of institutional sexism, "doubleday labour" and competition with their foreign counterparts (the standards set by the Western colonial female physicians) became part of their lifeworld (Bhadra 2011 and Ray 2014). The trajectory of the social, institutional and epistemological discrimination towards women practising medical science has been accomplished through a selected review of literature and fieldwork that comprised of personal face-to-face interviews of intern-doctors of a prestigious public medical

[14] The British colonial empire imagined Indian women to be suffering in zenana which is understood as sex segregated spaces. As found by historians, the British colonial regime were concerned about the health issues of native Indian women who avoided medical examination by male doctors due to local customs. As a result of which, the British colonial regime sought the help of Christian missionaries and female physicians from their country to address the health concerns of native women. For the female physicians of the west this became an opportunity to show their medical expertise and professionalize the medical profession in an attempt to entrench their contributions. The British colonial empire as well the female physicians and missionaries were guided by the ideology that were the messiah of women's health and that their efforts would emancipate helpless and passive native Indian women from illness. This brought out the essence of racist thinking prevalent among the British about local culture in India being steeped in patriarchy and intervention of western ideologies is a solution to that thinking (Cited in Burton: 1996).

college and hospital in Kolkata, West Bengal. The integration of primary and secondary data in some way hits at the everyday gendered encounters, symbolic violence embedded in medical discourse and marginalization of women in the medical profession. The empirical narratives in a limited manner have tried to dwell on the gendered experiences related to caste and class, highlighting the significance of these social factors in exacerbating the gradation of both the interns as well as their patients. The attitude of the interns towards their patients reveals the internalization of positivist tenets of medical science along with the patriarchal doctrines existing in multiple layers of the social fabric.

The empirical narrative segment of the chapter makes an attempt to broaden and supplement the arguments made in the first section. This section focuses on the lived reality of female and male intern-doctors and the gendered politics behind choosing specialties. Female interns have to encounter multiple nature and degrees of oppression, discrimination and marginalization within the trope of medical profession. The inherently masculine essence of the profession works in favour of male interns and doctors who are deemed as more eligible, incisive, competent and perseverant. Women on the other hand are treated as subsidiary and often reduced as nurses. For female doctors being compared to nurses is humiliating as it is viewed as an assault on their erudite medical scholarship of MBBS. This also leads to the situation of disputative relationship between the nurses and the interns. The antagonistic relationship between the two parties can be attributed to their differential location to power. Their tumultuous dynamic attempts to bring out the variegated interests of women based on the factors of occupational mobility, educational qualification, structural position, class, caste and age. Men and women interns choose specialties and disciplines based on the prospect of market for the specialty, impact on family life, time and effort required in

mastering the specialty and gendered experiences in the course of their medical training.

Chapter 2 titled 'Gendered medical socialization: An examination of selected literature' weaves a polemical account against the authoritarian, hegemonic, paternalistic and capitalist facet of medical science. This chapter employs selected literature (secondary data) to delve into the issues of medicalization, medical morality, construction of gendered bodies and inculcation of reductionist, instrumental and interventionist values that culminates into medical gaze with prolonged period of medical training[15]. The chapter begins with the contextualization of the moralistic and disciplinary power exercised by the medical community in defining, regulating and admonishing women of the nineteenth century in England. Gender stereotypes are reinforced and binaries of virtuous and vicious women are outlined masquerading as objective, empirical and scientific advice. It is followed by a discussion on the biased and andro-centric underpinnings about the female anatomy that emerges when the male anatomy and physiology is considered as the norm. The misogynistic representation of women in medical textbooks (through the description and extrapolation on the functions of female body) is common in medical science textbooks (See Keller 1982, Martin 1991 and Kutty 2005). The belief that the rise of more women into the medical profession would emasculate the andro-centrism is myopic. It is because the epistemology of medical science is couched in male-centric values and endorses the similar principles. This leads to the construction of a doctor who sees the world through a distorted, reductionist and instrumental lens. This is followed by an attempt to understand medicalization intrinsic to the discourse of medical science and its impact on the doctors and female patients regarding the process, state and functions of human body. Medical profession is

[15] The conclusion of Chapter 3 discusses this in detail.

premised on medicalization and conditions the doctor in specific manner to perceive women. Medicalization also leads to the gendered construction of illness by positivist and andro-centric medical science (See Wajcman 1991 and White 2002). Finally it underpins the relation between medicalization and capitalist market economy that renders women an eternal consumer in patriarchal medical economy (See Riska 2003). A class stratified nature of feminist movement emerged as response to medicalization. Middle-class women were targeted for such vigorous consumption as lower-class women lacked the adequate economic resources and hence were not profitable for the expansion of the medical market (See Annandale 1998). The next section engages in a reflection on the gendered construction of illness. It is found that women are overrepresented as patients because of the gendered construction of illness of phases and stages related to reproduction. The medical imaginings about women as weak and inferior do not take into consideration the inequity in the distribution of nutrients and resources and innate discrimination of cumbersome sexual division of labour--providing care to other members of the family, being responsible for the health of the child (White 2002). Medical training includes being familiarized with the range and ramifications of uncertainties, inculcating the traits of equanimity, being acquainted with grossness, developing detached concern, time management and learning to view the profession as different from the other professions (Fox 1979). The medical worldview stems, sustains and deepens during the period of medical training in medical school. It comprises of medical gaze, reductionist view, instrumentalist approach, reconstruction of the body of patients and objectification of patients (Candib 1973). The inculcation of the medical gaze informs the doctor to view the human body especially the body of the female patients through the lens of reductionism. There is a tendency to view female patients as reproductive agents and as argued by feminist critics of medical

science and health that the different phases and processes of a woman' body is pathologized and rendered medical meanings (Riessman 1992, Riska 2003 and Inhorn 2009). The engagement with literature on medical school socialization by Fox (1979) and Good and Good (1993) provides a gender-neutral account and do not examine the nuances and gendered underpinnings/ do not examine the diverse experiences of female medical students/doctors and male students/doctors in relation to medical socialization. There are discussions that biomedical knowledge includes both objectivity and subjectivity as against the popular notion of absolute objective and decontexualized medical gaze. The nature of the hospital setting (private or public) has implications on the construction of the doctor. The course curriculum and meritocratic nature of medical scholarship entrenches a superlative notion about this profession. At present, the strategy of biomedicine is not to repress women but to make them participants in their own surveillance. Feminists have identified that the web of medical knowledge are ways to exercise biopolitical control and greater surveillance into the biological lives of women.

Chapter 3 titled 'A perusal into the everyday gendered lives of intern-doctors: Empirical narratives' humbly attempts to supplement and strengthen the selected review of literature on several aspects of gendered medical socialization in Chapter 2. Medical socialization is a complex process. It begins right from the time a student decides to enter the medical profession and the collective factors that entrenches her/his decision. The motivations are an outcome of a web of pre-conceived notions of respectability, community-oriented feature, financial stability, the relatively higher status of women ensued through MBBS, having an edge above others in the school peer group along with parental mentorship. The entry into the medical school and the experiences accumulated can be read as steeping into the realm of medical science.

During this phase, a medical student is taught on how to see the world. This seeing as discussed by Fox (1979) and Good and Good (1993) makes the medical students realize that they are different from the “non-medicos”. A rigorous course structure and curriculum, learning about the reductionist, impersonal and objectified viewership of the human body, treating patient as a body of examination and intervention for advancing medical knowledge, learning to enact the role of doctor through bodily gestures, sartorial choice, certain demeanours and mastering the trait of detached concern embeds the mental make-up of medical students about the construction and imagining of a doctor. Gendered social relations in the form of sexual division of labour, cultural and regional moorings, mapping and defining the roles for women and men and, the nexus of gender, caste, class and religion (that emerges from certain instances of the fieldwork) permeates into the intern-patient interaction. It ensconces that medical socialization is not limited to learning the objective, empiricist and instrumentalist underpinning of biomedicine. It moves beyond as it can be seen that interns incorporate their everyday gendered experiences into their conscience and in turn reinforces and shatters certain notions through their subjective interpretations and actions. This becomes all the more pronounced during the internship phase. It has been shown that there are gendered motivations in the choice of specialties. However, the narratives from the different departments highlight the expertise over certain hard skills and soft skills that becomes an unwritten rule for excelling in each of the specialty. It can be either learning to survive under stress and continuous duty hours in gynaecology to acing fine skills of operation important for ophthalmology to remaining stoic towards the grotesque in surgery to developing expertise over both medicine and surgery, physical strength and equanimity for excelling in orthopaedics to the occupational hazard of bearing communicable diseases, and lack of occupational mobility in

community medicine. Exposure and familiarity with these specialties prepares an intern for the life of a doctor, reinforce her/his gender imaginings by assessing her capabilities and skills based on her/his gendered identity, and finally casting her/his choice of specialty for post-graduation. This section tries to probe deeper into the complexity of experiences specific to public hospital setting and circumstances that is involved in shaping the medical worldview of an intern and construction of a doctor. It can be found that medical school experiences have a profound impact on the intimate lives of interns. It is found that their views on intimate life is shaped by their interaction with the seniors and their family life, personal ordeals of failed relationships that emerged from being unable to cope with medical school pressure and demands of a relationship, professional rivalry between partners, and intersection of caste while choosing life partner, gendered expectations in family- the men being the primary earner and the woman being the care-provider, and the limitations and boundaries of gendered identities.

There is also a conclusion chapter at the end of the study that engages with the wealth of information and concludes the findings of this research endeavour.

Literature Review

Introduction

This research endeavour is humbly committed to the integration of feminist studies that have been polemical about the male-centric discourses that have infiltrated biomedicine and configured the medical profession. The review of literature contextualizes the thrust of the study through a reflection into the historical trajectory of women's relation to the field of medicine. The discussion then treads towards understanding the position, agency, and challenges of women physicians during the colonial and post-colonial India. This is followed by an attempt to weave literature that is based on feminist critiques on the epistemology of medical science and consequent repercussions on the lives of women. Finally, the review of the literature concludes with highlighting the quintessence and facets of medical socialization and the location of my study in this wealth of feminist and critical scholarship.

After the brief history of the trials and tribulations of women within the trope of medical science since the fourteenth century in Europe to the appropriation of women into the genderised medical profession to the incorporation of female physicians into the Indian medical scene as part of the zenana medical discourse during the colonial regime in India, there is a move towards consolidation of literature that highlights the sexist nature of medical studies and health scenario by practitioners and scholars that invisibilizes the gendered construction of illness, subjecting women to medical scrutiny, projecting women as more prone to illness and the multiple layers of stratification impinging the health conditions of women.

History of women's oppression within the spectrum of medicine

The encroachment of the agency of women can be understood through the position enjoyed by midwives followed by the "witch-hunting hysteria" from the fourteenth to the seventeenth century from Germany to England. Following this thread of argument, 'Witches, Midwives and Nurses' by Ehrenreich and English (1979), the essay 'Women in healthcare: The sexual division of medicine' (Iyer *et al* 1995) and articles titled 'The age of spiritual medicine' and 'The age of witch hunt' by Varma (2013) juxtaposes the luminous history[16] of women with their later plight in the European and US healthcare scene from the fourteenth century onwards. Women exercised their medical knowledge through their roles as healers, unlicensed doctors, anatomists, abortionists, nurses, counsellors, and midwives despite their parallel shaming as witches and charlatans. Midwifery indicates female community's knowledge, beliefs, and techniques for the care of women and newborns. Female traditions and cultural restrictions reinforced the midwife's important and diverse roles. With the infiltration of men into the birthing chamber, professionalization of medicine, the emergence of obstetrics as a medical specialty and a series of social and cultural metamorphosis altered the practice of midwifery leading to the disappearance of the practice. Sources have indicated that the midwives usually hailed from the artisanal, trade and farming classes. For the midwives birth was a natural process and they believed in the nature taking its course in such process. A midwife in the American colonies resembled midwifery in England. The colonial midwife played a key role in birthing chambers. She also healed a variety of ailments and acted as an expert witness in the courtroom in cases pertaining to sexual misconduct, abortions and the like (Tierney 1996).

[16] See 'Witches, nurses and midwives' for further information.

Considering the history of women's engagement with health and healing in Europe there are three principle tenets regarding the midwives as envisaged by Ehrenreich and English (1979: 9-16) (a) that they enjoyed an unchallenged monopoly on birth (b) it was implicitly stated that they enjoyed a monopoly on all the health concerns and they were an authority on abortion and contraception and (c) thirdly the authority and knowledge that they exercised in the exclusive female realms of the birthing room, elicited the suspicion and then they were witch-hunted for extermination by male medical practitioners and churchmen. The so-called "witch-midwives" developed remedies that reduced pain during labour. This came to be seen as an act of rebellion against the sanctity of church that believed that women's labour pain is a punishment for Eve's original sin. It is also believed that Digitalis and Belladona are both contributions of these midwives (*ibid*: 13). The witch-healers represented empiricism and reason that was a study in contrast to the anti-empiricist and fatalist stand of the church. However, the execution of witch-healers was not solely because of their "exclusive medical knowledge" but their position of that of a peasant woman. It has been found that witchcraft was also used to explain uncommon and unfamiliar occurrences in the religious textbook (Varma 2013: 70).

This highlights the issue of how power is infused in knowledge and poses challenge to the order and authority of church by sowing the seed of disbelief. The threat to the order further intensifies as this deviant knowledge was being espoused by women by breaching their feminine code of conduct. There is a calculation of risk from the knowledge of these women being countered through producing and reproducing mass hysteria or "witch-craze" in the thirteenth century. Hence, the nature of retaliation needs to be situated at the intersections of misogyny, fatalism and dogma, and classism (Ehrenreich and English 1979). The invisibilization and elimination of the healers and

midwives from the fifth to the thirteenth century took a different form with the establishment of medicine as a profession (Iyer *et al* 1995). Concerted efforts were undertaken to make the profession niche and out of reach of women irrespective of their class locations (Ehrenreich and English 1979: 15).

The era of the fourteenth century also identified as the genesis of modern materialistic medicine[17] and renaissance in Europe witnessed the complete usurpation of urban, educated and upper-class women from the pursuit of medical knowledge. This was a collusion to limit the monopoly of specialized/esoteric medical knowledge to the men of privileged classes. The male doctor was placed on a moral and intellectual pedestal making him a demi-god, medical "expert" and conferring upon him the power to categorize and compartmentalize women as witches (Ehrenreich and English 1979).

In the American social scene institutional obstacles in the form of verbal abuse from male peers, non-cooperation of professors to discuss anatomy, a tryst with textual misogyny regarding female anatomy, difficulty in securing internships, ordeals in finding patients through recommendations from male colleagues and inhibition of membership into medical societies heightened the ordeals of female doctors (*ibid*). Morantz (1970: 6) is of the belief that certain aspects of professionalization like increasing the admission requirements (in a situation when women were already in small number in the medical profession), emphasis on the internship year and the growing number of specializations might have restricted women from seeking medical education. Women were inducted into the highly genderised profession of nursing as the role of nurses was compatible with the gendered imaginings with the culture of the

[17] Materialistic medicine refers to the foundation of Ayurveda, Chinese Medicine followed by the age of Hippocrates.

nineteenth century. Nurses were expected to be the paragon of self-sacrifice and altruism owing to the ideological nexus between the interests of the medical profession, religion and the patriarchal society (Iyer *et al ibid*). The nurses were expected to "follow" the doctor and remain subservient to the authority of the former. The philosophy behind the nursing profession was that she would cultivate to the fullest her lady-like character. "To the doctor, she brought the wifely virtue of absolute obedience. To the patient, she brought the selfless devotion of a mother. To the lower level hospital employees she brought the firm but kindly discipline of a household manager accustomed to dealing with servants." [18] (Ehrenreich and English 1979).

The claims documented in 'Witches, Nurses and Midwives' came under attack from Green (2008) who argued that Ehrenreich and English relied on secondary and primary data to conclude that females were the victims of male medical control in the nineteenth and twentieth century. She deconstructs this grand narrative by asserting that many women exercised their agencies as patients, they willingly sought the medical help from male doctors and when they became medical practitioners they did not necessarily gestate a different perspective on the practice of women's medicine. The concentration of women in the medical specialty of obstetrics and paediatrics can be traced to the tradition of birthing practice by midwives (*ibid*). The possibility that a woman could also sexually offend another woman was discounted in the narratives of 'witches, midwives, and nurses' this is especially in a situation where one of the duties of European midwives in the pre-modern period was to masturbate the female patients as a

[18] This is in context to the socialization of the nurses during the nurse training period discussed by Barbra Ehrenreich and Diedre English (1979: 19 and 34-40). The authors strived to argue that more than skill acquisition nursing is about training to conform to specific role-play essayed by women in the essay.'

form of therapeutic practice for a condition termed as ‘uterine suffocation (*ibid*: 498). She emphasizes that another aspect that was overlooked was that cross-sex practice and their implications for social honour and shame could affect male doctors too (*ibid*).

Women in Medicine in colonial and post-colonial India

In the Indian context, it is the zenana medical care that catalysed the entry of both foreign Christian missionaries and Indian women as medical practitioners (Burton 1996). The role of *“purdah”* abstained upper-caste Hindu and Muslim women from seeking the treatment of male colonial physicians. Women preferred women doctors during childbirth due to cultural notions of modesty, regardless of whether or not women were secluded (Green 2008). According to Sehrawat (2013) the ‘female hospital movement’ thrived with the patronage of Lady Dufferin Fund. This zealous advocacy of zenana medical care was aimed at promoting the induction of female patients. The zenana medical care was founded on the threshold of providing cutting-edge and superlative western medical care to Indian women without contravening with the culture of “*purdah*” or female seclusion. The zenana patient was constructed as one who is a symbol of modesty, as one who needs to be restricted within the confines of “*purdah”* and observe seclusion from their male counterparts. The zenana medical care sought to accommodate the regional and social diversity in the dissemination of medical treatment. However, the principle of zenana care highlights that it was channelled towards the elite upper-caste Hindu women who strictly observed female seclusion as against the less privileged women who did not practice such stringent codes of modesty. The Bengali Press condemned the Dufferin hospitals for not providing ‘proper arrangements for the seclusion of the zenana patients like the presence of male staff and the lack of building enclosures to screen zenana patients from being overlooked by men from outside. As a response, the Victoria Lady Dufferin

Hospital dismissed the male janitorial staff and excluded male children above the age of seven from entering the hospital space. However, this advocacy invisibilized the possibility of female patient's preference for visiting the doctors with men (possibly male relatives) and at other times male waiting rooms were favoured by female patients (maybe these waiting rooms provided better facilities). Zenana medical care was tied to the multiple interactions between the failure of the Indian State to cater to the medical needs of Indian women, British medical philanthropy, the "orientalist view[19]" of the British imperial government to rescue native women, "feminization" of the empire where British women were envisaged as fundamental players in building the empire (one of its manifestations being the expansion of the role of British White women as harbingers of welfare measures and medical experts) , and this leading to the legitimization of new structures of colonial domination by reconfiguring the colonial racial and gendered dimensions of hierarchy (Burton *ibid* and Sehrawat *ibid*).

Anandibai Joshi, Kadambini Ganguly, and Muthulakshmi Reddy are some of the illustrious figures and early women entrants from India in the world of medicine. The collective factors of modernization, rising awareness about higher education, infusion of political consciousness, development in science and technology, aspiration of upward social mobility, motivation of lucrative income, expanding economic and market opportunities for women paved a favourable path for the entry of middle-class, educated women in the medical profession in India. In addition, another reason is that the perception of respectability (as it was considered as one of the "Learned Profession") concomitant with medical profession was in consonance with middle-class notions of respectable (Bhadra 2011). Regarding the female physicians in the colonial

[19] Orientalist view refers to the perception Western Europeans about the North Africans, West Asians and Middle-Eastern as veiled, backward, fettered by the parochial ethos are some of the images.

era, Ramanna (2008: 78) argues that "Indian women physicians were indeed the vital intermediaries in promoting western medicine and disseminating knowledge about safer births, though this was mainly in the cities and towns. They had the advantage of knowing the language, customs, and the entrenched birthing practices. They made a more realistic evaluation of the role of the much maligned *dhai* (midwife) and recommended her training rather than her outright replacement by the midwife who was otherwise considered alien. The other dimension was that women's and children's health alone was AMWI[20] (Association of Medical Women in India) considered the forte of these physicians. As for family planning, their views were moderate and birth control was seen as a means of tackling infant mortality, and poverty. They stood for professionalism and self-reliance" (*ibid*).

Medical science and distorted/negative image about women's bodies: Feminist critique

It is interesting to note that there has been a considerable fixation about menstruation in the medical profession. Shuttleworth (1990) argues that writings and pedagogy on female diseases were largely woven around the menstrual health with medical advice embedded in moral policing, patronization, patriarchy and regulation of the female body. This can be witnessed in William Buchanan's work on 'Domestic Medicine' where he lays emphasis on the conduct of a woman prior to her menstruation that 'would determine both her future and happiness."Menstruation acted as an external instrument, a barometer by which doctors could read the internal health, mental as well as physical, of their patients. The physiological, mental, and emotional economies of womanhood were all regarded as interdependent" (Shuttleworth 1990). Tierney (1996:

[20] AMWI (Association of Medical Women in India) was established in 1907.

924) argues that “In the field of psychoanalysis where women doctor played a substantial role in defining women, menstruation was generally viewed as a negative function.” Distinguished analysts like Helene Deutsch, Marie Bonaparte, Karen Horney, and Melanie Klein, writing roughly between World War I and World War II, argued at time that menstruating women were hysterical, perverse, and masochistic, that menstrual blood represented internal dismemberment or that menstruation was a sign of woman’s “lack” of her castration (*ibid*).

Shuttleworth (1990: 47-48) states that the medical and psychological literature of the period focussed on the interrelations of the nervous and vascular systems in the enclosed system of the female economy--- If the menstrual flow was interrupted or denied its usual exit, it would lead to havoc as the blood would flow to the brain and culminate into a psychological breakdown as envisaged by the doctors. During the Victorian era, women increasingly became the subject of medical regulation and control. Medical texts constructed the images of women for the consumption and direction of male practitioners, as in the case, many of the domestic medicines produced for the male clergy and heads of households, these advertisements were specifically addressed to a female audience-and were only elements within the newspapers of this era specifically targeted for female consumption. She delves deeper into the nexus between the quacks and qualified medical professionals who otherwise were at loggerheads but when it came to the health of women their collective misogyny was conspicuously evident (*ibid*).

Wajcman (1991) contends that the strength of the feminist critique of professional medical care not only dissects the medical-technological treatment but also the gendered nature of scientific and medical knowledge. The male norm intrinsic to biomedicine constructed the female body as frail and prone to medical and mental

disease and hence, the imperative for medical intervention. The profound gender bias in medical science justifies why the reproductive technology is aimed at "treating female infertility" rather than also addressing male infertility. She cites Jordanova's argument (Sexual Visions, 1989) where Jordanova through an acuminous study of advertisements in medical magazines found that how the construction of illness has gendered connotations. For example- Depression, Anxiety, sleeplessness, and migraine is associated with women whereas disorders that inhibit full movement or are associated with strenuous sporting are connected with men (1989: 144).

Feminists have found that the history of modern medicine and its treatment is the history of subordination of women. Gynaecology and obstetrics labelled women's defiance to their social roles with a special set of diseases like hysteria. The trope of illness stems from the social and cultural ethos of what is to be classified as pathological and normal. This can be understood in the light of the "health problems" addressed in gynaecology during the period of the 1950s. The problems that were being constructed as diseases were the refutation of traditional, mainstream and feminine roles by women. Some of the examples of gendered construction of illness are dysmenorrhoea, excessive pain in labour, menstrual irregularity, pelvic pain, infertility, a tendency to miscarry or deliver prematurely, and excessive nausea in pregnancy, toxaemia of pregnancy and complications of labour, 'infantile uterus', 'failed' trial of labour or placental 'insufficiency', 'irregular' menstrual cycles, hormonal 'imbalances', 'hostile' cervical mucus 'irregular' shedding of the lining of the uterus along with 'blighted' ovum and 'incompetent' cervixes (White 2002).

Annandale (1998), White (2002) and Inhorn (2007) argues that the medicalization of the bodies of women renders them inferior to their male counterparts and at the same time this is a collusion to exert greater control, regulation and surveillance on the

bodies of women through the language of medicine which is an epistemic violence. Kutty (2005), states that women in medicine are defined by biology and their reproductive abilities. Female patients are reduced to mere reproductive agents instead of embodied individuals. Female doctors have also internalized male-centric attitude. She also discusses on the grave blunder committed by two esteemed books on paediatrics. The author criticizes regarding the silence on the cultural and social issues in the context of sexual abuse, the tendency of victim blaming, erasure of adolescent pregnancy and indifference to the gender of the child.

The language in which women are constructed through the medical textbooks is pejorative and repugnant. Nagral (2005) reviewed two popular books on surgery taught to medical students with the objective of identifying gendered elements. These two books are (1) Bailey and Love's Short Practice of Surgery (1932) which has acquired a cult status in surgical education and (2) A Concise Textbook of Surgery by S Das which is popular among students for simplifying the surgical information. The author is of the opinion that medical textbooks on surgery should adopt a pro-active approach in including the issues pertaining to the female sex, notion of consent and respect of privacy of a female patient during instances of the breast, genitalia and pervaginal examination, and detailed information about variegated diseases that may emerge during pregnancy and a guideline on the management of the diseases without jeopardizing the pregnant woman. He further advocates for the inclusion of information on surgical complications during delivery and elaborate discussion on menstrual cycle and its relation in preparation and timing of the surgical procedure, sensitization of the medical students by a discussion on the trauma as an aftermath of rape and domestic violence. Finally, the author concludes that gender bias is a result of omission and not commission. In certain cases, there were factual errors, sometimes there was subtle bias

and in certain instances, there were gross insensitive statements in the form of gender typecasting of a female patient with gallstone by associating with obesity, fertility, middle-age and her female sex.

Medical Socialization and locating gender

Becker *et al* (1961) highlights two important characteristics that are pervasive among the physicians across generations. This discussion is instrumental in the light of medical socialization and to delve into the mental make-up of the doctors and discern their inside world. There is a divergence in the worldview between medical students and faculty stemming from their diverse roles. Although this divergence in social locations shaped the medical knowledge of students differently from their faculty members, there were, however, two common threads that tied them together-medical responsibility and clinical experience.

Medical responsibility is grounded on the traditional ideals of medicine that the doctor holds the life of a patient in his hands. As a result of which, the doctor considers it to be his personal responsibility of bad results. It also informs them to avoid serious consequences during emergency cases. Clinical experience underlines the first-hand experience with patients and disease. This enables a doctor to decide the procedure or treatment to be adopted or medicine to be prescribed during different situations- "The idea of clinical experience, it was suggested, guides his selection of facts and information, leading him to discount basic science and focus on classes in which instructors give practical information not found in books" (Sills 1968: 107).

However, I feel this study is gender-blind as it does not take into account the differential experiences of men and women. It solely interviews male students at the University of Kansas Medical School. There are feminist accounts of the gendered

nature of specializations that have been discussed in Chapter 1. I feel a gendered enquiry would supplement and enrich our understanding of other factors in addition to clinical experience and medical responsibility.

Hinze (1999) and, Davis and Allison (2013) discusses the diversified factors of educational loans, group closure carried by male exclusive strategies, life chances of minority groups like the Hispanics, the prospect of balancing family with work and gendered experience during the medical school being instrumental in the unequal distribution of men and women in the specialties.

In the essay 'Learning Medicine', Good and Good (1993) discusses on construction of body as an object of knowledge and the reconstruction of the subject in relation to that object. In addition, it also foregrounds on the laboratory production of scientific knowledge, the social organization of teaching enterprise at Harvard Medical School, and the clinical sites in which it is applied to the treatment of the patients. Internalizing the language and pulse of medicine is like learning the language of biochemistry. Acquainting with the language of medicine is being part of the biochemical world, a world of cell biology and of physiological systems- "Students are quite aware that they are learning an alternative way of seeing, that it is a way of seeing that they can 'turn on and off', and that they are learning to 'think automatically' in a way that is central to the medical gaze" (ibid). The medical profession entails intimate labour as it is characterized by touching other people, invading space of another person during medical examination and the continuous physical contact of the patient's bodies. The first eight weeks of medical education is woven around being acquainted about the "human body" through the integration of anatomy, histology, and radiology that furnishes a rudimentary level insight into the governing organization of the human body from the molecular to the organismic level (*ibid*).

Students were motivated to inculcate “anatomical thinking” to facilitate better understanding on the nature of bounded anatomical systems, the progression of pathology within such systems, the perils associated with pathology that contravenes the boundaries, and the use of such thinking in diagnosis, prognosis, treatment, and research. The histology lab provided a key site for entry into the body with the microscope providing entree into the world of the cell. In addition, gross anatomy lab and radiology also provided an entry into the human body. Lectures on histology, radiology and anatomy play a significant role in shaping up the medical perspective of a student (*ibid*). This study by Good and Good provides a detailed documentation into the making of a doctor by learning to reconstruct the human body and perceive it through a medical worldview. However, this essay do not bring in the aspects of gender in the form of whether the body of the patient is looked differently or the impact of medical school training male and female medical students.

Subha Sri (2010:7) an obstetrician-gynaecologist asserts that the medical profession essentializes and impersonalizes the bodies of women into physiological processes and anatomy, creating a culture of insensitivity in dealing with female patients. “The medical and allied professions have imbibed mainstream notions of women's sexuality as something that needs control - in a hierarchical power relationship between the healthcare provider and the woman accessing care, such power is exerted through the denigration of her sexuality. The reduction of women into bodies and further into reproductive organs paves the way for needless procedures like hysterectomies – “chop off something that is useless or has served its purpose” - and also helps commercial interests within the medical profession” (*ibid*).

Conclusion

The review of literature provides an insight into the history of the gendered medical profession both in the Western societies as well as India. The discussions on the foundational premise of medical science is defined by patriarchal ethos that can be attributed to the large presence of men in the field of science and the construction of scientific principles based on their values. It has also been found that the andro-centric disposition of medical science is promoted through medical pedagogy and training in the classroom. Being a doctor is about learning these norms, skills and developing a distinct attitude that has come to be understood as medical patriarchy.

My study largely seeks inspiration from the feminist criticisms of science and medicine and also the research conducted by Hinze and Davis and Allison who states that there is an encouraging number of women entering the medical profession, however they are placed at the bottom of the organizational prestige hierarchies (Davis and Allison 2013:21). They (*ibid*: 24) proposed for the inclusion of the indicators of citizenship status, academic background, doctor-patient interaction, individual agency and social class on specialization choice (some of which I have incorporated into the framework of my study). However, my goal is also to situate such stratified experiences within the larger framework of medical discourse and medical socialization and make an attempt to forge a perspicacious argument.

Chapter 1

Understanding gender hierarchy within the medical profession

"Medicine reinforces the image of women as emotional, passive, despondent, feminine, seductive, manipulative, subjective and untrustworthy" (Kevin White 2002).

This chapter focuses on the gendered history of the medical profession by bringing out the exclusion, inclusion and appropriation of women in the medical profession both in the Western context and in India through a critical engagement with the selected review of literature. It also delves into the contemporary state of women in the medical profession through personal interviews of intern-doctors of a reputed public teaching hospital in Kolkata (this is discussed in second section of the chapter).

The chapter has two main sections. The first section of the chapter with its two sub-sections 'Masculinization of the medical profession: Plight and challenges of women' and 'An examination of the gendered choice of specialties' provides the theoretical framework concerning the gendered dispositions of the medical profession. The first sub-section titled 'Masculinization of the medical profession: Plight and challenges of women' furnishes an account on the interconnections between state, colonial hegemony, racial contours, class power dynamics, caste relations that are inextricably intertwined with gender politics, and how these intersections have time and again regulated and determined the entry, exit, and position of women in biomedicine. In a climate of robust discussions by feminist scholars against the patriarchal nature of

biomedicine and the medical profession, the attempt is to look back at the different epochs in the history of medicine and health that exemplifies the trials and triumphs of women.

The second sub-section titled ‘An examination of the gendered choice of specialties’ provides an insight on the gendering of specialties within the medical profession. It has been found that certain specialties are perceived as “masculine” and certain specialties are viewed as compatible with women (Hinze 1999, Nagral 2005, Bhadra 2011 and Davis and Allison 2013). There is an attempt to understand the gendering of the specialities in the next section through empirical narratives of intern-doctors of Kolkata.

Drawing on literature from different time periods, this section demonstrates how mainstream notions of gender are reinforced into the gendered hierarchy of the medical profession. Thus the existent notion of gender in the society is reinforced in the organizational hierarchy of the profession.

Gendered History of medical profession: Critical engagement with selected literature

Masculinization of the medical profession: Plight and challenges of women

Women have not been the bystanders in the history of medicine. In this light, Ehrenreich and English (1979) argued that prior to the advent of professional medicine, women were "autonomous healers" and manifested the ideals of more humane and empirical orientation to healing than male professionals who were found to be disposed to untested doctrines and ritualistic practises (*ibid*: 2).The institutional sexism of the medical profession is as historically old as the medical profession (*ibid*). Institutional sexism combined with class system preserves male power. Women's struggle within the medical profession was not only a gender conscious political struggle but also an example of class struggle. It is because the women healers catered to the people's subculture, usually the lower class people (*ibid*: 4).The lower class people often were part of agitations against the established authorities. On the contrary, male professionals catered to the ruling class and they were supported by the ruling class, the philanthropic foundations, the law and the universities. The notion of professionalism in medicine is thus sexist, elitist, exclusive, racist and classist. The university trained male physicians were revered on a moral and intellectual pedestal whereas the local women healers were branded as witches and bastions of superstitions (*ibid*: 11).

The project of male monopoly over the medical profession was complete all over Europe by the fourteenth century except for obstetrics (even among the upper classes who otherwise consulted the university trained male physicians) which remained the domain of female midwives for the coming three centuries (Ehrenreich and English 1979: 10). Treichler (1990) states that the glorification of institutionalized obstetrics as

the backbone of civilization curtains the prolific contributions of women healers and midwives. This twin project of male valorization and exaltation of obstetrics rendered it as the cornerstone of modern civilization. However, it is the feminist account of the "history of civilization" that compensates for the invisibilization of women within male-centric scholarship. The medicalization[21] of childbirth was a reflection of the values of scientific progress, decisive clinical action, and professional sovereignty (*ibid*: 118). Childbirth as natural was ruled out and the aim was to make it a province of medical specialization and of professional development. Poovey and Donnison (1977) argued that the binary between science and nature was connected to "natural labour" which was equivalent to "manual labour" and hence, the domain of midwives (and General Practitioners) whereas scientific childbirth that involved forceps, anaesthesia, and other forms of intervention, were considered to be the realm of specialists (Cited in Treichler 1990: 118-119).

Wajcman (1991: 64) opine that women had to agitate against the appropriation of medical knowledge and practice by men. This appropriation of medical knowledge by men can be witnessed in the establishment of modern obstetrics. During the seventeenth and eighteenth century, non-professional "barber-surgeons" in England began substituting midwives on account of the former's claim to technological superiority through the use of obstetrical forceps. Forceps being legally recognized as a surgical instrument posed a restriction on midwives as it was unlawful and non-customary for women to commit to surgical practice. The incorporation of forceps into birthing

[21] Medicalization according to Conrad and Schneider (1980) refers to using medical vocabulary to define a problem, when organizations adopt medical approach to treat a problem of their specialization and during doctor-patient interaction when the doctors define a problem as medical and proceed with medical treatment (Cited in Gabe *et al* 2004: 59).

practice accorded these men edge over the midwives (Green 2008). The "barber-surgeons" transformed the obstetrical practice from neighbourly service to a profitable business which was followed by the entry of real physicians in the eighteenth century (Wajcman 1991: 64). This underlines how certain apparatus and instruments denote symbolic power and hence, there have been efforts to make them esoteric. In this way, childbirth that has historically been the domain of women was strategically wrested by men to obliterate the power and monopoly exercised by women.

Morantz (1978) discusses on the "male backlash" against female physicians during the twentieth century in the US. Drawing from the study of Walsh (1977), Morantz argues that men were perturbed at the overwhelming presence of women in 1900 and later systematically curbed the opportunities for women. The culture of sex stereotyping and the detached, god-like figure of the twentieth century physician combined with certain aspects of professionalization like increasing the admission requirements (in a situation when women were already in small number in the medical profession), emphasis on the internship year and the growing number of specializations might have constrained women from pursuing a medical career. Mandelbaum (1978: 138), Martin *et al* (1988: 335) and Riska (1989: 817) note that it was only in the mid-1960s and the new women's movement in the 1970s paved the way for affirmative action in the admission of female medical students and in the implementation of anti-discrimination legislation that made it possible for a large number of women to apply to medical schools in United States of America (US).

From the aforementioned illustrations it can be surmised that there is a glorious history of women being active participants in the field of medicine. Women were consulted for curative and healing purposes and played an important role in the birthing practise. It also underlines that women's early association with medicine catered to the poor people

who did not have adequate wealth to consult university trained physicians. This might be because these physicians charged high fees that were beyond the means of the poor people. However, it can be understood that it is the institutionalization of the medical profession that culminated to the end of female monopoly and local medical knowledge. When women wanted to pursue a medical career the path was not smooth. They had to rely on feminist solidarity that emerged from feminist criticism, to enter the medical profession which was already male-dominated and epitomized a culture of patriarchy. As women in US and Europe fought hard to pursue the profession of their choice, the journey of Indian women's induction into the medical profession marks the role of British colonial regime. The following discussion aims to look at the circumstances that motivated the entry of Indian women into the medical profession.

On the Indian soil, the advent of female physicians was an outcome of an evangelical project especially to cater to the zenana; this has been discussed in the works of Antoinette Burton (1996), Maina Chawla Singh (2005), Monica Green (2008), Mita Bhadra (2011), Samiksha Sehrawat (2013) and Sharmita Ray (2014) among others. Burton (1996: 369) contends that the British female medical missionaries envisaged Indian women as "prisoners" of zenana (sex-segregated spaces) who were languishing in pain, devoid of sophisticated medical care, suffering in unhygienic conditions and at the mercy of the archaic *dhais* (midwives) whose ignorance and superstition jeopardized their lives. Supported by the British colonial government, the missionaries in their evangelical mission then took upon themselves to prove their mettle and rigour as doctors. For the missionaries, "zenana" also became a fertile ground to foster the project of proselytization, practice allopathy medicine on native women in "zenana" with the notion of engaging in philanthropy and use this as an exposure for their clinical training along with classroom education. Hence, the efforts of these female medical

missionaries to cater to the women at the zenana can be perceived as a ploy to meet their professional and status ends (*ibid*).

Similarly, the concern of British female physicians witnessed in the proposal for training of the midwives should not be read as allowing agency to the zenana women. This can be understood through Burton's (1996) analysis of the zenana medical care. She argues that the zenana became a foundational justification for British women's imperial intervention. The British women doctors who could not practise in their native country due the local economy that was unable to support influx of doctors and also because of resistance from male physicians, found the zenana medical care as an opportunity to demonstrate their competence, expertise and professionalism (Burton 1996: 374 and Green 2008: 497). Sehrawat (2013) argues that the western female medical sympathy was tied up in the web of their relentless struggle to justify women's professional activities and hierarchize doctor/patient, doctor/nurse, and doctor/midwife relationship. Female physicians in Victorian England linked their cause to the progress of science, medicine, and civilization.

Sehrawat (2013: 102) states that Association of Medical Women in India (AMWI) laid emphasis on the importance of female medical agents in communicating and interpreting the needs of the Indian women-"AMWI sought to appropriate the zenana patient and use of potency of gendered imperial ideologies to shore up demands for better pay and working conditions for British medical women"[22] (*ibid*). Instead of

[22] See Colonial Medical Care in North India, page 102.

challenging the structure of zenana, the women doctors of the Dufferin Fund[23] practised within the confines of the zenana.

However, it is ironical that the "*purdanasheen"* women whose health concerns became a justification for the entry of Indian women into the medical profession did not enjoy autonomy in choosing their doctors (Ray 2014: 5). The collective factors of cultural deference, ideological commitment to official policies of religious non-interference, professional self-interest and scepticism about the potential of Indian women made the zenana a site of medical professionalism for both Western women as well as their newly professionalized Indian counterparts (Burton 1996: 395). Thus, the need for female doctors in India was felt in a Victorian colonial backdrop as a result of the 'white woman's burden' (Burton 1996, Green 2008 and Sehrawat 2013).

There was an ideological opposition from male physicians practicing in India about women "learning about their own bodies from doctors of their own sex" whether native physicians or their western counterparts (Burton 1996: 381). There were instances of grievances from some male physicians practicing in India who believed that their female counterparts in the medical profession were not competent and hence, women should stay away from institutionalized medicine (*ibid:* 380). Instead the newly educated female physicians may turn to missionary endeavours as it was deemed as feminine. For the author this antagonism was a result of entrenched patriarchalism of institutionalised religion and institutionalised medicine (*ibid:* 381).

[23] According to Lal (1994: 29-66) the Countess Dufferin Fund sponsored the establishment of Dufferin hospitals in India and also funded scholarships for the training of female physicians. The Dufferin Fund provided dispensary positions and hospital posts to qualified female physicians. It is also identified as the first endeavour to promote the entry of female physicians to India (Cited in Burton 1996: 371-375 and Bhadra 2011: 25).

Singh (2005) argues that the female missionary despite her medical knowledge, proficiency, and success was deemed as the "cultural other" as she was the one without any caste and hence unclean. Conservative Hindu interpretations based on "purity[24]" and "pollution" subjected the British women to humiliations like bending down on the ground to pick up medicine or refusal by high-caste Hindu patients to accept liquid medicine or by hiring upper-caste hospital cooks and men to draw water from the well. These missionaries had to persistently adapt to the cultural mores, native preferences and local resistance against western therapeutics out of cultural compulsions or social pragmatism. This underscores the reverse process of acculturation and posits a different view from that of Antoinette Burton. Unlike Burton (1996) who projected the women medical missionaries as invaders of space, gender, race and culture, Singh (2005) encapsulate the challenges of these missionaries in negotiating mission patriarchy, colonial bureaucracy, gender, medicine, race, and religion in early cross-cultural medical initiatives for Indian women.

Much like women missionaries, female native doctors were also pushed to a cobweb of trials and tribulations. Ray (2014) opines that some of these challenges consisted of cumbersome "doubleday labour"[25], the institutional violence within the medical profession that ranged from low payscale to sexual harassment to reduction of female

[24] The concept of 'purity' and 'pollution' has been discussed by Louis Dumont in Homo Hierarchicus: The caste system and its implications (1970). According to Dumont the structural hierarchy of the Indian caste system is arranged in order of the purest caste (in terms of ritual observances) and most polluted caste (in terms of ritual observances) at the bottom of the caste hierarchy. In Dumont's view this is the premise of caste hierarchy in India.

[25] Doubleday labour refers to the burden of managing both the domestic responsibilities (of household chores, cooking, rearing the children and taking of elderly family members) and the paid labour in the public sphere.

physicians as midwives. Women who did not come from families with a medical background also stumbled upon severe challenges. Apart from the mesh of patriarchy, Indian female physicians were subjected to racial discrimination on account of their position as Third World women. They had to adopt several coping strategies like (a) maintaining a balance between being a modern western educated woman as well as "new woman" or "*bhadramahila*"[26] (b) presenting themselves as the sister of native womenfolk as well as competing with their European counterparts (c) shouldering the "double burden" of proving themselves as doctors while at the same time encountering gender-based discrimination and (d) fulfilling the expectations of devoting to their personal lives while at the same time accomplishing their professional commitments (*ibid*:16). Despite such hardships, Dr Kadambini[27] Basu Ganguly, Dr Haimabati Sen[28], Dr Jamini Sen[29], Dr Anandibai Joshi[30], Dr Rukmabai[31] and Dr Muthulakshmi Reddy[32]

[26] The term bhadramahila refers to upper-class English educated Bengali women during the reign of British colonial empire in undivided Bengal.

[27] Dr Kadambini was the first woman to graduate from Calcutta Medical College (CMC) in the year 1886. She became the first Indian woman doctor director of Lady Dufferin Hospital, Calcutta (See Bhadra 2011 and Ray 2014).

[28] Dr Haimabati Sen graduated from Calcutta Medical College as a hospital assistant with a degree in Vernacular Licentiate for Medicine and Surgery (See Ray, 2014: 63).

[29] Dr Jamini Sen was the first woman ever to earn the prestigious title of Fellow of the royal Society of Science and Physicians from Glasgow University in the year 1912 (See Ray 2014: 64).

[30] Dr. Anandibai Joshi became the first Indian woman doctor to graduate from the University of Pennsylvania in 1880 (See Bhadra 2011: 28).

[31] Dr. Rukmabai qualified for MD in Brussels in 1894 and was trained at the London School of Medicine for Women (LSMW) (See Bhadra 2011: 28-29).

among others made a name for themselves in the history of medical profession in India (See Ramanna 2008 and Bhadra: 2011). Jhirad (1960: 9) contends that Indian women were teaching gynaecology and obstetrics along with tuberculosis, general medicine and orthopaedics in mixed medical colleges in colonial Bombay by 1957 (Cited in Ramanna 2008: 78). The assiduousness of the female doctors in various districts, dispensaries and zenana hospitals steadily increased the number of patients (Ray 2014). It is interesting to note that although allopathy medicine is a product of western knowledge but for the native Indian women it became a tool for asserting their autonomy (Ray 2014: 17 and Ramanna 2008: 78).

The above illustrations show that the entry of native Indian women into the modern medical profession took place during the British colonial regime. The concern over women's health in colonial India and the culture of zenana prevalent in then India was utilized to the optimum by the Christian female medical missionaries and foreign female physicians[33]. Back in their native place, the culture of patriarchy precluded them for making the most of it. Hence, this became an opportunity for them to demonstrate their medical expertise and for the missionaries the opportunity to promote Christianity while addressing the health issues of Indian women. Both the missionaries as well as female British physicians had to encounter resistances as found through the discussion made in these literatures. It may be because it was deemed as unfeminine for women to practise medicine which is a male-dominated profession. Another reason was that, it was not seen as proper for women to be learning about their physical functions from

[32] Dr. Muthulakshmi Reddy joined Madras Medical College in 1907 and graduated in the year 1912. She was the founder of Avvai Rural Medical Service and Cancer Research Institute at Chennai (See Bhadra 2011: 30).

[33] See Burton 1996, Bhadra 2011 and Sehrawat 2013.

another woman. It was also during this era it was realized that health concerns of Indian women can be rightfully understood by their native women due to shared culture and willingness of Indian female physicians to cater to the female patients in remote districts (Ray 2014). Along with this the middle-class value for higher education and medical profession having a philanthropic image inspired Indian women from across the country to pursue medical career. However, their professional journey has not been easy. Despite that their commendable endeavours will remain inedible in the history of medical profession in India. In contrast to the Western context, it was not any organized feminist movement that contributed to the entry of Indian women to the medical profession.

The following discussion is concerned with the ideology behind the nursing profession. Being an important stakeholder in the medical profession along with the profession's genderised history (Iyer *et al* 1995: 3-6 and Ray 2014: 59) it is pivotal to delve into its foundational premise. This is also an attempt to understand the complexities and nuances of gender hierarchy within the medical profession.

Connolly and Rogers (2005) argue that although nursing has been a gendered female domestic task but the thought of women tending men in the war zone (public sphere) and engaging in the messy functions associated with nursing was looked upon as a breach of female delicacy and sexual propriety. Iyer *et al* (1995) writes that in the nineteenth-century America, Victorian notion of womanhood that imagined women as symbols of piety, purity, and domestic bliss was dominant. Inherent patriarchal values offered limited respectable alternatives to women who wanted to work. It was the effort

of Florence Nightingale[34] to recast the nursing profession as one that defined purity, cleanliness, and virtue that was typical of Victorian morality (Iyer *et al* 1995: 3 and Connolly and Rogers 2005: 45-46). Maggs (1983: 11-15) opines that during the Victorian era there was a belief that women were naturally disposed to caring but they needed training and right kind of education to become nurses. Additionally, the values of altruism and self-sacrifice connected with nursing was favoured by Christianity of the nineteenth century England and America that felt that the nursing profession was morally compatible with the entry of middle-class, educated women (Cited in Iyer *et al* 1995: 4).

Connolly and Rogers (2005) expose the travails of the nurses both on the account of their gender as well as the gradation experienced due to the lower hierarchical position with respect to that of the doctors. The meagre 5.4 percent male nurses in the US (United States of America) might create an illusion that male entry into the nursing profession is a recent phenomenon (*ibid*: 45). However, contrary to popular belief, for a long time, there existed male-only nursing schools that rose in parallel to the proliferation of female nursing schools. In this light, the authors discuss on the Bellevue[35] training school for nurses in New York City (NYC). Bellevue established a "men's only" nursing school[36] through the patronage of New York philanthropist

[34] Florence Nightingale (May 12, 1820- August 13, 1910) was a British nurse and statistician. She was in charge of providing service to the injured soldiers during the Crimean War. She is credited with founding the modern nursing school.

[35] The Bellevue Nursing School was established in 1873 in New York City under the patronage of Louisa Schuyler (who was a descendant of Alexander Hamilton) along with a committee of wealthy and philanthropic women

[36] The school has been credited with graduating almost 480 male nurses.

Darius Ogden Mills who felt the need of male nurses to cater to the male patients (*ibid*: 47).

Bellevue nursing school provided gendered differentiated training to its male and female students. Women were excluded from training in urology whereas the men were not allowed to have a rotation in obstetrics, gynaecology, and paediatrics[37]. The nursing education of the male nurses was overwhelmingly oriented in psychiatry and urology[38]. The compositions of the nursing students were majorly white across the two nursing schools. Few nursing schools at that time inducted African, American, Asian or Hispanic students.

The female nursing students at Bellevue, staying loyal to their Victorian middle-class morality were garbed in multi-layered long dresses typical of the middle-class gentlewoman. It is interesting that this essay does not discuss the attire of the male nurses. The female attended the female patients whereas the male cared for the male orderlies[39]. Men in the nursing profession referred to it as a "matriarchal system" as it was hostile to men. It also talks about the view of a surgeon that medical students are rough whereas the nurses are benign and compliant. In the nursing profession, it is the women who perform the maximum work and also supervise the work (*ibid*: 49).

The above discussion on the foundation of the nursing profession brings out certain issues. Nursing as an occupation for women have been promoted in the Victorian society because it is compatible with the image of a good woman who was serving the

[37] See page 4 of 'Who is the Nurse? Rethinking the history of gender and medicine'.

[38] Urology is the branch of medical science that is concerned with issues specific to the urine system.

[39] Orderlies refer to the non-medical attendants in the hospital who are responsible for the maintenance of the hospital.

society and was not necessarily trying to assert her autonomy. Secondly, there was a taboo of female nurses catering to the male patients possibly because of the notions of morality-chastity that premised on the principle that it is immoral to touch an unknown person from the opposite sex.

The discussion till now has been concerned with the socio-political climate that facilitated the entry of women in the medical profession both in the Western societies as well as India, and the challenges and contributions of those women in the pursuit of their medical career. The brief discussion on the inception of the nursing profession made an attempt to bring out the gendered history of the nursing profession---Its inherent feminine principles can be juxtaposed to the masculine disposition inherent in the medical profession (See Ehrenreich and English 1979: 19). Retaining the essence of the previous discussions, the following section strives to explore the occupational mobility of women within the modern medical profession and focus on the discussions of feminist critics of medicine and health on the gendered choice of specialties.

An examination of the gendered choice of specialties

Thomson (1998) stated that liberal feminists have focused on the clear inequalities in women's participation in medicine and especially in the specialties. Even when women get into post-graduate medicine, it is often in the spheres of psychiatry and paediatrics-two areas that are associated with care and nurturing. The patriarchal nature of the medical profession can also be demonstrated in the gendered structure of the medical workforce. The overall numbers of women entering medical training have been increasing. However, women graduates do not tend to pursue post-graduate work or to positions in teaching hospitals. They typically end up in part-time GP (General

Practitioner) work, with smaller careloads, and lower fees than their male colleagues (Cited in White 2002: 138).

Bhadra (2011), a medical anthropologist contends that despite the visibility of women in the medical profession, the patriarchal system made it challenging for the Indian women to practise their profession. Since the rise of Kadambini to the present state, despite the fact that women are increasingly pursuing higher education and taking up a medical career, the blight of glass ceiling, male backlash and horizontal and vertical division of labour simultaneously continue to operate. For instance, the "masculinisation" of the branch of orthopaedics on the grounds that it entails handling of complex instruments that are not favoured by women and has long served to regulate the entry of women in this domain. Female physicians are also found to choose their specialty or switch specialty based on the prospect of balancing career with family responsibilities. Therefore, greater presence of women in the arenas of gynaecology[40], paediatrics[41], radiology[42], anaesthesiology[43], ophthalmology[44], dermatology[45] and psychiatry[46] can be attributed to the fact that these specialties require minimal or

[40] Gynaecology is the branch of medical science that is concerned with the issues specific to female reproductive system.

[41] Paediatrics is the branch of medical science that is concerned with the issues specific to infants and children.

[42] Radiology is the branch of medical science that involves medical imaging to diagnose and treat illness pertaining to the human body.

[43] Anesthesiology is the branch of medical science that is concerned to the care of patients and reducing the pain of the patients before and after surgery.

[44] Ophthalmology is the branch of medical science that is concerned with issues pertaining to the eyes.

[45] Dermatology is the branch of medical science that is concerned with the issues related to skin and hair.

[46] Psychiatry is the branch of medical science that is concerned with treatment of mental illness.

superficial contact with the adult male body. Surgery too is a highly masculine specialty and there are a number of reasons that have regulated women's entry in the domain of surgery. The taboo of a female touching a male body acts as a barrier for women wanting to pursuing surgery (*ibid*: 38). It may be surmised that due to the cultural notion of modesty prevalent it's a taboo when an adult female touches the male body other than a family member and vice versa.

Regarding surgery, Rinke (1981) and, Altekruse and McDermott (1987) argue, there are more number of men in surgery and administrative positions whereas female physicians are concentrated in low-paid and low-prestige specialties like paediatrics, anaesthesiology, pathology[47], general practice[48] and psychiatry in United States (Cited in Riska 1989: 816). Nagral (2005) writes about the masculinisation of the specialty of surgery in the essay 'Teaching Surgery'. He found that a female medical student aiming to pursue surgery is often demoralized by the peers and the faculty about the absence of an adequate temperament, difficulty in adjusting to the lifestyle and lack of competency to survive in the field of surgery. Instead, women who are motivated to take up surgery are advised to steer towards ophthalmology and plastic surgery[49] as these specializations are deemed to be less physically demanding (*ibid*: 1835). Nagral (2005) also highlights the preponderance of male authors in the field of surgical education. Davis and Allison (2013:26) in context to surgery discuss the study by Colquitt (1994).

[47] Pathology is the branch of medical science that is concerned with the laboratory examination of the causes, effects and diagnose of diseases.

[48] General practice (GP) in medicine refers to a physician who treats who all kinds of illness and doesn't have specialization on any specific branch of medical science.

[49] Plastic surgery is the branch of medical science that is concerned with the reconstruction of the parts of a human body for the purpose of improved functions or appearance.

Colquitt have argued that women prefer to avoid prestigious specialties like surgery as it is time-consuming and poses challenges to the family life of women. Hence, they tend to gravitate towards less demanding specialties like psychiatry which, according to Hinze (1999: 12) is at the bottom rung of the occupational prestige hierarchy because of the nature of work of the psychiatrists (who sit and talk with their patients) that leads them to be viewed as inactive and passive bodies in contrast to surgeons who are considered to "hold life in their hands and use their hands to save lives". Hinze (1999: 10) and Creed *et al* (2010: 1085) have found in their respective studies that surgery is ranked and considered to be a highly prestigious specialty as it requires devotion to learn the specialized skill, longer training period and because of the financial returns it generates. In the study conducted by Creed *et al* (*ibid*) surgery has been found to be the least lifestyle friendly specialty by the female medical students in comparison to the male medical students.

These studies show that there certainly exists gendered choice of specialties within the medical profession. Surgery and orthopaedics are largely viewed as male-dominated that may be linked to the nature of the profession. For women there is a tendency to confine to certain specialties like gynaecology, psychiatry and paediatrics that can be attributed to the factors of these specialties allowing the prospect of balancing family with career or the presence of more number of female mentors and role models. The next part of the chapter attempts to extend the discussion on gendered choice of specialties and perception of male and female doctors through data elicited from the field. I have also tried to engage with the nature and conditions of different specialties in the lives of the interns through empirical study that have been discussed in chapter 3.

This second part of the chapter is based on narratives that generated from personal interviews with intern-doctors of Bengal National Hospital and College of Medicine[50]. This empirical study draws its arguments from the critical engagement with selected literature and strives to highlight the present gendered stratification in the light of a public teaching hospital in Kolkata. The objective behind integrating field view with book view is to corroborate that despite vigorous criticisms from feminist scholars there have been negligible transformations in the plight of female medical professionals and in their gendered imaginings both within the medical profession and among the public.

Gendered stratification within the medical profession: Empirical Narratives of intern-doctors of Kolkata

In the previous section, through the review of literature I have made an attempt to delineate the gendered history of the medical profession and the doctor being imagined as a male and authoritarian figure. Being an important stakeholder in the medical profession, the doctor exerts great influence on the consumers of medical service who in turn subjectively interpret the profession based on their "life-world"[51] (Husserl 1936). In this context it is imperative to ascertain the agency, role and power enjoyed by female physicians, the multiple dimensions of their inclusion and exclusion in both overt and covert ways, their dynamics with the nurses that aims to bring out the

[50] Name of the fieldsite has been changed for the purpose of the study.

[51] The term life-world was first used by phenomenologist Edmund Husserl and later also employed by Alfred Schutz to argue his idea of phenomenology. According to George Ritzer, the term life world refers to an inter-subjective world in which people both create social reality and are constrained by pre-existing social and cultural structures created by its predecessors.

structural levelling and gradation in the field of medicine and finally the factors that inform their decisions about prospective specialties.

My field site is Bengal National Hospital and College of Medicine which is a government funded teaching hospital. The collective factors of low-cost medical care, geographical location of the hospital and competent doctors has made this hospital favourable among a large number of people from the marginalized sections. The family members of the patients are referred as patient-party by the members of the medical college and hospital. Established during the colonial rule in India, this public teaching hospital is considered to be a premier institution for medical education in the state of West of Bengal.

This micro-ethnographic part of the research endeavour is a co-production of knowledge generated from the lived experiences of the seven participants combined with my engagement with the field and an attempt to understand and interpret the biographies of the intern-doctors. Pseudonyms have been used for all the participants to maintain confidentiality. Dr Antara Das a close friend, facilitated my entry into the field and sensitized me a priori regarding the field, the various social actors in the field and advised me on how to act in the field. She introduced me to the participants for the study. In the light of my study her role and position can be understood as that of a key informant. She chose interns who would be interested to share their views and at the same time would be articulate in such expressions. The seven participants of my research are Dr Antara Das (female and scheduled caste), Dr Debashish Basu (male and upper caste), Dr. Dipayan Dastidar (male and upper caste), Dr. Joyeeta Sil (female and scheduled caste) , Dr. Prantik Maity, (male and upper caste), Dr. Suneha Majumdar (female and upper caste) and Dr. Tamal Sikdar (male and scheduled caste). All the participants identified themselves as middle-class. Personal face-to-face interview with

the participants regarding the various aspects of gender hierarchy within the medical profession have led to the emergence of two main themes (a) Female Doctors and Male Doctors, and (b) gendered politics behind choosing the specialties.

Female doctors and male doctors

Despite the "feminization of medicine" (Reichenbach and Brown, 2004 and Lechien *et al* 2017) it is found that there are only 65 female doctors out of 250 doctors in the batch of 2012-2018 of Bengal National Hospital and College of Medicine (my field site). The breakdown of the seats for MBBS candidature is 15% for all India quotas (AIPMT or All India Pre-Medical Test have their own reservation quota according to guidelines of all India entrance exams).

Female doctors are subjected to harassment both by their male peers as well as the male patients. Male colleagues view their female counterparts as objects of desire and source of recreation from their onerous nature of tasks. According to Dr Antara Das[52]---

"Some of the male peers in their act of desperation would position themselves in a manner so that they can have a glance of the cleavage or bra line of their female peers!"

There is an expectation by the patients for female doctors to manifest maternal dispositions in the exercise of their duties. Martin *et al* (1988: 338) stated that female physicians were viewed as more humanistic, altruistic, sensitive, empathic and keen listeners. Dr. Suneha Majumdar[53] feels that the patients are yet to come to terms with the fact that "lady-doctors" is very much part of the profession and there's more to a woman than just being nurses. She deliberately employed the term "lady-doctor" to

[52] Personal interview with Dr. Antara Das on April 18 20, 2017 in Kolkata, West Bengal.

[53] Personal interview with Dr Suneha Majumdar on May 21, 2017 in Kolkata, West Bengal.

draw attention to the pejorative underpinnings associated with women who are doctors. Dr Das rued that "*males are doctors but female doctors are nurses or sisters!"* She informed me about her exasperation regarding the persistent tendency of "patient-party" (patients are referred to as patient-party by the interns) to address female doctors as nurses. She finds it humiliating as it is not just an assault on the prolonged years of medical scholarship of students to become doctors but it further bridges the hierarchy between the doctors and nurses. During instances of outrage and dissent expressed by the patients' family over medical negligence, the demise of a patient or disagreement with the hospital administration, the female doctors often have to face predatory behaviour in the form of inappropriate touch, verbal abuse and sexual assault embedded in sexism and legitimised violence against women.

According to Dr Dipayan Dastidar[54] male patients sometimes do not feel comfortable discussing male-specific diseases with the female doctors. He recounts one such experience where a male patient with a hernia refused to get examined by a female doctor. It begs the question of whether there is a sense of laceration on masculinity in the context of male patient-female doctor interaction.

The above statements by the female interns of the study may indicate that they are conscious about gender discrimination, gender violence and the subordinate imagination and treatment meted out to female physicians in the medical profession. It is also important to state here that all the female interns identified themselves as feminists and were unapologetic about their feminist ideologies. They have also told that because of their unequivocal support for gender equality they have been branded as feminists especially by their male peers. According to them this label of feminism was

[54] Personal interview with Dr Dipayan Dastidar on April 30, 2017 in Kolkata, West Bengal.

done to ridicule their feminist ideology. It may be argued that the power of feminist consciousness to dismantle the male hegemony and expose the normalization of patriarchal ethos that privileges men and masculine values is seen as a threat by these male physicians. Because for the male physicians, it would mean that their behaviour, attitude and statements would be now be scrutinized by their colleagues with feminist dispositions and hence, they will be put through trials and tribulations for their patriarchal attitude which they have come to perceive as normal without realizing the embedded male entitlement, male privilege and andro-centric bias.

Despite the encouraging presence of women in the medical profession and the apparent image of medicine as a "suitable" and "respectable" profession for women, the field view presents a study in contrast. The notion that male doctors are considered to be the embodiment of knowledge (See Ehrenreich and English 1979 and Iyer *et al* 1995) was once again buttressed during the fieldwork experience. Dr. Joyeeta Sil[55] told that in case of a situation where the male and female doctor both are present, it is the male doctor who would be rendered more importance. Any medical query would always be volleyed to him as he is considered to be more incisive and competent. Take the case of Dr. Sil who was once travelling via train along with her younger brother who is also a doctor. One of the passengers had a medical query but instead of enquiring her it was the younger brother (who has just joined medical education) who was considered a more worthy contender. According to her by virtue of their gender, male doctors are deemed as the "repository of knowledge".

Through my fieldwork experience, I came to understand that casteism functions in a subtle but everyday manner. The General Category students use the term "Sonar

[55] Personal Interview conducted with Joyeeta Sil on May 7, 2017 in Kolkata.

Chand" (SC) for Scheduled Caste students and "Sonar Tukro" (ST) for Scheduled Tribe students (that has casteist underpinnings) which can be read as an act of symbolic violence. For example one of the participants' told his male peer (who was an SC candidate) that he didn't expect him to perform a task so efficiently indicating the former's myopic view of the abilities of SC students. Dr Sil and Dr Das had to bear the "double burden"[56] of proving their medical knowledge both as women and women from the lower caste who made it through "reservation". The "reserved" category students are looked down upon and their merit is constantly under scrutiny. They are considered to be the ones who had it easy while making it to the medical college in comparison to their peers. In case of men who secured their seats through reservation like Dr Tamal Sikdar[57] and Dr Dipayan Dastidar, the degree of discrimination may be lesser as male entitlement to an already masculine profession accords them advantage over their female peers of lower-caste. This demonstrates that although both male and female interns from the marginalized section, face covert forms of violence (in the form of doubting their abilities and the pressure to continuously prove that they are at par with their 'General Category' peers), it is the female students who are subjected to the double jeopardy on accounts of their caste and gender.

Another important and intrinsic gendered aspect in the lives of interns is the nature of the relationship with the nurses. The relationship between interns and nurses underscores the gradation and power differentials that exist within the organizational structure of medicine. In the structural hierarchy, the position of nurses is lower than

[56] See Sharmila Rege (1998) 'A Dalit feminist standpoint' for more information on the double burden faced by Dalit women on account of their gender and caste identity.

[57] Personal interview with Dr Tamal Sikdar on April 20, 2017 in Kolkata, West Bengal.

the doctors. In the discussion on the emergence of nursing profession[58] it was found that they were accommodated within the masculine medical profession only to supplement healthcare service and fulfil the "feminine" task of caregiving in the public institutional setting. The antagonistic and disputative relationship shared between the nurses and the interns especially the female interns indicates the gendered struggle for power. In the light of the study, it busts the claim of universal sisterhood[59] and foregrounds the demands and experiences of women based on their social location of the class, caste, age, institutional position and occupational mobility. Dr. Dipayan Dastidar[60] said that---

"A senior nurse by virtue of her seniority is domineering towards the interns. Their relationship with the female interns can be defined as that of a cold war. Nurses also bequeath the loss of not being able to become doctors during their interaction with female interns. They find these interns as competitors. They believe that they also could have been in the position of these female interns but it is meritocracy that shattered their dreams."

During the fieldwork I was informed by the participants that the nurses do not give adequate recognition to female interns. The strain between the nurses and the female doctors become all the more resonant when the former refers to male interns as 'Dr' but many a time doesn't refer to the female interns with the same respect. I was also informed that nurses who marry doctors have different economic stability and that economic capital bolsters them to assert their supremacy over fellow nurses and interns.

[58] See Ehrenreich and English 1979, Iyer *et al* 1995 and Connolly and Rogers 2005.

[59] Radical Feminism an ideology and movement of feminism that took place from mid-1970s promoted the view of solidarity among all women to fight the structures of patriarchy. See Radical Feminism for more information.

[60] Personal interview with Dr. Dipayan Dastidar on April 30, 2017 in Kolkata, West Bengal.

Dr Prantik Maity stated that they do not receive cooperation from the nurses during a medical emergency. It may be argued that the evidently peripheral position in the occupational structure triggers the nurses to ventilate their anger towards interns who are younger than them and yet enjoy more social prestige both within and outside the hospital premises. The interns state that the job of nurses in public medical hospital provides them immunity against any arbitrary dismissal from the job. Nurses also have a strong mobilization and unionization, as a result of which they become strengthened to act according to their will.

Dr Prantik Maity[61] feels that "nurses are the worst creation of God" because of their haughty and non-compliant attitude. Nurses are touted as gossipmongers by the interns. They are occasionally involved in manifest and latent forms of stress and strain with the doctors. Only if the doctor maintains a self-important and lofty attitude then the nurses would take them seriously. If they are 'docile bodies' for example if an intern is submissive then they are appreciated but those who show resistance are despised by the nurses. Dr Debashish Basu's mother is a nurse and it was found that he was less critical about the behaviour of the nurses unlike his colleagues. This can be attributed to the respect for parental profession determining and formulating an opinion about the culture of a specific occupation.

There is an undercurrent of a gendered and classist relationship between the doctors and the nurses. There are incidents of both cooperation and contestation. There is an ongoing tension between the structural constraints and agency in the nursing job. There is a division of knowledge, power, and authority between the doctors and the nurses. Within the gendered framework and institutional barriers, nurses seek opportunities to

[61] Personal interview with Dr Prantik Maity on May 10, 2017 in Kolkata, West Bengal.

exercise their position as knowledge actors and also reconfigure the sexual division of labour (See Williamson 2001).

Gendered politics of choosing specialties

A melange of factors determines the inequality in the distribution of female and male doctors in certain specialties. Women are found largely concentrated in the non-clinical subjects of Anatomy[62], Pharmacology[63], Microbiology[64], and Physiology[65] as these subjects are deemed as less time-consuming for higher education. In addition, pursuit of these subjects would not demand erratic working hours or dealing with patients. Thus their family life won't be jeopardized according to Dr. Dipayan Dastidar. Studying these subjects would allow them to pursue a medical career without entering into the superspecialties which would entail two more years of their life after five years of MBBS (Bachelor of medicine, Bachelor of surgery), one year of internship and three years of MD (Doctor of Medicine)/MS (Masters in Surgery). Martin *et al* (1988: 336) state, since 1960s after completing their graduation more women compared to men have been found to veer towards academic medicine. Reichenbach and Brown (2004) write that medical school faculty and practitioners essay the role of formal and informal gatekeepers. They mentor and groom medical students for working in academic and clinical medical settings, and influence the students on choosing the specialties. In academic medicine, gender disparities in the occupational mobility and gender gap in promotion rises from fewer women mentors, professional networks and lack of vigorous collegial support.

[62] Anatomy is the branch of science that is concerned with the structure of the living organisms.

[63] Pharmacology is concerned with the branch of medicine that is concerned with the study of drugs.

[64] Microbiology is the branch of science that is concerned with the study of micro-organisms.

[65] Physiology is the branch of science that is concerned with the functions of living organisms.

According to the interns there is a perception among the public as well as the physicians that female doctors are less perseverant and competitive which can be attributed to their family obligations. For similar reasons women are found in less number in the post-graduate courses and superspecialties because higher education is considered to be an obstacle for finding the right groom- Marrying at the right age takes centre stage than pursuing higher education. After marriage, there is a tendency to not pursue superspecialties because of filial responsibilities. The female doctors further don't want to ruin "domestic bliss" by not "being there" to look after the "*sansaar*"[66]. For the otherwise ambitious doctor, her medical career becomes secondary, subordinate and the career of the husband is placed above her personal aspirations. The amount of time required to engage in medical scholarship can become hectic after marriage. This along with lack of family support and the pressure for motherhood veers towards stalling of the career mobility of female doctors as articulated by Dr Antara Das. The elongated period of education is viewed as an impediment in marrying within a certain age. Hence, there seems to be a lassitude approach of women in not pursuing superspecialties. Mandelbaum (1978: 141) states that the marital status of women physicians along with the status assigned by them to different specialties are two important factors determining the selection of their specialties. Martin *et al* (1988: 337) argues that female physicians irrespective of their occupational status are expected to share domestic responsibilities and many a time spend more in housework even in circumstances where they have hired help.

Women take up gynaecology assuming that there would be a large number of female patients accessing their medical service. Female doctors prefer to choose specialties

[66] Sansaar is commonly used Bengali word that refers to the domestic life or life in the private sphere of the household.

like gynaecology and obstetrics, paediatrics, dentistry[67], ophthalmology, dermatology, ENT[68] (Ear, Nose, and Throat), anaesthesia and radiology portending that subjects like orthopaedics[69] and surgery would not generate patients for them because of their gender. Dr. Suneha Majumdar states that even if women decide to pursue subjects like surgery they will have to be mentally prepared that they are not going to have a generous count of patients compared to their male counterparts. Dr Prantik Maity is predisposed to taking up general surgery because of his the status and demand of surgery. He doesn't wish to take up gynaecology as it would mean specializing or dealing with only a specific organ of the human body. Dr Joyeeta Sil states that although large concentrations of gynaecologists are male yet there is a taboo among male interns to confess that they would pursue gynaecology. I found this to be a paradox that may be rooted in the sexualisation of the specialty of gynaecology combined with the sexist-bigoted belief---There might be a prevalent view among the public that a man who is interested in gynaecology is obsessed with the female sex organ (vagina) and his sole motive is to satiate his untamed and hypersexual desires.

Dr Tamal aims to pursue orthopaedics, surgery or oncology because pursuing these subjects would allow him to "give time to his family in the future". According to him, physicians specializing in general medicine and gynaecology are always are saturated with patients and therefore, their personal lives are compromised. His statement may indicate that not just women but men may also look at the prospect of balancing career

[67] Dentistry is the discipline of medicine that is concerned with the issues specific to the teeth and gums.

[68] ENT is the branch of medical science that is concerned with issues pertaining to the ear, nose and tongue.

[69] Orthopaedics is the branch of medical science that is concerned with the issues specific to the bones and muscles of the human body.

and personal life while deciding on specialization. Dipayan Dastidar too dreams of acing in surgery. It is because he feels that a surgeon would not have to invest too much time to deal with patients unlike the clinical subjects of general medicine and the likes. At the same time, one or two surgery would fetch a surgeon a lucrative income which is a big draw for him to choose surgery. He puts forth another reason for his interest in surgery---the smell of blood, the sight of treating burn and wounds, and his intrinsic passion for dissection also draws him towards this specialty. In other words, it is macabre that sustains his interest and he finds surgery perfectly compatible with his pursuit of the macabre.

Gynaecology is perceived as a "safety-net" specialization among the participants as there would never be a draught of patients. This brings the role of capitalist market that also determines and informs the decisions of medical students and interns while choosing their specialty. As feminist health research[70] has also shown, women outnumber men patients owing to their reproductive health. Since gynaecology is woven around the reproductive health of a woman and women are expected to visit gynaecologist either related to menstruation or pregnancy related issues or menopause, gynaecology is always booming with the patient population. Therefore, it can be argued that it is also a specialty that concerns all women of all sections of the society. As a result of which gynaecology ensures a continuous flow of money. In context of gynaecology, Dr Debashish Basu[71] has observed a notable trend that unmarried women would prefer to go to a female gynaecologist but once they conceive they would visit a male gynaecologist. This he attributes to the notion that the men are better with equipment and hence they would be good at surgery (See Wajcman 1991).

[70] See Annandale 1998, White 2002 and medicalization of women's health in Chapter 2.

[71] Personal interview with Dr Debashish Basu on April 15, 2017 in Kolkata, West Bengal.

There is a common assumption that female doctors are incapable surgeons. In fact, such an ideology was reiterated by female doctors too as they felt most of their female peers lack ambition, vigour, and tenacity to excel in surgery. According to Dr Suneha Majumdar even if a female surgeon is more qualified than her male counterpart, there is a propensity among patients to root for male surgeons. The notion is that a woman is not strong enough to deal with "hard-core" surgery; she lacks the adequate strength and emotional stability required for it. From Dr Majumdar's contention, it may be inferred that surgery is enmeshed in the idea of physical strength and robustness which emerges as juxtaposition to the ideals of "femininity" of women. The accounts by Dr Joyeeta Sil and Dr Suneha Majumdar echoes the standpoint of Nagral (2005: 1835) who contended that women are discouraged from pursuing surgery because of the overarching masculine character of the discipline. Instead, they are encouraged to advance into gynaecology, plastic surgery, and ophthalmology with the belief that such disciplines are in conjunction with the temperament of women.

Similarly, even if there are women in orthopaedics, the climate of toxic masculinity heightened with insolent behaviour of the peer group exerts pressure on women to constantly prove themselves as competent in the discipline. They are persistently made to feel that they are transgressing moral boundaries by entering into a specialization which is not their rightful domain. This statement by Dr Sil reminds of Sonal Sukla's (2007) findings (Cited in Bhadra 2011: 37) that orthopaedics has traditionally been associated with vigour and arduousness. The ambience of orthopaedics department reeks of a masculine culture. In addition to it, handling the complex instruments and appliances demands devotion of time. Dr. Joyeeta Sil informed that--

"The concentration of women in gynaecology and the detestation of my male peers towards gynaecology are anchored in the abhorrence towards anything that is feminine. Since gynaecology deals with the subject and illness related to women, hence there is a reluctance of public confession by the male interns or male medical students that they would want to pursue gynaecology or there is an absolute denial of the possibility of pursuing it for higher studies."

She nurtures the desire of specializing in gynaecology with the belief that women would feel more comfortable in the presence of a female gynaecologist and hence it will work in favour of her gender. She is firmly of the view that there is a paucity of gynaecologists and feels more number of medical students should take up this specialty. According to Dr Joyeeta Sil--

"Women prefer to choose gynaecology because it is a familiar territory evidenced by a visible number of female doctors. She can be the "boss" and circumvent herself from the occupational hazards that she will have to endure in other specialties that are dominated by male doctors. It is a comfort zone for the female doctors as the ratio of male and female doctors are almost same. Hence, she can wave off stiff competition. She won't be under the pressure to put in extra efforts owing to her gender. After a prolonged period of MBBS followed by gruelling internship experience, it is natural for the doctor to make a calculated decision regarding the risk and advantage in case of each specialty".

Hence, as it may be surmised from these narratives that for the female interns the possibility of competition from the female peers might be limited. This also raises the question that whether the male physicians are imagined as more competent and intelligent by the female physicians. The female interns said that they do not feel threatened by their male peers but because of the societal perception of men being the ideal physicians, it sometimes makes it challenging more women to make their mark.

This phenomenon is redolent of Sylvia Walby's (1990) concept of "public patriarchy". According to Walby, although the modern institutions allow women to be present in the public sphere that doesn't indicate the end of an exercise of patriarchy-"The public gender regime is based, not on excluding women from the public, but on the segregation and subordination of women within the structures of paid employment and the state, as well as within culture, sexuality, and violence." (*ibid*: 17) In the public sphere, patriarchy operates through collective appropriation and manifests as segregationist and subordinating (*ibid*).

According to American Medical Association (1994) despite the increase in women in the medical profession, internal segregation confines women in less prestigious specialties of gynaecology, obstetrics, paediatrics, family practice and psychiatry whereas women physicians are underrepresented in surgery, surgical superspecialties, anaesthesiology and radiology(Cited in Hinze 1999: 218). The study by Davis and Allison (2013) found that gendered goal development of specializations stems from the differential socialization of men and women, prospect of balancing work with family and experience in the medical school. The authors also argue that supply-side explanation in the form of entry of women into highly-paid occupations and demand-side explanation like the discriminatory factors in the workplace is instrumental in the gendered choice of specialties (*ibid*: 20-22).

Dr. Dipayan Dastidar is of the view that women are less likely to take up forensic science as a specialty because it involves the routine handling of the corpse which can become quite grotesque. Apart from that there might arise legal obligations that are common during police case as a forensic doctor needs to be present during such circumstances and would need to be available t any time of the day. A forensic doctor may also face life threat and possibilities of sexual violence. Forensic experts are

distinguished from “normal” doctors. “Normal” doctors are more revered than a forensic doctor despite the fact that a forensic doctor has expertise in multiple disciplines. They hold a powerful position as their decision and signature is crucial in a criminal case. In the hierarchy of medical specialties, they do not enjoy a respectful and dignified status. Another reason why women would not want to associate with forensic science as stated by Dr Suneha Majumdar is that daily interaction with the death can desensitize the doctor, leading to abnormal or diluted sex drive. The female interns of this research shared the same thoughts as articulated by Dr Dastidar. According to Dr Tamal Sikdar women show a predilection for radiology as it does not demand too much of physical labour, no erratic working hours that interfere with the personal life and in addition to it, there is also the scope of generating a lucrative income.

In Ophthalmology the possibility of emergency is less, physical labour is minimal and at the same time inflow of patients is less as stated by Dr Sil. Women are found to be largely concentrated in dentistry, ophthalmology, and anaesthesiology. She is of the opinion that it is the immaculate nature and may be the purity associated with ophthalmology, dentistry, and dermatology that women prefer to enter it. On the other hand, Dr Tamal Sikdar opines that these are delicate and hence preferred by women.

These statements steer towards certain possibilities---First, the aforementioned specialties are considered to be delicate or soft within the medical profession because there is a large concentration of women and hence by default, it becomes inferior and considered to be less competent. Another possibility is that women adopt these specializations assuming that they won't have a problem in the steady inflow of patients because of their gender identity unlike surgery and orthopaedics that is considered to be intrinsic to the personality of men. The third possibility is that in these specializations,

the female interns are able to find female role models and feel that it is compatible with their gender (the toxic environment generated by public patriarchy will lesser).

Fourthly, it may be argued that within the medical profession there are certain specialties that are believed to be more “purer” than the others and women owing to their gendered socialization may gravitate towards such specializations that are less messy. Lastly, it may be argued that embracing these specializations would allow the female interns to maintain a balance between medical career and personal life that might not be possible if they choose the other available specialties.

Medical students securing higher ranks enjoy the leverage of entering into general medicine and anaesthesiology as these are considered to be the domains of the top rankers. Students securing low ranks can enter surgery. This highlight the contradiction that although studies have shown that surgery is a high-prestige specialty but for pursuing surgery in post-graduation a medical student do not need high rank. I feel a future study should be taken up to enquire into this issue.

Regarding the motivation behind choosing the specialties, Becker *et al* (1961) argued that medical students choose specialties assessing the opportunities for medical responsibility and clinical experience. Their study has found that a desirable specialty is one that that offers a melange of experiences. The extent of responsibility is such that a mistake can lead to the demise or disabling of a patient. In other words, the challenge is at the peak. Thus, there is a trend for medical students to veer towards internal medicine, surgery and paediatrics and these have emerged as the most popular among all the specialties (The study was conducted in the US in the University of Kansas). The “mechanical” character of surgery, the desire to work with children serves as an inspiration to embrace these specialties. Subjects like dermatology and allergy (Cited in

Sills 1968: 107) were found to be unpopular as these specialties involved fewer challenges or in words minimum medical responsibility.

However it is only with the intervention of feminist scholars that the role of gender in the choice of specialties was taken into consideration (See Hinze 1999 and Gabe *et al* 2004). Drawing from the wealth of feminist scholarship on this issue, I have humbly tried to highlight the influence of gender that determines the choice of specialties of the interns in Bengal National Hospital and College of Medicine. At the same time, this section also tried to weave in the various imageries specific to female physicians and male physicians.

Conclusion

The data from Kolkata on the gendered hierarchy within the medical profession seems to be consistent with the selected literature analysed in the first part of the chapter. The narratives unveil that gendered underpinnings exist in everyday interactions with the peers, faculty, nurses and patients. Male medical students, interns, and doctors are considered to be naturally attuned to the profession. A female doctor might be revered but her status is always subordinate in comparison to her male counterparts of the same qualification and academic credentials. Caste violence operates on symbolic contours and it becomes more burdensome for women than men to prove their academic potential as well as breaking the gender barriers. In the light of the fieldsite, the female intern is often equated with the nurses and the former find that quite humiliating. The gender power imbalances become pronounced and visible in the interaction between the male doctor and nurse and female doctor and nurse. The nexus of occupational hierarchy, agency within the organization, nature of hospital setting (private or public), caste, class, and gender differentials underscores the antagonistic relationship between

the interns and the nurses. This also highlights the subservient position of nursing within the medical profession. On the question of gendered choice of specialties, the study shows that female interns are quite rooted in their feminist politics but also realize the boundaries that constrain their career decisions. The female interns identified themselves as feminists and were vehemently critical of the male-dominated attitude pervasive in the medical profession. However, regarding their specialty aspirations, they are determined to pursue those specialities that would ensure an inflow of patients, amiable working conditions, less competition to prove to their male peers and financial stability. It has been found that women also gear towards non-clinical subject by assessing the less strenuous nature of work. The view of the male interns about the career choices of their female counterparts is quite telling about the gendered perception emerging from the traditionally and historically privileged gender (the male). The male interns believe that most of their female peers lack the grit to survive in the medical profession and that certain specialty is suitable for men. Interestingly, all the male interns aspired for specialities (3 of them wanted to become surgeons and 1 of them wanted to become a practitioner in General Medicine) that are considered as high-prestige specialties within the medical profession (See Hinze 1999). Similarly, all the three women wanted to either join gynaecology-obstetrics or paediatrics that is considered to be less prestigious but compatible for women. However, one narrative brought out the aspect of purity and pollution like handling the deadbodies in forensic, less grotesque nature of ophthalmology compared to other specialities essaying a key role in the choice of careers for women. In the third chapter there is a further exploration of the experiences of the interns in different specialties along with the variegated gendered dimensions that intersect with medical socialization and shape the distinct lifeworld of the doctors.

Chapter 2

Gendered medical socialization: An examination of selected literature

"The Columbia University study of medical education sought to demonstrate that the student, the course of training, develops a conception of himself as a doctor, absorbs the knowledge he needs in order to be secure enough to deal with patients without too much anxiety, and attains the capacity to cope with basic uncertainty in clinical practice" (Eliot Friedson 1974).

This chapter makes an attempt to understand the notion of medical socialization with a focus on gender. Medical socialization is a complex process. It is a product of medical training and continues to operate throughout the lives of medical students. In order to understand the distinctive nature and temperament of medical socialization, it is imperative to have a coherent understanding on the concept of socialization. Hafferty (2007: 2931) states that socialization underscores on "learning the rope", acing the "rules of the game", transmission of group culture to an individual/ group, a special form of learning that entails internalization and identity formation, the "glue" that links individuals to groups and the process through which neophytes/outsiders are oriented towards the norms, skills, and language desired for an organization, group or society. In other words, medical socialization refers to the training received, the values learnt, perspectives nurtured, personality developed and the common patterns that tie the community of physicians across nations (*ibid*.).

There are variegated aspects, characteristics, and nature of the medical profession that contributes to the making of a doctor. Relevant literature has been selected and analysed to forge a feminist polemical narrative against the essence of medical socialization which includes medicalization, the medical gaze, reconstruction of the human body, and the interventionist/instrumentalist approach. These characteristics are adopted and internalized by the medical students during the course of their medical school training through the exposure to the medical textbooks, experience and lessons from the practical classes, and interaction with the faculty members, peers, and patients. The chapter comprise five sections namely 'medicine as a bastion of moralistic and value-laden canon', 'epistemic violence and countercurrents: gendered imaginings', 'feminist polemics of medicalization and gendering women's health', 'medical training: experience in the medical school', 'medical worldview and construction of the body', and 'instrumentalist or interventionist approach'. Through an engagement with existing literature, this chapter tries to argue that the epistemology of medical discourse premised on the principles of objectivity, rationality, empiricism, and experimentation bequeaths these values to the medical students who accumulate and imbibe these in the course of becoming a doctor.

Medicine as a bastion of moralistic and value-laden canon

This section delineates the role of medicine as a moralistic canon through a critical reading of three volumes (named as Volume I, Volume II and Volume III) of 'Medical Advice for Women' in the time period between1830 and 1915. The rationale behind choosing these textbooks is to highlight the moralistic, authoritarian, disciplinary and intrusive nature of the medical profession during the nineteenth century and twentieth century which becomes the basis for the succeeding section on the feminist critique of medicalization.

It is paradoxical that the “scientific” and “objective” advice given to women in the form of a manual is nothing less than a sermon on leading a lifestyle of propriety that would be in consonance with the subjective societal perception of a good woman. The texts document the bigotry practised by medical science in the guise of scientific objectivity and in this way is a patriarchal and paternalistic harangue towards women. It further underlines the power and influence of medical discourse on society. The Medical Advice is nothing more than a manifestation of the values and normative codes embedded in the society. The Medical Advice instructs women on leading a blissful marital relationship and prioritizes the inculcation of wifely virtues over scholastic feat or nurturing of talent. In fact, these texts unambiguously and unabashedly projects women as subordinate, naive, juvenile, whimsical and thus in immediate need of regulation. A woman is blamed for wrecking her domestic bliss by not performing household chores, not attending to her husband and transferring her share of domestic chores to the servants. In Volume II the medical advice is woven around the socialization of a woman into an ideal wife and some of the attributes that are indispensable in her perfect role-play are being cheerful, occupation-oriented (here occupation being managing the domestic sphere with finesse) and indulging in healthy activity. The internalization of all these virtues has been deemed cardinal for maintaining both the self and the other happy (Robins 2009: 25). The newly married wife is advised to be guided by reason and not by fashion and elaborates it by stating that married women should refrain from participating in activities that stokes excitement. It is because such emotions are succeeded by depression! It prescribes gardening, archery croquet bowl making and botany as alternatives. There is a lament towards the ‘degeneration’ of women--

"Why is it that she is not taught to understand thoroughly all household duties? In olden times, the daughters of a gentleman's family spent an hour or two every morning in the kitchen and in the laundry.....But now look at the picture, - the daughters of a gentleman's family of the present day consider it very low and horridly vulgar to understand such matters!" (*ibid:* 29).

It justifies the exasperation of the man of the family if the food is badly made by the cook. The wife is held accountable for failing in her household duties. A woman who transfers her share of household work to the servants is sketched as idle and idleness is viewed as vice in women. There is a notion of marriage being an entry into a reformative phase in a woman's life as it would decontaminate/sanitize her from the naive and puerile romantic aspirations. The following statement encapsulates the sentiment of the doctors on this thread of argument-

"As soon as a lady marries, the romantic nonsense of school-girls will rapidly vanish, and the stern realities of life will take their place, and she will then know, and sometimes to her cost, that a useful wife will be thought much more of than an ornamental or a learned one" (ibid: 33).

The series actually pontificates about the code of conduct to be followed by wives while masquerading as scientific medical advice. It reinforces the status-quoist "functionalist"[72] (1951) view about the sexual division of labour- A woman should be confined within the vicinity of the private domain whereas the public domain is the

[72] Functionalism believes that each institution of the society has a specific role to perform that would allow the society to function in a proper manner. According to Parsons' (1951) functionalist view sexual division of labour is indispensable for the order and harmony in the society. The man is expected to perform task-oriented role of earning money to run the household whereas the woman is expected to provide primary socialization of children and emotional support for group cohesion.

rightful territory of men. The medical advice directed towards women unequivocally accounts the woman for maintaining the family whether it is looking after the needs of her husband or making her responsible for the 'deviant' child. In Volume III on the section of 'The little girl' (*ibid*: 9) the medical community lambasts against the mothers who want to dress up their daughters according to the "latest style"- the author writes that physicians were worried that the simplicity of childhood would be lost if mothers tried to model their children according to the trends of the latest fashion (*ibid*: 125). In one of its concatenations of advice the manual reads about the pernicious nature of a little girl--

"A forward or loose manner in the company with little boys is suspicious conduct, especially in one who has previously shown no disposition of this sort. Girls addicted to this habit usually show an unnatural fondness for the society of little boys, and not infrequently are guilty of most of the most wanton conduct" (ibid: 175).

It is clear how the then existent medical discourse permeates into the private sphere of the patient especially women. There is a legitimization of the medical community advising women on leading a chaste life without transgressing the boundary of the good girl. There is a supercilious attitude adopted by the doctor while instructing the female members regarding the prescriptions and proscriptions of being a woman. There is further an implicit categorization of normal and pathological women according to the performance of their gender roles. The above-mentioned excerpt is a clear indication of slut-shaming, moral policing and character assassination of women.

Although penned down in the nineteenth century the reality of twenty-first century is barely different. It has been found that women are frequently subjected to gyno-

shaming[73] by their gynaecologists on instances of engaging in pre-marital sex or seeking abortion during accidental pregnancy. Gynaecologists take it for granted that they are the custodians of moral principles and rebuke female patients for contravening the 'traditional' code of conduct. Gynaecologists have also been accused of employing the rhetoric of marriage as a prescription for solutions to the excruciating menstrual cramps amongst others. Thus, the fine line between medical advice and moral policing often blurs in the paradigm of medical science.

Epistemic violence and countercurrents: Gendered imaginings

Studies have found that medical science is embedded in the patriarchal ethos which on its confluence with the medical worldview produces and harbours negative, distorted and biased notions about female anatomy, functions, and processes. Medical science legitimizes the power exercised by doctors to engage in the labelling of health and illness. One of the consequences of this is that women are being defined and treated more medically compared to their male counterparts (Reissman 1992). The female body becomes an "other" to the male body and inherently "pathological" (Martin 1991, Birke 1992 and Harding 1992). The profound gender bias in medical science justifies the role of reproductive technology in treating female infertility at the same time failing to address male sterility (Wajcman 1991).

Through an analysis of the undergraduate level medical textbooks in 'The egg and the sperm', Emily Martin (1991) lays bare the misogynistic lexicon of biomedicine that is

[73] Gyno-shaming refers to being moral policed by gynaecologists. For illustrations see http://www.revelist.com/feminism/bad-stories-from-the-gynecologist/4565and https://www.bustle.com/articles/98389-have-you-been-judged-by-your-doctor-14-people-weigh-in-on-what-it-feels-like

couched in male-centric cultural belief. Menstruation is touted as “debris” of the uterine lining that is a consequence of necrosis and death of tissue whereas the production of sperm is deemed as valuable. There is a stark juxtaposition of the male against the female-while the male organ is understood to be producing fresh germ cells the female organs stockpile germ cells since birth (*ibid*: 486-492). Shuttleworth (1990: 48) writes that medical literature represented women for the consumption and guidance of male physicians. Menstruation was constructed as something dangerous thus, indicating the greater need for regulation and control through medical science.

Gupta (2000) documents the alliance between patriarchy and medical science in manufacturing value-ridden ideologies in the garb of “objective” and “scientific” knowledge. The intervention of feminist medical historians has unveiled that there are two cardinal perceptions revolving around the woman’s body. The first idea comes from Aristotle where he states that men are “normal” and women are “abnormal” (deviant). The physical, intellectual and emotional quotient of a woman is measured against the male norm and the conclusions derived from such comparisons are that women are “imperfect” beings. The second idea central to the medical discourse is that the ‘natural’ role of women is to reproduce. This ideology can be traced to the genealogy of the Darwinistic theory of evolution. Social-Darwinists like Herbert Spencer considered woman inferior to man and associated her with procreative functions whereas the man was associated with civilising culture. The emphasis upon the natural proximity of women to nature was a strategy to license the subordination and control of women by men for the progress of culture. Medical science acted as an intermediary to reinforce the cultural dogma and stereotypes regarding the nature-culture dichotomy on one hand and man-woman dichotomy on the other. A woman was

defined on the basis of her biological function, her capacity to reproduce, which was associated with nature, and both were viewed negatively[74] (*ibid* and Wajcman 1991).

In the light of childbirth, Inhorn (2009: 12-13) discusses Emily Martin's (The Woman in the body: A cultural analysis of reproduction, 1987) work that draws attention to the medical jargons like labour that emphasized upon the imperative to tame, regulate and "deliver"[75]. The connotations associated with menstruation and menopause amongst others in medical textbooks postulates a negative and inferior image about the female body that in turn is reiterated by the doctors.

Hence, the incorporation of more women within the manifold of medical knowledge does not indicate that the negative and distorted assumptions about the body would become less. It is because this knowledge trickles down from the discourse of biomedicine. The male norm intrinsic to biomedicine constructed the female body as frail and prone to medical and mental disease and hence, the imperative for medical intervention (Candib 1973).

Feminist polemics of medicalization and gendering women's health

The preceding sections encapsulate the power of medical discourse over the social lives of individuals especially women and medical imaginings about women thus becoming another mechanism of social control rooted in patriarchal ideology. This may be

[74] Merchant (1980) argued that from the fifteenth to the seventeenth centuries in Europe the conceptualization of scientific investigation and nature were based on man's violent relationship violent and misogynous relationship with women (Cited in Wajcman1991: 6)

[75] I have discussed the usurpation of the midwives and monopoly of the male obstetricians succinctly in the review of the literature and also in the section on 'Instrumentalist/Interventionist' approach in this chapter.

understood as medical patriarchy. This section will enable one to comprehend the essence of medicalization and the feminist intervention to critique the medicalization thesis. In this section, pertinent literature has been curated that provides an insight to medicalization, a term that is important to understand the gendered elements of medical science and how it may inform doctors during the phase of medical socialization. In this context, Riska's (2003) essay 'Gendering the Medicalization Thesis' have been employed as it provides a chronological trajectory of the medicalization thesis followed by the three important epochs (First phase[76], Second phase[77], and Third phase[78]) of feminist scholarship and praxis. Other texts that criticize medicalization have also been looked upon to broaden the view on the same.

Riska (2003: 59) discussed medicalization thesis which was a term conceptualized by functionalist-sociologist Talcott Parsons (1951) that indicates the power of medicine as a culture and profession to define and regulate social behaviour. Parsons further noted that medicine as a social institution regulated the kind of deviance for which individual

[76] During the first phase of feminism (in the 1970s) on medicalization, medicalization was explained and understood in gender-neutral ways. During this period the social control and regulation characteristic of medicalization was propounded by Irving Zola, 1972 (Cited in Riska 2003: 64-65).

[77] The second phase on medicalization, the feminist identified that women were victims of the medicalization of their bodies and later during the 1990s women came to realize their capacity to medicalized their own bodies. During this phase feminist scholars criticized the cultural hegemony of male-dominated medicine that defines the bodies of women as healthy and unhealthy (Cited in *ibid*: 66-71).

[78] The third phase on medicalization addressed the reductionist medical premise. This third phase highlighted that biomedicine also medicalized the men's health; however there has been limited studies on the subject. However, feminist scholar Reissman was of the view that in comparison to men's health, women's routine and everyday experiences has come under greater medical scrutiny (Cited in *ibid*: 71).

was not morally responsible and a medical diagnosis could be found. The medical profession is perceived as an agency of social control and maintains the division of labour that constitutes the bedrock of functionalist philosophy.

Medicalization is the pathologization of normal bodily processes and states by medical science[79]. One of the prominent illustrations would be biomedical science defining obesity and anorexia and advising patients on what constitutes the ideal body type. Friedson (1970) states that the term medicalization addressed the rising moral power and control of medicine, a trend perceived as universal in western, increasingly secularized societies (Cited in Riska 2003: 60). Irving Zola (1972) opines that the controlling function of medicine was "an insidious and often undramatic phenomenon accomplished by 'medicalizing' much of daily living, by making medicines and labels 'healthy' and 'ill' relevant to an ever increasing part of human existence" (Cited in *ibid*: 60).

The genesis of the concept of medicalization thesis was a turning point for an astute study of medicine and the medical institutions. However, it was only the feminist scholars who made an effort to make it gender-sensitive by highlighting the aspects of gendered medicalization and related practices of the medical field during the mid-1970s. According to radical feminists, Barbra Seaman (1975), Gena Corea (1977) and Margaret Sandelowski (1981) women are the victims of new scientific medicine (Cited in Riska 2003: 66). Radical feminists proposed that the increasing medicalization of women's health needs to be situated in the larger context of medical surveillance and the wielding of control over women's body precipitated from the interests of patriarchal ideology and profit-oriented market economy. Ehrenreich and English (1973: 42)

[79] See Riessman 1992: 124, Riska 2003: 60, Gabe *et al* 2004: 61 and Inhorn 2009: 13

opines that the idea of professionalism in medicine is the institutionalization of a male upper-class monopoly (Cited in *ibid*). Sandelowski (1981: 139) argues that perception about women has been that they are uninformed, misinformed and hence are willing to be participants for mass experimentation that involves chemical agents, contraceptive devices, and surgical and psychotherapeutic techniques (Cited in *ibid*). Scientific medicine has been known as an abstract, biased, male and sexist knowledge that has little in common with women's own experiential knowledge of their bodies. The various branches of the women's movement believed that women's health has been medicalized in the past, and that gender biased medical knowledge, diagnoses and treatments of women decided by biased male physicians has resulted in the overtreatment of women documented in the high-surgery rates of hysterectomies and mastectomies, and overuse of drugs especially psychotropics (See Fee 1977). In 1984 it was found that the National Health Service prescribed psychotropic drugs like tranquilizers more for women compared to men (Kirkup and Keller 1992: 73). Fee (1977) argues that liberal feminists advocated for space for more women doctors and greater medical information available to women so that the erstwhile medical knowledge would be amended (Cited in Riska 2003: 67).

The propensities of medical discourse to victimize[80] and objectify[81] the bodies of women were castigated by feminist scholars who challenged the cultural hegemony of male-centric medical knowledge. Feminists wanted a complete redefinition of the woman's body that has been touted as pathological and so, incessantly medicalized[82]. The universal man was indeed a male and the male body was considered as the norm and the yardstick of human health. Medical textbooks from 1943-1972 recorded information on female sexuality which reflected the traditional sex-role stereotypes rather than scientific and research-based information about women's health (Riska 2003). The second phase of the women's movement in the context of medicalization thesis argued that men's health established as norm was confirmed by scientific research using only male samples, although the results were generalized for both genders (Keller 1982). Feminists advocated for the demystification of women's bodies. In other words, women have to be aware of their own bodies and normal functions so that they can make informed decisions. Critics have argued that medicalization rested in

[80] The issue of victimization or an invasion of women's bodies indicate the tendency to experiment with women's reproductive health in the form of contraceptives, barrier method like Copper T, hysterectomy, the biasness shown in reporting more women as prone to 'mental illness', defining many of the normal stages in a woman's body from menarche to menopause as a state of disease or condition that is to be managed through biomedical intervention (Inhorn, 2009: 13-14).

[81] Objectification- Doctors internalize the psychiatric theories of the development of gender that are premised on the existing gender stenotypes prevalent in the society (Riessman, 1992: 134). There exists a nexus between the discourse of biomedicine and the market in medicalizing the bodies of women and create sustained consumers (ibid).

[82] From the 1970s there was a shift from total domination of childbirth by male obstetricians to home-birth movement, partner-assisted, intervention free, natural childbirth and assistance by midwives. This challenge to the medicalization of childbirth can be traced to the impact of the second wave of feminism and the publication of the pathbreaking text 'Our bodies, ourselves' (1973).

mutual interest that physicians and women from the upper and middle classes have had in redefining certain human events in putting them into medical categories (Reissman 1992: 140). Rather than demedicalizing women's health needs, the middle-class character of women's health movement resulted in a confirmation of the trend towards medicalization[83] (*ibid*). Such a trend becomes problematic as it indicates the alliance between the capitalist market and patriarchy turning women into not just victims of patriarchal canon but also a slave of the medical market (Annandale 1998). From the perspective of dual-systems theory, capitalism is inherently sexist and both needs to be understood as a unified system. Hence, struggle against patriarchy and uprooting of capitalism would usher in the emancipation of women. By persistently emphasizing on women's health in terms of her reproductive potential and "inability" of the same as a medical condition in need of treatment, the capitalist medical patriarchy objectifies and reduces the bodies of women as profit generating machines (Riska 2003). Sharma (2009: 216) argues that advertisements in colonial India that reiterated that the responsibility of good mothers lies in nurturing healthy children. The consumer was imagined as the mother attracted by the image of an alert, robust and well-groomed baby pretending to talk on a toy phone. Qualities such as the robustness, intelligence, and beauty associated with the ruling race were implicitly accessible to the children of the Indian consumer as well. The underlying logic was that the claims of the advertisement would be accepted and the consumers would choose a product that

[83] The demand for medical information and access to healthcare services turned out to be a double-edged sword as women became sustained consumers for the medical market. These women healthcare consumers exemplified by the middle-class women became favorable for the market. Their purchasing power constituted the locus for the middle-class consumerist elite nature of the healthcare movement discriminating lower-class women who were excluded from family planning and healthcare services (Riska 2003: 68).

nurtured the idealized fair, male child. These advertisements reinforced the notions of masculinity and femininity (*ibid*). Thus it is rightly inferred that the normalising and disciplinary power of medicine are inextricably tied to the advances in medicine and medical knowledge.[84]

Kevin White (2002), Jonathan Gabe, Mike Bury and Mary Ann Elston in the section on 'gender' in Key Concepts in Medical Sociology (2004) and Marcia C. Inhorn (2007) also documents the confluence between medicine and patriarchy that defines and appropriates women. White (2002: 132) stated that women are hospitalized more than men between the ages of 15 and 44, that is, during their reproductive age. The positivistic data "predefines the reality" and provide a skewed scenario of women's health. If data supports that more women visit doctors than their male counterparts what it conceals that these have more to do with reproduction (menstruation, pregnancy, menopause, etc.) rather than illness. Medical science envisages that an essential characteristic of a woman is her ability to reproduce: - to give birth and to mother her children. Therefore, the medical and public health fields devoted to women's health largely target women as reproducers or potential reproducers. For instance, the field of obstetrics-gynaecology is exclusively dedicated to women's reproductive organs and complaints and to the processes of pregnancy and childbirth. Other kinds of women's health issues are to be dealt by other specialties, although, for many women around the world, reproductive health services are the only point of contact for healthcare and delivery (*ibid*).

Gabe *et al* (2004: 9) states that differences in men's and women's health issues may also be attributed to diagnostic behaviour and treatment by doctors. Health

[84] This has been discussed in detail in the section on 'Instrumentalist approach'.

professionals play a vital role in defining the symptoms as sickness, sanctioning entry into the “sick role” and making decisions about treatment, all of which might be influenced by gendered norms and assumptions. White (2002: 131) propounds that in patriarchal medicine, women's bodies are defined in contrast to the good and healthy male body. Hence, women are deemed as inferior, sicker and more at biological risk than men. The analysis about the bodies of a woman begins with the social category of mother, houseworker, carer and shifts to the biological category of menstruating, pregnant and menopausal woman and finally combines the two, thereby obscuring the social basis of women's problems. The medical discourse casts the woman as weak, meek and subordinate on account of their reproductive capacity. The social indicators of class, race, etc, also become important factors in determining health status of a woman.

Gabe *et al* (2004: 9) and White (2202) argue that there is a paradox at play in relation to the health of a woman- women are diagnosed as suffering from ill health while they live longer. They are targeted for cervical cancer and breast cancer as a result of which they have to be continuously in the check-up. Women are also overrepresented in the health statistics as a result of their caretaking roles for children- They shoulder the onus of looking after other members of the household and the extended family (White 2002: 133). Contratto (1984) stated that since the 1950s the medical profession is attributing disorders of children ---asthma, colic, eczema – to psychological disorders in mothers and mothers seeking medical advice on behalf of their children are met with prejudice, hostility, and derision (Cited in White 2002 133). Medical assumptions about women can affect the doctor-child-mother relationship. Verbrugge (1989) contends that women are more likely to consult doctors on how they feel compared to men who would avoid consultations unless it is to do with physical factors (Cited in *ibid*: 134). The corollary

to this is that men are less likely to be diagnosed as suffering from stress or depression and more likely to be diagnosed with a physical ailment (White 2002: 136). Hence, it can be stated that women's representation in medical statistics is socially constructed that reeks of male bias in the guise of objective analysis.

White (2002: 135) contended that a web of powerful and dogmatic social assumptions forms the bedrock of medical imaginings about women that is manifested in the diagnosis and treatment of them. Such discourse plays a pivotal role in defining the doctor-patient relationships. Barrett and Roberts (1978) in their study on the interaction between male doctors and middle-aged patients found that women are remorsely confirmed in traditional and domestic family roles and her refutation to confirm to gendered division of labour resulted in hospitalisation and electro-convulsive therapy (Cited in White 2002: 135). The same study has also found that the higher the status of the doctor, the greater will be the sexism and inequality in doctor/patient relationship. It has been unveiled that women do not suffer greater levels of depression but women seek health interventions more often when they experience low levels of ill health. According to Newman (1984) this gets represented as depression across a range of self-scaled questionnaires, that averages women's depression across a range of scales. This leads to a skewed representation that more number of women suffering from depression (Cited in *ibid*: 136).The issue is not that women are more depressed than men but it is that they are diagnosed as more depressed. It also appears that men and women respond differently to stress, men show the propensity to internalize stress and anger while women tend to express it. This statement can be substantiated by the studies conducted by Kessler *et al* (1994) and Meltzer *et al* (1995) that if alcohol and drug abuse in men are taken into consideration then their rates of psychiatric disorder can be equal to that of women (Cited in *ibid*: 136-137).

However, in White's essay, the social location of the women being discussed remains obscure. It is written in a manner which generalizes the struggles and ordeals of women across the society without investigating into the influence of social factors pertaining to the health of women.

Regarding the health conditions of women, Hope Landrine and Klonoff (2001) argue that there are more women than men who make visits to hospitals, more visits to emergency rooms, and have to undergo more surgical procedures even after controlling pregnancy. It is interesting to note that ethnicity and social class come into the picture and influence women's visits to the hospital. The study revealed that poor women and minority women make fewer physician visits and have fewer hospitalizations than white and middle-class women because of their lack of health insurance and access to health services. While women are sicker than men, it is the poor and minority women who are sickest among them all (they have high morbidity). In the developed and the developing nations, a portion of women's high morbidity and mortality can be attributed to the inequity in the distribution of food that prevails as a consequence of gender hierarchy. When this intersects with the sheer inequality in the consumed food, it pushes women to illness. Hence, it is found that more women are sick as compared to their male counterparts. Whereas in the developed nations, women are exposed to the hazardous chemical in domestic cleaning substances, women in the developing nations are exposed to wood smoke from the fires, burning in their poorly ventilated homes. The smoke produced is responsible for the high frequency of cancers, bronchitis, pneumonia, carbon monoxide poisoning and respiratory and eye diseases found among women. When it comes to sterilization women are prone to the risk of death along with high expenditure whereas for men it is "inexpensive, easy and does not pose a threat to

their life". This indicates that one of the reasons for the greater morbidity rate among women is also due to the gender inequality in sterilization (*ibid*).

By weaving in the arguments by Landrine and Klonoff there is an attempt to compensate to the propositions made in 'gender, health and medicine' (White 2002). Landrine and Klonoff, move beyond the data of men being afflicted with particular diseases and women with particular diseases and instead locate the larger socio-political context of gendered expectations and gendered performances in a patriarchy society. Unlike White who highlighted and exposed the medicalization of women's bodies by the medical profession, Landrine and Klonoff provides an explanation regarding how the various aspects of health impinges a woman or have implications based on her social location or differential position in distribution to power.

Till now the discussion has pertained to the power of medical discourse and the role it plays in defining the health of women and construction of illness through medicalization. The next two sections aim to understand the nature of medical training that constitutes the lifeworld of the doctors and shape their medical worldview. There is also an attempt to explore this in the next chapter through an engagement with empirical narratives of interns.

Medical training: Experience in the Medical School

This section examines two essays by Fox (1979) namely 'Training for Uncertainty' and 'The Autopsy: Its place in the attitude-learning of second-year medical students'. These essays are interwoven and explore the training phase of medical students in Cornell University Medical College by specifically emphasizing the traits of uncertainty and detached concern lingering the profession and the experience of an autopsy being a coming-of-age tale for the doctors.

‘Training for uncertainty’ discusses the range and ramifications of uncertainties that are intrinsic to the medical profession and the training imparted to familiarize with these uncertainties for becoming a physician. The first common and evident uncertainty is a consequence of “incomplete or imperfect mastery of available knowledge” (*ibid*: 20).The variations in aptitude, skill and knowledge steer towards individual differences in the range to which students respond and experience uncertainties posed by shortcomings of skill and knowledge--

“For example those who find it easy to memorize details may have an advantage over their classmates in the study of anatomy; those whose manual dexterity is highly developed may not experience the same degree of personal inadequacy as the less adroit students when they begin to carry out surgical procedures...” (*ibid*).

The second type of uncertainty emerges from limitations posed by medical knowledge as a result of which no physician can provide an answer (*ibid*: 24-28). An illustration of this would be the consensus regarding the loopholes in psychiatry surpassing that of obstetrics and gynaecology. The third nature of uncertainty emanates from the challenge in distinguishing between personal ignorance or ineptitude and the shortcomings of the present medical knowledge (*ibid*: 20*).*

The second essay titled ‘The Autopsy: It’s placed in the attitude-learning of second-year medical students’ is woven around the first autopsy attended by a medical student as part of the medical course. The exposure to the autopsy and the experiences derived is crucial in the formation of an efficient physician. The autopsy phase inculcates the value of “detached concern” among the medical students (*ibid*: 56). The notion of “detached concern” is premised on duality that a doctor needs to continuously balance between maintaining an impersonal attitude similar to that of scientists and yet at the

same time maintain sensitivity to the human implications towards the patients. It is during the autopsy period that the patient's family enters into the consciousness of the medical student in the following ways of seeking written consent from the relatives of the patient before embarking upon autopsy, the attitude of medical students are moulded by taking into account the implications of death and permission of post-mortem examination from the patient's family and the pace at which the autopsy proceeds is determined by the sentiments and desires of the patients family about the funeral and burial (*ibid*: 60). Autopsy also socializes medical students to acquaint with putrefaction and the macabre, and it instils the values of scientific detachment, depersonalization, objectivity, equanimity and intellectual absorption. The appearance of the autopsy room epitomized by extreme cleanliness, bright lights, and shiny stainless steel enable students to cope with revulsion during the procedure making the setting appear like an operating room rather than a butcher's shop. Finally, the socialization into detached concern, uncertainty, management of time, and medical morality inspires a medical student to develop a professional self-image and realize that their worldview is different from people outside the medical profession (*ibid*: 76-77).

Medical worldview and the construction of body

Medical worldview is a way of looking that distinguishes the perspectives of doctors from the outsiders (non-medical professionals). It stems from, sustains and deepens during the period of medical training in medical school. It comprises the medical gaze, reductionist view, reconstruction of the body of patients and objectification of the patients. The inculcation of the medical gaze informs the doctor to view the human body especially the body of the female patients through the lens of reductionism.

To extrapolate these arguments Good and Good's (1993) essay titled 'Learning Medicine' has been chosen here, as it is pivotal in situating the understanding about the nature and essence of training in medical school. The authors explore the structure of early medical education and the structure of knowledge in the context of Harvard Medical College. Biomedicine embodies the empiricist theory of language, biomedical "reductionism"[85], western worldview of "individualism", "mind/body dualism"[86] that traces its epistemic premise to "Enlightenment"[87], and it reproduces social dogmas/conventions rather than value-free understandings of the natural world (*ibid*: 82). The authors further argue that biomedicine is inculpated for objectifying the patient and the disease, constituting both decontexualized and asocial objects of the medical gaze. A disease is recognized and treated as a dimension of human biology rather than as socially produced misery or human suffering. Medical knowledge is

[85] Scientific reductionism refers to "the idea of reducing complex interactions and entities to the sum of their constituent parts, in order to make them easier to study." For example scientists would say that the emotion, intelligence and all other human conditions is a product of chemical reactions and complex physical processes. Accessed December 15, 2017. https://explorable.com/scientific-reductionism

[86] In metaphysical philosophy mind-body dualism refers to mind and body as separate substances. This idea was propounded by Rene Descartes in the seventeenth century who believed that mind and body has different nature. Earlier Christian ideology believed in the mind-body unity. Hence, illness was attributed to personal faults of the persons. However, Descartes' idea about mind-body dualism had an impact on modern medical science. Diseases concerning the body were now being studied medical science. Accessed December 15, 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3115289/

[87] The Age of Enlightenment in Europe and North America was between late seventeenth century and early eighteenth century. Enlightenment period is known for promoting the values of empiricism, scientific enquiry, rationality, progress and liberty.

constructed as an "intersubjective reality"[88] in the context of highly organized interpersonal and institutional relationships (*ibid*).

Learning medicine is about internalizing the contents of biomedical science. Medical education begins by entry into the body through the activities of viewing through the microscope, entering physically into the gross anatomy lab, viewed through the marvels of contemporary radiological imaging or presented by master scientists. Students begin a process of attaining intimacy with the body, making an effort to understand its organization and structure three-dimensionally, and examining tissue from total function to molecular structure. The body is the object of attending and skilled manipulating, and the site of unending learning. Within the lifeworld of medicine, however, the body is newly constituted as a medical body, quite distinct from the bodies with which we interact in everyday life, and the intimacy with that body reflects a distinctive perspective, an organized set of perceptions and emotional responses that emerge with the emergence of the body as a site of medical knowledge. Medicine is learned from the perspective of individual cases (*ibid*: 86-91).

Good and Good (1993: 91-94) found that for the contemporary American physicians and medicine the dual discourse characteristics of care and competence are keys for transforming into a good physician. These two characteristics culminate in friction as being competent is associated with value-free facts, knowledge, skills and techniques and action. On the other hand, being caring is associated with the non-technical personal aspect of values, relationships, attitudes, compassion, and empathy. It is competence that is conferred primacy and expressing the self-worth of the physician in

[88] Intersubjective Reality- This term refers to the common meanings, shared symbols and commonsensical knowledge used by individuals in their everyday interactions to interpret the aspects of their social and cultural life. See Phenomenology and Ethnomethodology for more information.

negotiating boundaries among specialties, and in providing the sole grounds for compensation for failures of medicine to provide a benefit (*ibid*).

Another critical and multifaceted aspect of transforming into a competent physician is through the reconstruction of the person who is the object of the medical gaze. Sufferers of illness are reconstructed as cases. The socialization of the medical students during their anatomy lab experience instils in them an understanding of anatomy lab as a separate order with distinctive moral norms. In this redefined context, the human body is rendered a new meaning and there emerges a new manner of interacting with the body. The whole other world epitomized by an intimate engagement with the human body, a physical world which is a complex three-dimensional space, a thing of compartments, tubes and the electrical system becomes the paramount reality in the anatomy lab. Students are quite aware that they are learning an alternative way of seeing, that they are learning to think automatically in a way that is central to the medical gaze (*ibid*: 94-97).

While the contents furnish elaborate descriptions of acquiring medical worldview during medical school, the following text by Ghosal (2011) reinforces the dialogue on medical gaze and subsequent objectification of patients in the light of Indian medical settings. For Ghosal (2011: 16) biomedical knowledge "stands on the cusp of being subjective and objective". 'In hands-on learning', the author sheds light on the inculcation/cultivation of 'medical gaze' that is achieved through the socialization of medical students. Public hospitals constructed with the foundation of disseminating medical welfare services also become a space for 'studying/scrutinizing' the patients by medical students. The logic behind such action is coated in the rhetoric that since the patients are receiving free service they have an obligation in some other way. She also raises the argument that although the discourse of medicine is supposed to be objective

during the course of medical practice the acts of touching, feeling and saying entails subjective conclusion-making.

Although Good and Good, and Ghosal documents the nature and impact of medical gaze but they do not engage in a feminist critique. To compensate for such shortcomings and enhance the position, B Subha Shri's (2010) work has been incorporated. Based on her experience as a medical student in a public medical college in Chennai and later as a physician for community health project in a village in Maharashtra, she states that objectification of the patients especially the female patients as things or "cases" is inherent in the patriarchal arrogance of the medical profession. Another tendency that is intrinsic to the medical profession is that patriarchal ethos interwoven with the dominant grand narrative of the reductionist view of the human body as anatomy produces a culture of medical patriarchy. Unmarried female patients who come for abortion are ruthlessly assessed through the morality-chastity discourse, female doctors and paramedical staff are vulnerable to sexual abuse and women accessing healthcare are rendered as pathological bodies of diseases and illness. The author thus concludes that the medical profession and its allied practices dehumanize the body of the woman by referring her as a patient and a case without recognizing that she is not just a body for examination but a human being who needs to be treated with dignity. There is an assumption that the caste and class composition of the female patient along with the type of hospital setting (government or private) determine the attitude of the doctors towards the patients (*ibid*: 52-57).

Instrumentalist/Interventionist approach

Carrying forward the exposition on the medical worldview that formed the crux of the previous section, this section investigates the characteristic of an instrumentalist[89] orientation or an interventionist (invasive and intruding) approach acquired by a physician owing to the positivist medical science.

Keller (1982) underscores that knowledge in general and scientific knowledge, in particular, serves two gods: power and transcendence. This line of argument can be seen in 'Women, medicine and capitalism' while examining these three-fold characteristics of doctors (a) they are the gatekeepers of medical knowledge, (b) to exert control, they maintain distinction through physical comportments and uniform that promotes hierarchy and (c) finally the course of medicine is made to be gruelling, tedious and elongated positing the view that one needs to be superlative and competent to enter and thrive in this profession (Candib 1973: 6). Another mode of distinction is sustained through pseudoscientific jargons that are celebrated as medical knowledge. It is through the smokescreen of "mystification" the doctors maintain their act of "being busy" that compels the patient to postpone the visit and also inhibit their scrutiny regarding the method of his treatment. She further argues that biomedicine objectifies the bodies of patients which according to her allow the performance of operations on patients objectively and scientifically. The patient body is viewed upon as one who is the carrier of disease and the doctor becomes the interventionist/instrumentalist who would demonstrate his esoteric knowledge in a medical setting where the body of the

[89] Instrumentalism in science refers to "a theory of pragmatism holding that ideas and theories are instruments that function as guides for action or prediction, their validity determined by their degree of success rather than any criterion of truth." Accessed December 15, 2017 https://www.thefreedictionary.com/instrumentalism

patient is horizontal and passive like an object. Gynaecology and obstetrics, the branch of medicine pertaining to the illness of women leads to the alienation of the female patients from their own bodies and genitals (*ibid*: 7).

Male obstetricians in order to distinguish themselves from the general practitioners endorsed the impossibility of normal pregnancy among the general public and ensconced the technological intervention (surgical method and instruments) into the discourse of childbirth (Reissman 1992: 133-136). Annandale (1998: 72) argues that before the end of the nineteenth century, the body of the patient was perceived as an object disconnected from the socio-emotional experiences of the patient. The patient was not perceived as a person but a catalogue of "anatomical and biophysical terms" nineteenth-century physicians believed that female anatomy was destiny, women need to rest their physical energy toward the womb and male obstetricians turned the natural event of birth as a risky event to exert greater control over the bodies of women. Nettleton's (1992) study on dentistry regime (Cited in Annandale 1998: 38) found that the dental gaze incorporated mothers as the moral guardians of dental health. In the post-modern era, the power of medical discourse does not lie in exclusion or repression of women[90] but by normalizing the medical gaze and making women subjects of medical surveillance in the guise that is for their own benefit and well-being. Medicalization of pre-menstrual syndrome (PMS) by the gynaecologists generates the notion that mood shifts and bodily changes need to be controlled and hurling them all the more towards clinical scrutiny and legitimizing all-encompassing medical intervention into a woman's life[91] (Reissman 1992: 133-136). Another illustration is the

[90] The literature review chapter and Chapter 1 discuss the exclusionary history of the medical profession.

[91] Similar to medical control and scrutiny through moral policing that we found in the three volumes of 'Medial Advice to women'.

routine visit of a female patient to her gynaecologist for Polycystic Ovarian Disease (PCOD), irregular menstruation or fertility/infertility issues. This underlines Foucauldian understanding of the diffused nature of the power of medicine. Sawicki (1991) noted that NRT (New Reproductive Technologies) wrest control over women's bodies not through repression or coercion but creating new subjects in the form of surrogates, deficient bodies, and infertile women. These newer forms of medical technologies although provides women the avenue to seek alternative modes of reproduction, at the same time allows for surveillance and intervention into the bodies of women. In addition, the vision behind NRTs (New Reproductive Technologies) and ARTs (Assisted Reproductive Technologies) lingers around the discourse of compulsory motherhood, rendering women solely to her reproductive worth, thus pushing women to the vicious circle of enslavement through medicalization, technologization, capitalism, and patriarchy (Cited in *ibid*: 40). This is further echoed by Inhorn (2007: 13-18) when she argues that feminist works have identified that medical knowledge and interventions with respect to women's biological lives often form a nexus with biopolitical control and surveillance. The proliferation of cutting-edge, high-profit medical technology witnessed greater intervention into the bodies of women namely electrical foetal monitoring in childbirth, caesarean sections, cosmetic surgery, etc (Annandale 1998: 84).

Conclusion

The chapter begins with the contextualization of the moralistic and disciplinary power exercised by the medical community in defining, regulating and admonishing women of the nineteenth century England. Gender stereotypes are reinforced and binaries of virtuous and vicious women are outlined masquerading as objective, empirical and scientific advice. This is followed by an attempt to understand medicalization intrinsic

to the discourse of medical science and its impact on both the doctors and female patients regarding the process, state, and functions of human body. The next section discusses the biased and andro-centric view about the female anatomy that emerges when the male anatomy and physiology is considered as the norm. The linguistic bias emphasized by medical textbooks in describing and extrapolating on the functions of the female body is evident. Medical science has imported the patriarchal imagination of women as natural reproducers. The belief that the entry of more women into the medical profession would emasculate andro-centrism is myopic. It is because the epistemology of medical science has an element of epistemic violence and persuades doctors into seeing the world through distorted, reductionist and instrumental lens. The medical profession is premised on medicalization and conditions the doctor to perceive women in a specific manner. Medicalization also leads to the gendered construction of illness by positivist and andro-centric medical science. Hence, studies on women's health indicating that they are perpetually ill and hence, weak needs to be carefully examined. It is also important to locate the stratified nature of women's health. It underpins on the relation between medicalization and the capitalist market economy that renders women an eternal consumer in patriarchal medical economy. A class-stratified nature of feminist movement emerged as a response to medicalization. Middle-class women were targeted for such vigorous consumption as lower-class, poor women lacked the economic capital to expand and augment the medical market. From the feminist critique of science and medical science, the next two sections attempts to understand the norms and values learnt during the period of medical school training. Medical training includes being familiarized with the range and ramifications of uncertainties, inculcating the traits of equanimity, being acquainted with grossness, developing detached concern, time management and learning to view the profession as

different from the other professions. The medical worldview stems, sustain and deepens during the period of medical training in medical school, as mentioned earlier. It comprises of medical gaze, reductionist view, instrumentalist approach, reconstruction of the body of patients and objectification of patients. The inculcation of the medical gaze informs the doctor to view the human body especially the body of the female patients through the lens of reductionism. There is a tendency to view female patients as reproductive agents. There is a viewpoint that biomedical knowledge includes both objectivity and subjectivity as against the popular notion of absolute objective and decontexualized medical gaze. The nature of the hospital setting (private or public) has implications on the viewpoint of the doctor. The course curriculum and meritocratic nature of medical scholarship entrenches a superlative notion about this profession. At present, the strategy of biomedicine is not to repress women but to make them participants in their own surveillance. Feminists have identified that the web of medical knowledge is ways to exercise biopolitical control and greater surveillance into the biological lives of women.

Chapter 3

A perusal into the everyday gendered lives of Intern-Doctors: Empirical Narratives

"The physician is the most prominent among member of the generally recognized professions.....The study of physicians does offer the sociologist the opportunity to test both the truth and the utility of various orientations toward the concept of profession" (Sills 1968: 105).

The previous two chapters have tried to establish the gendered history of the medical profession and the nature of medical science being essentially masculine. The plight of female physicians within the medical profession busts the myth that an influx of women into the medical profession would neutralize the masculine nature of the profession. In an attempt to broaden the understanding on the gendered undercurrents of the medical profession, it was felt that there is a need to critically examine the discourse of medicine and the diverse aspects of medical training that would facilitate an understanding on medical socialization. The contentions on medical socialization reveal the inherent andro-centrism of science and medical science that is promoted through the values and methods of everyday medical training and medicalization of the bodies of women. Drawing from the reflections that emerged from a critical review of literature, this chapter delves into the notion of medical socialization with a special focus on gendered medical socialization in the backdrop of Bengal National Hospital and College of Medicine.

This chapter makes an attempt to understand the nature and impact of gendered medical socialization. It begins by looking into the diverse motivations that guided aspiring medical students to pursue the medical profession that could be mentorship from parents, desire to treat the ailments of people or the financial security ensued from the profession amongst other reasons. Then the chapter tries to engage with some of the experiences of interns during the period of medical school training that lasts for five years and the internship period that lasts for one year. This discussion tries to locate the gendered experiences that are also informed by other social factors. Finally, there is a brief discussion on the personal lives of interns with the aim to understand the impact of medical school training experience that is believed to have implications on their perception of love, relationship and family.

Motivation for entry into the medical profession

As mentioned earlier in the first chapter, I personally knew Dr Antara Das who at the period of the study was working as intern in the Bengal National Hospital and College of Medicine (my field site for the research). She is the key informant for my research[92]. Dr Das introduced me to the participants who would be articulate about their opinion and also take interest in providing me with an in-depth scenario about the lived experiences of doctors. An examination into literature around this theme led to a realization that to ascertain the nuances, connotations, implications and processes of medical socialization there is an imperative to engage in conversations that are beyond the traditional questionnaire method. Since medical socialization is a complex process

[92] Key informant denotes to the person who primarily helps the researcher in providing an overview about the field of study, the various social actors in the field and also brings in insider view that enables the researcher to understand the nuances of the field.

and situating gender within it is all the more complex, the objective was to begin from the foundation---in this case, to recognize the sources of motivation for intern-doctors to consider medicine as a career choice. Identifying the intentions and aspirations were necessary to corroborate understanding regarding the streams and sources of motivation that inspires aspiring students to become doctors despite the strenuous, meritocratic and competitive nature of the profession.

Below is the list of participants along with the occupation of their parents to comprehend the role of the family in the construction of a doctor. It is followed by a detailed examination of the multiple dimensions that made them gravitated towards the medical profession and their aspirations and expectations from the profession.

Dr Tamal Sikdar's (male, scheduled caste and middle-class) mother is a homeopathic doctor, Dr Antara Das's (female, scheduled caste and middle-class) father is a HoD (Head of the Department) of Community Medicine in Calcutta Homeopathic Medical College and Hospital, Dr Dipayan Dastidar's (male, scheduled caste and middle-class) father is a homeopathic doctor, Dr Debashish Basu's (male, upper-caste and middle-class) father is a General Practitioner (GP) and his mother is a nurse, Dr Prantik Maity's (male, upper-caste and middle-class) father is the owner of a jewellery showroom, Dr Suneha Majumdar's (female, upper-caste and middle-class) father is a Bank Manager in SBI (State Bank of India) and Dr Joyeeta Sil's (female, scheduled caste and middle-class) father is a government employee and her mother is a teacher. Thus, four out of seven interns are from families with a medical background that seems to play an important role in their decision of entering the medical profession. A parent with a medical background acts as a mentor and role model for the child. The child may feel inspired to carry forward the legacy of a medical career in the family. In addition to it, parents also enjoy a sense of prestige and higher status in introducing

their ward as a doctor. From the parental professions it can also be assumed that all the interns of this study belong to fairly well-to-do family, enjoy class privilege and possess "economic capital" for a decent living. In this respect, the issue of economic position of the family is important because all these interns either took coaching or took tuitions from private tutors to crack WBJEE (West Bengal Joint entrance Examination). Coaching for medical entrance examination and training to become a physician involves a high amount of investment. Hence, the class location of these interns hints at their class privilege. However, it also needs to be remembered that the fee structure of the aforementioned public teaching hospital is quite less compared to the private medical colleges in the city of Kolkata.

It is found that although Dr Das, Dr Dastidar and Dr Sikdar have parents who are qualified homeopathic doctors and there is a large following of Homeopathy in India yet they were motivated to pursue Allopathy (See Varma 2013: 209). Roger Jeffery (1978: 101) states that "Allopathic doctors occupy a very privileged position in Indian society...." They are perceived to be "scientific" and "western" and are distinguished from the homoeopathic, Ayurveda[93] and Unani[94] practitioners (*ibid*). In this context, it can be argued that parents of these interns are aware that homeopathy does not enjoy the power and prestige as that of allopathy and therefore, they did not encourage their children to pursue a career in Homeopathic medical practise. This hints at the hierarchy among different systems of medical practise in the society (See Varma 2013).

[93] Ayurveda is an ancient system of medicine that employs natural remedies for cure and healing. Ayurveda is believed to be as old as 5000 years.

[94] Unani is a traditional system of medicine that is to be dating back 5000 years to Greece. The drugs used for the treatment through Unani are sourced from the nature and therefore, the Unani prescribes natural remedies to illness.

Like many of his peers, Dr Debashish Basu's[95] ingress into the medical profession can be traced back to his parental profession. His father is a general practitioner whereas his mother is a nurse. He has spent his childhood in the medical quarters and has frequently accompanied his father to the hospital. His inaugural into the "world of syringe and stethoscope" at quite an early stage further prepared him to internalize the medical environment. In other words, his early entry into the world of medicine provided a favourable and a natural ground for him to embrace the medical profession.

Dr Basu believes in hands-on learning or learning on an everyday basis rather being dependent on textual knowledge of medical books. He aims to establish himself as a private practitioner alongside working for a hospital. He feels that as a private practitioner he would be able to provide maximum time to his patients. The personalized space without any bureaucratic surveillance would enable him to foster intimate bonds or have affable terms with his patients.

For Dr Tamal Sikdar[96] the motivation can be traced back to the childhood tragedy of witnessing his paternal uncle's wife being engulfed by cancer and his inability to do anything about it. The incident left a profound impact and compelled him to introspect-- had he been a doctor he would have been able to rescue her from the malady. Another reason that has served as a source of inspiration is that the prefix of 'Dr' that imbues a sense of honour, social status and prestige.

Dr Joyeeta Sil always wanted to become a doctor. She was inspired by her elder sister who also happens to be a doctor and also because of the intrinsic respect associated with the profession. Another reason for opting for a medical career as she stated is that-

[95] Personal Interview with Dr Debashish Basu on April 15, 2017, Kolkata, West Bengal.

[96] Personal interview with Dr Tamal Sikdar on April 20, 2017 in Kolkata, West Bengal.

"I lost my grandfather and realized that if I was a doctor I would have been able to alleviate his pain.".

From these accounts, it can be understood that the benevolent dimension of the profession of serving the public and treating their illness is one of the pivotal factors along with mentorship by parents from a medical background in choosing the medical profession in addition to the factors of social status and respect. As Roger Jeffery (1978: 101) argues that doctors claim to be treated differently since their professional value is not "commercial" and the prolonged period of scientific training received by them is for the welfare of the society. This renders them a philanthropic image. There is a culture of revelling in the medical career as "noble profession" and that the doctors are performing "selfless service".

Dr Antara Das nurtured the dream of becoming a doctor since her childhood. She recounted the pride she experienced in seeing her father treating patients and the respect he has earned over the years. Both Dr Prantik Maity and Dr Suneha Majumdar dreamt of becoming a doctor as there was no doctor in the family and was also emboldened by the respectability associated with the profession. Dr Dastidar wanted to be part of this profession as it guarantees financial stability and provides honour for the individual. His parents also inspired him to become a doctor.

The different accounts and versions resonate with the study conducted by Agarwal *et al* (2015). The study was conducted at MIMER Medical College in Pune through the survey method. Female students outnumbered male students in the survey research of 150 students. The researchers found that 74.7 % of participants hailed from medical families and 25.3 % of them belonged to non-medical family-Within which 80. 5 % male students and 69.9% female students had relatives in the medical profession. 51. 8

% opted for a medical career with the motivation of patient care. In the same study 22.4 % male students reported an interest in science as a source of motivation. The female students received greater encouragement to embrace a medical career than their male counterparts. The study rolled up to a conclusion that male students gravitated towards medical profession for status and security and attributed personal skills as a motivating factor. On the other hand, female students geared towards the profession as it allowed an opportunity for patient care and self-employment through a medical career. The “scientific nature” of the discipline and the concomitant intellectual rigour constitutes the bedrock of motivation for all medical students.

The findings of the study by Agarwal *et al* (2015) reinforce the notion that women are oriented towards caring and nurturing roles and the medical profession becomes an outlet for them to demonstrate such nurturance. Another observation is that acquisition of high status and security associated with the profession is a determining factor for male students are rooted in the societal expectation of men to be the primary earning member of the family and hence, opting for a profession that accords security. The study invisibilizes the caste and class identity of respondents which is instrumental in gauging the responses and how that has motivated their pursuit of a medical career.

Experiences in Medical School: Locating gendered undercurrents

This section begins with outlining the course structure and curriculum[97] in the medical college to provide an insight into the academic rigour[98] and the level of diligence required to earn the MBBS (Bachelor of Medicine, Bachelor of Surgery)[99] degree. This brief overview is succeeded by documentation of narratives on the five years of MBBS and one-year duration of internship that are replete with gendered insinuations.

Courses taught in each year of the MBBS (Bachelor of Medicine, Bachelor in Surgery) phase.

[97] Each subject has a theory (Internal + External) and practical exam. In order to secure a Gold Medal a set of students have to go through a three-stage procedure. In the first stage, a student has to appear for a written examination. In the second stage candidates who have cracked the written examination will have to appear for a viva. In the third stage, there is a final selection of the qualified candidates.

[98] Dr Tamal Sikdar enlightened me regarding the different subjects taught at the medical school. There are 4 university examinations namely First Professional M.B.B.S. Examination, Second Professional M.B.B.S. Examination, Third Professional M.B.B.S. Part I examination, Third Professional M.B.B.S. Part II conducted under WBUHS (West Bengal University of Health Sciences) Board.

[99] MBBS – The Latin full form of MBBs is Medicinae Baccalaureus, Baccalaureus Chirurgiae. This denotes under graduation in two professional courses-Medicine and Surgery.

Session	Name of examinations	Subjects
1	First Professional M.B.B.S. Examination (1 year)	Anatomy, Physiology and Biochemistry (Non-clinical subjects)
2	Second Professional M.B.B.S. Examination (1.5 years)	Pathology, Pharmacology, Forensic Science, Medicine and Toxicology, and Microbiology (All are non-clinical subjects)
3	Third Professional M.B.B.S. Part I examination (1 year),	Otorhinolaryngology (ENT), Ophthalmology, Community Medicine (Also known as Preventive and Social Medicine) (All are clinical subjects)
4	Third	Medicine, Surgery,

	Professional M.B.B.S. Part II (1 year)	Orthopaedics, Paediatrics, Obstetrics & Gynaecology (All are clinical subjects)

Dr Joyeeta Sil is of the opinion that clinical subjects require more diligence and investment of time than non-clinical subjects. Doctors specializing in clinical subjects do not have a life of their own. It has been discussed in Chapter 1 that women prefer to pursue non-clinical subjects as it is compatible with their lived reality of balancing family and career, there is no compulsion to veer for advanced studies and yet enjoy the leverage of being a doctor.

An important aspect of medical socialization (that I understood during the course of fieldwork) is learning about the human body in a co-educational setting and learning to perceive human body according to the positivist epistemology of medical science (See Good and Good 1993 and Subha Sri 2010). As stated by Rakhi Ghosal (2011: 16) "This body is a social body, a body that bears and plays out "social responsibilities" (so one is urged to lend the body for medical knowledge), a body that is on one hand shaped through the contours and explanations of the anatomo-clinical paradigm, and on the other anchors a titled power equation and a body that helps in generation of new knowledge and consolidation of others' skills." Medical training thus, induces the medical students to see the human body as a medical body that is a site of skilled manipulation and advancing the medical knowledge. This alternative way of viewing the human body have come to be understood as the medical gaze (Good and Good 1993). Dr Debashish Basu (male, upper-caste and middle-class) stated that the

graphical content of the anatomy classes or forensic classes have never abhorred him owing to his early tryst with the medical world. Dr Suneha Majumdar (female, upper-caste and middle-class) initially found it embarrassing to study and discuss human genitalia in a mixed/heterogeneous environment. It was only with the passage of time that she learnt to shed off her inhibitions and adapt to the world of medicine that accords a different way of seeing[100]. She told that during the practical classes female dead bodies are doubly objectified, first as deadbodies that are 'object of medical intervention' to further knowledge and secondly as women whose naked bodies are subjected to medical scrutiny by male and female students. It was found that the interns and Post-Graduate Trainees (PGTs) surround the dead body and closely engages in a perusal of the body. Rather than respecting the embodiment of a dead person, the body in the medical science becomes a site of observation and eliciting knowledge. At the same time, a female anatomy garners more curiosity and also it becomes the object of lascivious interests of the male medical students. Male peers share jokes regarding the female anatomy that strengthens male bonding through collective voyeurism[101]. Subha Sri (2010) argues that physiology textbook was embedded in the patriarchal notion as it equates female sexuality with childbearing. Classes on forensic science taught rape and sexual assault steeped in voyeurism and lacked sensitivity. Thus, she asserts that teaching modalities on such issues can reinforce gender stereotypes masquerading as scientific pedagogy.

[100] In Chapter 2 I have expounded on this aspect through the review of Good's and Good's essay on 'Learning medicine'.

[101] Voyeurism refers to deriving sexual gratification by watching sexual activity of others or deriving pleasure by looking at a naked body (Also see https://www.merriam-webster.com/dictionary/voyeurism).

The interns told me that a part of medical training involves breast examination to derive knowledge about breast or scrotum examination to know whether the patient has developed a hernia. The confluence of the male gaze along with the discursive contours of biomedicine[102] and positivism[103] makes the medical profession a highly patriarchal. As stated by Rakhi Ghosal (2011: 16) residents and medical students in the teaching hospitals that are usually public hospitals, learn on the patients admitted there during the course of their training. "It is common to see a group of young doctors each, in turn, palpating a patient whose diagnosis is already known as a part of their training. However, for patients, this can be an unwanted intrusion and a painful one at that" (*ibid*). Dr Tamal Sikdar (male, scheduled caste and middle-class) said that the consent of the patient is taken into account before such an examination that involves intimacy. During such examinations, a male or a female attendant is present depending on the sex of the patient. He believes that these examinations on patients are necessary to advance knowledge about the state, nature and position of illness. There is a ubiquitous view among the doctors and the non-medical community that since patients in public hospitals are receiving "free treatment" these examinations are a form of payment for that free service (Ghosal 2011: 16).

The participants were mentally prepared to study anatomy in a co-educational environment and did not feel awkward about it. Their only moment of embarrassment emerged when a female professor taught about human body using her personal example in a dramatic manner. The findings pertaining to this context is a point of departure

[102] Biomedicine refers to the branch of medical science that is concerned with application of biology and physiology into clinical practice.

[103] Positivism is a paradigm that is premised on natural phenomena and their properties and relations are verified by the empirical sciences.

from Subha Shri's (2010) experience in the medical school. According to the author when she found it difficult to understand female external genital in the anatomy class she refrained from making any queries. It is because the classroom atmosphere was quite intimidating and made the students diffident. As a consequence, they referred to the female anatomy as an impersonal object of study rather than looking at one's own anatomy to derive a better insight.

Another aspect of medical socialization has to be performing the role of a physician in maintaining the front[104]. The stethoscope carried by a doctor especially worn around the neck accords him distinction, superiority from others and becomes an overt marker of professional identity. Fox (1979: 77) notes that "the requirement that they wear white uniforms for the autopsy and practice aseptic techniques often gives them the feeling that in appearance and behaviour they are acquiring some important characteristics of physicians."

During the fieldwork I realized that sartorial choice and body language is an important component in becoming a doctor. Dr Basu (male, upper-caste and middle-class) is of the view that one's sartorial choice is important in the hospital setting. Formal clothing with closed footwear posits a refined, dignified and immaculate appearance. Otherwise, there emerges the possibility of not being taken seriously as a physician or being unable to maintain the doctor-patient hierarchy as stated by Dr Basu. In this light, it can be assumed that the male embodiment, overarching masculine traits and class disposition

[104] The Front Stage- It is a concept developed by American micro-sociologist Erving Goffman. In his dramaturgical analysis, Goffman discusses how each social actor is playing the defined roles to continue the flow of social interaction. In this context he uses the term, 'Front' that refers to the interaction in the public space or professional setting. The front stage comprises of two important components (a) Settings and the (b) Personal Front.

concomitant with the medical profession allows Dr Basu and his colleagues to command recognition among the patients as they are easily able to distinguish a doctor not just based on attire but also his demeanour and comportment. Lucy Candib (1973) in her feminist critique of the medical profession states that a section of small medical elite preserves its own position through mystification[105] buttressed by symbolic dress, language and education. Dr Debashish Basu sometimes doesn't wear the characteristic white coat or carry stethoscope around his shoulder but he said that it is his body language that is enough to communicate to the patients that he is a doctor. This body language can be understood in terms of the elitism entrenched in the profession that is a product of a prolonged period of medical education, observation of the peers and the internalization of cultural-moral superiority associated with the doctors and is manifested through certain kind of bodily dispositions.

Dr Antara Das (female, scheduled caste and middle-class) made an interesting observation that when female interns or PGTs (Post-Graduate Trainees) are not garbed in western attire they become more prone to be referred as *"didis[106]"* or *"mashis[107]"*.This highlights the relation between class and sartorial choice. Western clothing and aesthetics are associated with the identity of upper-class, upper-caste, English-educated and urban-located social groups. Distinction in clothing is one such aspect that brings out the difference in the "cultural capital" (Bordieu, 1979) of doctors who are the embodiment of sophistication and patients of public hospitals who are the

[105] Mystification in this case refers to creating an aura about oneself by using certain strategies, thus leading to a false notion of a doctor being important and supreme in the minds of the patients and the public.

[106] In Bengali 'didi' refers to the elder sister.

[107] In Bengali 'mashi' refers to the sister of the mother.

embodiment of uncouthness. Bordieu (1979) states that the cultural capital which is a collection of symbolic elements like clothing, posture, mannerisms, credentials, skills and tastes is a result of one's membership into a particular social class. The difference in this cultural capital by the usually urban-educated interns and their patients (who are lower-caste, lower-class and mostly Muslim, in the context of this hospital setting) leads to a state of "symbolic violence". Drawing from the above account of Dr Antara Das it may be assumed that this choice of dressing has implications for female interns to demarcate their boundaries from the nurses as well as female patients and thus sustain the gradation and protect their gender-class-caste stratified roles and ideologies.

Medical socialization is not just about learning to develop a distinct view about the human body but also about learning to perceive oneself through the eyes of the patients, incorporating lessons from one's everyday interactions with the various stakeholders (hospital administration, faculty members, peers, nurses, ward boys, patients and their family members, medical representative, pharmacist, and the society at large) of the medical profession and consciously and unconsciously assimilating those perceptions, values, ideologies and cultural moorings in the exercise of duties.

Another feature of medical socialization is mastering detached concern (Fox 1979). Test of nerves, emotional stability and equanimity are some of the key ingredients in becoming a doctor. Dr Dipayan Dastidar[108] (male, scheduled caste and middle class) said-

"While interacting I don't look at the patients as eye-contact with the patients can infiltrate emotions and make one weak."

[108] Personal interview with Dr Dipayan Dastidar conducted on April 16, 2017 in Kolkata, West Bengal.

His statement hinted that there may be a tendency among the physicians to practise detached concern in dealing with the patients. They are concerned about the amelioration and well being of the patient but resist any form of care that is embedded in emotion. Emotional attachment with the patient is believed to be an impediment to efficient execution of their tasks. However, Dr Joyeeta Sil (female, scheduled caste and middle-class) and Dr Tamal Sikdar (male, scheduled caste and middle-class) did not harbour negative view towards emotional bonding with the patients. Dr Sikdar told that he feels great when a patient remembers his name or when he is recommended by patients. There have been instances when the interaction with the patient went beyond the paradigm of diagnosing the disease and prescribing medicine---He has counselled his patients dealing with relationship troubles and earned their trust and respect. In this context, it is important to discuss Angoff's views on the aspect of detached concern. Angoff (2013) drawing from Jodi Halpern's (2001) argument states that emotions are already there in the doctor-patient relationship and hence there is an imperative to constructively make use of emotions. She (2013:3) further argues that the process of diagnosing the illness of a patient using medical evidence and clinical training (learnt during the course of medical scholarship) involves emotional reasoning in addition to a detached, objective reasoning in order to derive a keen insight into the condition of the patient's experience of illness. Hence, for her clinical reasoning is a combination of emotional engagement as well as detached reasoning. In this way Angoff busts the myth that the act of critical clinical decision making by physicians is absent of emotions.

However, Dr Antara Das and Dr Suneha Majumdar had different views on developing emotional attachment. Both[109] of them opine that it is an occupational hazard for female doctors if they nurture the intimate bond with their patients especially from the opposite sex. Firstly, it will infiltrate and transgress the professional space of medical practice. Secondly, as female doctors, they might become prone to sexual advances. Thirdly, the doctor-patient interaction induced through emotional bonding might disturb the doctor-patient gradation.

Fox (1979) emphasizes the duality of being sensitive towards the patients and at the same time balancing it with scientific detachment as part of the training of becoming a doctor. Good and Good (1993) envisages that entering the world of biomedicine revolves around mastering the dual characteristics of care that emphasizes on the "non-technical" aspect and competence that is imbibed by excelling in the "technical aspects."

Dr Debashish Basu opines that patient counselling is a significant component of being a successful practitioner. Patients visit doctors with their crisis and it is the onus of the doctor to make the patient feel comfortable, imbue assurance about amelioration about their illness and maintain rapport that would enable the patient to share her/his problems with ease. Jeffery (ibid: 4) states that one of the favourite phrases of doctor is that he is a "friend, philosopher and guide to their patients."

Dr Dipayan Dastidar said that he has observed female doctors being immune or indifferent to grotesque or being accustomed to touching the male body without inhibitions but on interaction with the female participants it was revealed that there are

[109] The personal interview of Suneha Majumdar was conducted on May 2, 2017, and during that time Dr Antara Das was also present.

subtle and nuanced indications regarding their apathy to deal with what they are dealing. The gendered choices of specialties are linked with the gendered socialization both within the institutional academic medicine and also lived experiences as women through the combined interaction with the generalized others and intimate others.

The female doctors seemed to have internalized the male-centric view that since surgery demands arduous labour[110] they lack the adequate stamina to pursue surgery. Davis and Allison (2013: 21) drawing from Hojat's (1994) opine that women prefer to take up gynaecology and obstetrics, and paediatrics because of "maternal and nurturing attitudes" accumulated during the primary socialization. Drawing from Colquitt's (1994) argument, the authors contend that men and women import the gendered ideologies into their choice of specialties.

During the internship[111] phase an intern is exposed and familiarized to each of the clinical subjects they have learnt in the duration of five years of M.B.B.S. On receiving the registration number, an intern becomes eligible for practising as a general physician. During the internship period, the interns are divided into groups and have to serve in different departments (clinical subjects taught during MBBS) in the course of one year. The first year PGTs (Post-Graduate Trainee) monitor and evaluate the tasks

[110] The empirical narrative section of chapter 1 has a discussion on the same.

[111] The internship period for the batch of 2012-2017 commenced from 23rd March 2017 and will persist till 22nd March 2018. An intern is paid a stipend of 19, 450 per month. The convocation is held on January every year and the interns are awarded the degree before the completion of the internship. After the completion of the internship in each of the departments, an intern needs to collect the Ward Completion Certificate. Once, the one-year internship is over, an intern needs to apply for registration as a doctor. The application fee for which is 4,000 INR. The application takes around 1-1.5 months to materialise.

of the interns in their respective departments (specialties). This may indicate that power and authority enjoyed by the PGTs and their influence in further shaping the medical worldview of the interns. The internship period acts as the fulcrum-the rites of a passage defined with gendered experiences and structural hierarchy in different departments, this section also navigates into the variegated hard skills and soft skills required to enter, survive and excel in each of the specialty.

Duties in the departments of gynaecology and obstetrics, surgery[112] (that includes radiology and anaesthesia), general medicine (that also includes duty in the psychiatry department for one week) and community medicine are assigned for two months. ENT (Ear, Nose and Tongue), orthopaedics, ophthalmology, blood bank, general emergency (Gen ER) and paediatrics are a month each and anaesthesia is for a period of one week. Every Department is usually divided into 5-6 units.

In the views of the interns, gynaecology and obstetrics is considered to be a "hostile" department since labour room is characterised by cacophonic patients, parturition, ideological conflict translating into a cold war, verbal abuse, doctor-"patient-party" power dynamics becoming salient, rush of delivery-In other words, hustle and bustle culminates to a state of extreme pandemonium. The high-risk quotient heightens the hostile environment as there is immense pressure to save two lives- the mother and the foetus (successful parturition). Dr Joyeeta Sil argued that Gynaecologists exude "rough" behaviour as a mode of survival strategy to respond to these highly tense situations epitomizing the department.

[112] Green coloured gowns are worn by the doctors during surgery. In OT (Operation theatre) a doctor has to wear 3 layers of the gown the second layering is called lade and the final outerwear is saffron (it is tied and also at the front, it provides greater stability).

This is a reminder of obstetrician George Little's statement that "Being born is one of the most dangerous times of one's life." He emphasized birth as an inherently "high risk" event which can suddenly develop complications that require medical intervention (as Lindheim notes that a pregnancy and birth can be diagnosed as "normal" retrospectively only when the mother and the child have been discharged in good health). The high-degree of medical intervention into the process of childbirth by medical science has reduced the pregnant woman to a patient and childbirth as dangerous or a pathological event, a case of double medical emergency in which the lives of both the mothers and infant are seen as being at risk (Cited in Treichler 1990: 117).

The gynaecology and obstetrics department is also marked by extreme work pressure. A gynaecologist will always have patients with the issues of menstrual health and reproductive health as they concern all women irrespective of their class, caste, age or other social conditions as unanimously declared by all the interns. This can be understood through the debates on medicalization discussed in the previous chapter. Medicalization of the health of women brings women under the purview of continuous medical surveillance (See Annandale 1998 and Riska 2003). Female patients feel uncomfortable while talking about their menstrual cycle to male doctors. The latter have to use a combination of local terms and rhetoric like "*mashik*[113]" "*melamesha*[114]", etc to make their female patients comfortable. These instances

[113] Mashik is the Bengali colloquial term for sexual intercourse.

[114] Melamesha is the Bengali colloquial term for sexual intercourse. In the context of my fieldsite, this term is used by the doctors during their interaction with the patients especially the patients who are deemed as shy and modest. This term is an attempt to break the barriers on the discussion of the sexual

suggest that the cultural taboo of discussing menstruation with men is also evident in the medical institution. The interns irrespective of their gender have to break the barrier by deploying different local terms to address the reproductive health related issues of female patients. This instance can also be connected to the statement made by Dr Joyeeta Sil (documented in chapter 1) that female patients would feel more comfortable in the presence of a female physician and therefore, she would want to pursue gynaecology.

Inaugurating his internship in the gynaecology and obstetrics department has instilled Dr Sikdar with a sense of confidence to embark on internship duties in other departments. It is because the nature of work in this department is gruelling, however, at the same time, it trains an intern to shoulder responsibilities and learn to function under the toughest of situations. Being in the gynaecology and obstetrics department one learns the art of stitching that is helpful if one wants to pursue surgery. It is often said among the interns that if one begins the internship with gynaecology the stress level and intensity of learning opportunities will enable the intern to ace internship duties smoothly. Dr Prantik Maity opines that-

"Gynaecology is an easy market whereas, in Orthopaedics, a doctor needs to work ten times harder."

This resonates with Davis and Allison's (2013: 21) findings that it is the anticipation of long work hours that deters women from entering surgery. The statement by Dr. Maity may also indicate that male doctors perceive gynaecology as a soft or easy specialty possibly due to the large presence of women and also possibly because of the

health of the female patients in the public teaching hospital. Majority of them belong to the lower economic class and follow Islam.

preference for gynaecology by the female interns. On the other hand, the preference for orthopaedics may indicate that because orthopaedics largely comprises of male physicians it becomes a site of exercising masculine ideals for the male physicians---that their labour is more rigorous and intense than the feminized specialty of gynaecology.

The profiling of the patients along with their religious belief towards family life is in discordance with the scientific and rational belief of the doctor. The lower-class Muslim patients view the birth of children as the gift of "Allah" and hence, the deployment of protective sex is a breach of their religious faith. On the contrary the doctors feel that the patients should exercise protective sex through condoms or Copper T. One of the participants noted that even if the female patient is ready to wear the Copper T, it is the husband who clinches the decision on protective sex and in all of the cases it is the husband who is found to be against the wife using contraceptive. This resonates Burton (1996) and Sehrawat's (2013) argument that although zenana medical care targeted "*purdanasheen"* women but patriarchal ethos precluded these women from having full access to it. In this context, it may be indicated that the notions of patriarchy in Islamic society curb the reproductive agency of these marginalized Muslim women. As inferred through the discussion with the interns it is found that these female patients are subjected to admonition from both their doctors on taking care of their reproductive health as well as their husbands for their wish to adopt protective sex. Dr Dipayan Dastidar's internship experience is quite telling---"*purdanasheen"* Muslim women prefer male doctors which are quite contradictory according to his imagination. Burton (1996) argues that "*purdah"* refrained upper-caste Hindu women and Muslim women from seeking the treatment of male physicians during the colonial period.

Dr Antara Das said that she is repulsed at the sight of the vagina of lower-class women as they lack a proper sense of hygiene and do not clean their private parts. This statement by her contradicts the argument made by Good and Good (1993) that doctors see human bodies as asocial bodies and solely as a site of medical intervention. During the course of medical training, medical students are taught to view the human body in a distinctive way as discussed by Fox (1979) and Good and Good (1993), however the aforementioned statement by Dr Das may indicate that doctors are not above the feeling of repulsion. They have their own perceptions of hygiene and cleanliness, and during the interaction with patients such conceptions play at the backdrop. The gynaecology and obstetrics department although is filled with female patients, they are treated as just another body for medical control and without personhood.

Regarding paediatrics, Hinze (1999) noted that although paediatricians use their hands to diagnose or soothe the body or hold the baby it is not viewed as a high status specialty. It is because such activities are not viewed (by the residents interviewed by the author) as requiring the intervention of "active hands" that means hands being used to "probe, manipulate or cut the body open, often assisted by sophisticated technologies" (Hinze 1999: 233). In the view of the interns, the paediatrics department is the epitome of equanimity, jauntiness and affable behaviour. This is because the nature of the doctors is mirrored through the nature of their work environment. The compositions of the patients are children in this case and hence, the doctors change their behaviour accordingly. Interaction with children demands composure and cheerful attitude. Austere and stern behaviour with children is a strictly prohibited for the physicians. On the admission of a child in the paediatrics department the mother or a female attendant (relative or any female known female known to the child) needs to be present and on admission of the child patient stay the mother or any female relative

needs to stay with the child during that period. It is interesting to note that the presence of a female member is made mandatory with the assumption that women are naturally attuned to accomplish affective roles (essentialising the role of women as natural caregivers). It doesn't take into consideration that a man can also perform childcare. This practise poses certain questions that whether it is a violation of the rights of the father in not being considered as a legible attendant for his child. Secondly, whether this rule that has possibly generated from the patriarchal ethos of sexual division of labour reinforce the notion that men are suitable for "instrumentalist"[115] role and women for "expressive"[116].

The orthopaedics department is another department that is defined by grossness for example traction, joining the bone of the patient and other allied activities are considered to be quite odious by the interns. The gender ratio is quite low in orthopaedics. Dr Antara Das states that it is because orthopaedics demands intense physical strength while performing the surgery on the patient and at the same time its characteristic grossness keeps away women from orthopaedics. During one of my field visits, I found that the male ward of the orthopaedics department is a dwelling of bodies lying on the floor amidst squalid walls smeared with stale blood stains and dingy floors scattered with food waste. There is barely any space for doctors and relatives of the patients to move around. Doctors have accepted working in such conditions and they move across the patients. In the absence of beds, the patients have to occupy the floors.

[115] Instrumental role- According to the Functionalist ideology of Parsons (1951) the husband's role in the family is that of as a primary bread-earner and catering to the financial needs of the family.

[116] Expressive role- According to Parsons (1951) the role of the women in the family is to take care of the children, cater to the emotional needs of the family members and perform the tasks of a homemaker. For Parson, this is based on the sexual division of labour.

In case of orthopaedics, a day of continuous twenty-four hour duty is succeeded by two days of holiday. However, the strain and exhaustion incurred during such duty hours leave the interns feeling lethargic. Dr Sikdar feels that that in orthopaedics one needs to extensively draw in order to explain things. Since he enjoys painting orthopaedics interests him. Another reason for his interest in the subject, he feels because of his ability to grasp the issues related to orthopaedics and diagnose the problem of the patients. Being an orthopaedician indicates that one needs to be an expert in both medicine and surgery. The opportunity to display one's expertise in both clinical skills as well as surgical skills makes him quite motivated to pursue surgery. According to him, he would prefer a specialization that would allow him to move around and also has thrills associated with it. Unlike general medicine, surgery involves an elaborate amount of physical movements, control over one's nerves especially during the time of surgery and composure to accomplish the task. From this statement it maybe indicated that the nature of orthopaedics that includes intense physical mobility and the aspect of demonstration of one's surgical skills seem to make it preferable for men. It is because this kind of "active participation" and "physical rigour" is associated with the temperament of men in a patriarchal culture. It might also be inferred that because of such masculine temperament associated with certain specialties, women may feel discouraged to pursue it. An elaborate discussion on gendered choice of specialties found through existing literature and empirical narratives have been documented in Chapter 1.

According to Dr Sikdar, the nature of problems with which the male and female patients visit the orthopaedics department differs- For women it is usually body pain and body aches due to rheumatism[117]. The men who visit an orthopaedician usually suffer from broken bone due to a road accident or sports accident. It is usually the older female patients who visit the orthopaedician with the issue of a broken bone. The nature of the illness of the patients has gendered connotation. It is mostly men who are active in sports or car driving that contributes to their bone fracture, however when it comes to women their cause of Rheumatoid Arthritis (RA) the symptoms of which are bone fractures, joint dislocations and ligament. More women are diagnosed with osteoarthritis than men. Dr Basu explained in detail this gender dimension. Studies have found that men are prone to experience arthritis in the hip region whereas for women it is the knees and hands. There is a belief among researchers that female hormones have an effect on the cartilage that sits between the bones of the joints to move about smoothly. Female hormone oestrogen protects cartilage from inflammation but with the decline in the oestrogen level in the body of a woman the cartilage becomes vulnerable to inflammation. Dr Antara Das said that female patients visiting the Orthopaedics are affected with brittle bones due to two reasons (1) After menopause the bones become weaker (2) In case of "*purdanasheen"* Muslim[118] a woman, their sartorial choice prevent them from absorbing sun rays which are a rich source of Vitamin D[119]. This show that illness and health hazards of the body is influenced by the social and cultural factors as discussed by Landrine and Klonoff (2001). It also

[117] Rheumatism is a disease that causes inflammation in the muscles and joints of the body.

[118] Dr Antara Das has told me this based on her reading of medical textbook.

[119] Vitamin d is an important vitamin that helps in the absorption of calcium. Hence, deficiency of Vitamin D also leads to the deficiency of Calcium.

indicates that male and female patients who visit the orthopaedician have different health issues that emerge from their gendered nature of activities.

During his orthopaedic days Dr. Sikdar has recognized a trend among male anaesthetists to be dominating, trying to control the environment of the operation theatre by taking the upper hand and instructing the surgery team, and asserts their superiority by asking the surgeons to perform the operation quickly so that the operation can be performed within the duration of anaesthesia and minimise their labour of inducing another anaesthesia. According to his experience, it's the male anaesthetists who are disposed towards such attitude which is a stark contrast to their female counterparts.

The interns recounted that the general emergency (Gen ER) department is a physically exhausting experience. They are assigned eighteen hours of duty followed by a day off alternatively. This continues for six days. Even in the General Emergency Ward patients are taken to the benches or just held in the lap of their relatives in the absence of beds. Dr Joyeeta Sil shared a gendered experience during her duty in the Emergency Ward (I have documented her verbatim lines when she called me up one day to recount this incident) --

"When I had my general emergency duty, we were a group of three girls. Maybe the only all-girls general ER from our batch, even the interns from Orthopaedic and PGT were women. When we were about to give our duties, some really exclaimed, sob meye (all women)! I charged at some of them but always cannot charge at everyone because of age and circumstances. Some of them whom I charged were defensive saying no we do not doubt the abilities of girls but it is that General ER is always saturated and quite tricky! Different types of people come and it might become cumbersome for women to shout at the men who arrive in a drunken state and want to create a nuisance. I overheard a patient –party saying that this is a

ploy by the hospital authorities to preclude physical violence like we were being used as Shikhandi[120]!"

This narrative busts the notion of ubiquitous doctor-patient hierarchy and brings out the gendered negotiations and meanderings that operate through symbolic violence. The female doctor despite her degree, mettle and erudite scholarship always remains a "lady-doctor" in the mental image of the patients. The upper-class and usually upper-caste composition of interns might guarantee them the benefits ensued through their cultural capital but in the web of powerful gender relations, the privilege of these female physicians are continually under attack. Scepticism towards the physical strength and vigour of women in an already masculine profession shapes the mental makeup of a female intern about the expectations from her profession and on similar lines acts as a directory for her when articulating her experience, communicating as an insider to the non-medical world and setting future goals. Despite being a member of a sophisticated world of medical science and training into the objective and abstract scientific knowledge, a female intern realizes that the medical profession demarcates boundaries and buttresses socially prevalent gendered gradation. Davis and Allison (2013) write that "medical institution as a whole may foster inequality and femininity within the profession might be devalued."

On his experience in the ophthalmology department, Dr Tamal Sikdar said that an ophthalmologist requires finesse and fine skills to successfully conduct eye operation. Due to microsurgery being common in the ophthalmology department, too many doctors are not required while performing the operation. The light nature of workload in this department allows an intern to take frequent unofficial leaves. This indicates that

[120] See the role of Shikhandi in the battle of Mahabharata for more information

different departments require different number of people for the performance of tasks. Some departments like ophthalmology and also psychiatry as pointed out by Dr Basu allows the interns to shirk their duties, thus hinting at the instances of flexibility during internship duties. During his duty in the bloodbank, Dr Prantik Maity had to go for outdoor (8 days of Blood bank) in Madhyamgram- Mayapur region of West Bengal. During an outdoor session the interns are provided with accommodation, food and in addition, there is an arrangement of alcohols. However, Dr Maity (male, upper-caste and middle-class) avoided drinking with the Group D staff (who are mostly from the lower economic strata and belong to lower caste group) or sharing the same bed with them. This incident shows that Dr Maity moulded his actions to indicate the Group D staff that they are unequally placed in the social hierarchy and therefore, should be cautious about their boundaries when interacting with doctors. This incident is also reflective of strategies adopted by the doctors in the performance of their duties to maintain professional hierarchy along with class and caste distinction. I was told that no such outdoor night duty was compulsory for female interns. It may be because the culture of fear propagated in a patriarchal society limits and control the mobility, activity and aspirations of women. None of the female interns of this study had to go for outdoor duty during their term in the community medicine. Dr Dipayan Dastidar informed that community medicine is considered to be inferior in the hierarchy of specialties. Doctors practising Community Medicine are referred to as *"bleaching doctors"*. This pejorative connotation associated with community medicine practitioners can be traced to the function of bleaching powder. Similar to bleaching powder that is used for disinfecting water from pathogenic[121] organisms, the job of physicians practising community medicine is to prevent illness that may affect the

[121] Pathogenic organisms refer to micro-organisms like bacteria or other that produce diseases.

community. In West Bengal community medicine as a speciality does not hold a promising future. Dr Sikdar buttressed the same saying that his senior in community medicine discouraged him to enter this specialty as it can become quite monotonous and lacks opportunities for diversification. He is of the view that compared to other specialties, the status and position of physicians practising community medicine is low. This he states is due to the absence of the application of clinical and diagnostic skills.

The medical profession is defined by a continuous interaction with the patients. The client-dependant characteristic of the profession, especially in case of gynaecologists, paediatricians and ophthalmologists (Sill 1968: 109), indicate that doctors are dependent on their patients for further reference, securing more patients and in strengthening their professional growth. As a result of which doctors are required to weigh their behaviour and remain in the good books of their patients (clients). This also means that even when the patients display coquettish behaviour it becomes a sensitive issue for these interns. They often struggle with handling it with caution. There is a common perception that it is women who are subjected to sexual harassment at workplace and the other gender (male) is vilified. However, I found that the male interns of this study were equally perturbed by flirting from their patients. They feel that their articulation on such experiences will not be considered with seriousness because a man expressing grievances on these issues is looked with a question on his masculinity. They also felt that unlike their female peers, they won't receive the solidarity. Dr Tamal Sikdar recounts--

"*I have been frequently subjected to flirting from my female patients. Once during my duty in the orthopaedic department a middle-aged woman came for check-up. She was insistent on*

getting her chest examined despite my repeated assurance that her health is perfect condition. While exiting from the OPD[122] *she threw a mischievous smile at me!"*

It can be indicated that sometimes the courteous behaviour of the doctors towards their patients is perceived as intrinsic to her/his personality and makes patients being romantically inclined towards their doctors. They feel that the one who is their saviour during a crisis is also the one who would be able to shoulder the responsibility of protecting them during an ordeal like that of a husband (in case of female patients). When it comes to dealing with the children even the most austere and reticent doctor mellows down! Recounting one such incident, Dr Sikdar is of the opinion that once he blew a hand glove into the shape of a fish so as to convince his child patient to take medicine.

There are instances when patients can create extreme annoyance for the doctors--

"A child patient was so stubborn that he was not willing to take the injection, the mother accompanying the child was simply smiling and not cooperating with the doctors to convince the child."

The above illustrations buttresses that the axes of gender, class, caste and age determine the doctor-patient interaction. From the conversations with interns of my study I found that they exercise caution while interacting with members of the opposite gender to resist any form of intimate advances. The interns told that they prefer to maintain a stolid and professional behaviour with their patients to retain the sanctity of the professional space. They also feel more nonchalant in the presence of child patients. Despite the stress and risk concomitant to the paediatrics department, they feel that it

[122] OPD refers to Outdoor Patient Department. In their duty in OPD interns are expected to provide medical consultations to the patients and also learn to interact with the patients.

provides the most convivial working conditions. It is also important to understand that the disciplining trait of the medical profession influences the doctor to assert their paternalistic behaviour on the patients. Patients who do not want to conform to the medical advice or those with too many questions are disliked by the doctors. Thus, indicating that child patients might comply easily compared to older patients as a result of which the experience of working in the paediatric department has been somewhat relaxing and hence, satisfactory for these interns. It also busts Good and Good's (1993) notion that medical students learn to view human bodies as decontexualized and asocial. It demonstrates that interns interpret and alter their interaction with the patients taking into account the social reality rather than depending on an absolute objective gaze. This also reiterates Rakhi Ghosal's (2011: 16) contention that biomedical knowledge is not only about the objective scientific gaze of the human body but it also encompasses subjectivities.

Intimate life of the interns

Till now it has been understood that gendered medical socialization is an outcome of "professional socialization" that refers to learning the nuances, traits and professional demeanours for the medical profession (Gabe *et al* 2004: 168-172) and gendered socialization induced by the various institutions of the society. In this light, it is pertinent to have an insight into the intimate lives of the interns with the objective to understand the impact of gendered medical socialization in the lives of the interns. These episodes that occurred during the period of medical training in the personal lives of the interns also have implications on their perspectives of family, relationships and health. These interns have battled heart-break, cheating, rejection, trauma, depression and declining physical health that have taken a profound impact in their lives. This discussion is timely and imperative as the perspectives on family and relationship are

sculpted by their unique social location of the profession, position in the professional hierarchy, gender, age, caste, class and several other factors.

Dr Antara Das (female, scheduled caste and middle class) felt that the early exposure to the world of sex and sexuality along with the biomedical understanding of the anatomy and physiology desensitizes the doctors towards sex life. She said that she would prefer to marry someone outside her profession. She argues that being with a non-medico[123] would keep the relationship more interesting and also avoid professional rivalry. She will always have the urge to compete with him. She also said that she is highly ambitious and seeing her male partner (in case he is a doctor) succeed or fail would jeopardize the relationship.

Dr Suneha Majumdar (female, upper-caste and middle class) based on her past relationship experience opine that female doctors have a tough time finding a suitable life partner. An ambitious female doctor intimidates the potential life partner. Her intelligence and the status she would enjoy as a doctor poses a threat to the male ego. She feels that some families prefer a doctor daughter-in-law as they can flaunt her like a showpiece; she is like a "trophy daughter-in-law" but will not be valued. The prospective family-in-law may reject her as they may aspire for a "*ghorowa*"[124] daughter-in-law. The men (in this case they are not doctors) she has met so far do not want to adapt to the life of a doctor where emergency cases would compel the concerned doctor to be at the beck and call of the hospital. She also feels that these men

[123] Non-medico refers to someone who is not from the medical profession.

[124] Ghorowa is a Bengali colloquial term that refers to a homely and domesticated person. In this, it refers to a woman who would devote herself to the management of the family and perform the intimate tasks of accomplishing the household chores and taking care of the family.

are intimidated by female doctors because ambition and personality of female physicians are in discordance with male ego. In a rather dismayed tone she said that men by virtue of their gender feel that domestic duty is the sole responsibility of a woman and the nature of the medical profession is viewed as an obstruction for leading an ideal family life.

Martin *et al* (1988: 337) argued that more male physicians compared to female physicians tend to get married and have children. When female physicians marry they are the ones who perform greater amount of housework. Possibly this is the reason that provoked my female participants to decide that they would rather remain unmarried than choosing marriage over a career. Dr Antara Das told that she doesn't wish to have a child as it would mean an obstacle to her career. As stated by Martin *et al* (1998: 338) "remaining single or electing to not have children may lessen the conflict between professional and personal life." The authors attribute the gender socialization of family perception that acts as a key in the career decision or specialty choice for female physicians.

Dr Debashish Basu (male, upper-caste and middle class) said he wants a partner who would understand the demands of the medical profession and accordingly adjust. However, that does not mean that he would prefer to marry someone from his own profession. He is flexible about marrying anyone who would be compatible. Dr Dipayan Dastidar (male, scheduled caste and middle class) is firm about his decision that he does not want a doctor as his wife fearing that there would be an ego clash. He wants someone who would look after the family and therefore would prefer to have a homemaker. This indicates that Dr Dastidar knows that his professional demands would make it difficult for him to look after the family and as a result of which he wants someone who won't have to devote time to earn money and hence would be able to

look after the household. Secondly, it highlights that marrying someone within the same profession can breed competition between the couple which according to him is not good for the future of the relationship. Thirdly, his attitude might be a result of primary socialization when a child grows up watching the "sexual division of labour in the family" and imbibes such norms. Dr Prantik Maity (male, upper-caste and middle-class) feels that a medical professional should practise "professional endogamy" which according to him is marrying within the profession believing insider would be more empathic about the rigorous nature of the medical profession and the inconsistent work schedule. This particular account resonates with Fox's (1979) view that how the medical socialization makes the doctors realize that they are different from their non-medico counterparts. The medical school training instil in the interns that their "world" is different from the "world" of those who are not doctors. They perceive their fellow physicians as close-knit community or "little society" as envisaged by Fox (1979: 31). Interestingly, Dr Joyeeta Sil (female, scheduled caste and middle class) also agreed with Dr Prantik Maity's views on a doctor should marry another doctor. It might be interpreted that for both the male and the female doctors there are advantages and disadvantages of marrying someone within the profession. Another reason might be that the status of the spouse as a doctor can elevate the status of the concerned person rendering them the power couple[125] position. Dr Sil also said that she would either marry a partner who conform to gender equality otherwise would not marry.

According to Dr Tamal Sikdar (male, scheduled caste and middle-class), frustration in the lives of doctors is an outcome of not having a girlfriend, toxic marital relationship, onerous family responsibilities, making it to the medical school after several failed attempts, unfulfilled professional aspirations and absence of a "healthy" sexual life.

[125] Power couple refers to two ambitious people with powerful careers married to each other.

Lack of intimacy, work pressure, shirking the internship duties by peers and instead preparing for upcoming entrance examinations, stress and strain, and cold war with the nurses are some of the common reasons leading to frustration. He feels that a scheduled caste person should marry someone who is empathic towards her/his position rather than an upper-caste person especially Brahmins who show the tendency to look down upon him/her by making feel guilty and incompetent for seeking the seat in medical school through reservation. This account by Dr Sikdar indicates that occurrences in personal life have implications in the lives of the interns. However, that is not all. Their day-to-day experience of surviving in the medical school and learning to cope with the uncertainty of future and the prolonged period of medical scholarship can take a toll on the lives of the interns. These experiences and revelations might serve as a determinant for choosing the specialties and mapping the career plan. It may be argued that Dr Sikdar is conscious about his caste position that might have been an outcome of his interaction with the peers and public. This supposed consciousness might have made him realise the power imbalance that can exist between couples with different caste locations. It also may also be interpreted that students who belong to scheduled caste have to continuously negotiate their caste identities with their “general category” peers. However, as mentioned earlier in this chapter as well as in chapter 1, their middle-class location may level these negotiations and struggle in the course of their interaction with their peers and the public.

Conclusion

Medical socialization is a complex process. It begins right from the time a student decides to enter the medical profession and the collective factors that entrenches her decision. The empirical data attempts to look into medical socialization and locates the gendered undercurrents, quirks and mores. Entry into the medical profession is

determined by not just family background and perceptions about the profession but gender is at play. Status acquisition and financial stability seem to be important irrespective of gender. However, it is important to note that the history of medical profession being respectable especially for women, a predilection for the learned profession and the status it accords to women in a male-dominated society are also some of the factors that may have inspired these women to pursue medical career. The middle-class position of these interns can be seen as a determinant for choosing a medical career. The high investment required for preparing for the medical entrance examination combined with the fees at the medical school highlight the possession of economic capital by the families of aspiring medical students is important. Medical students are shedding their inhibitions when it comes to the human body and there seems to more healthy exchange of words regarding the human body in a co-educational setting. Medical training in a public teaching hospital involves maintaining the professional demeanours that means playing the role of the doctor according to the consensus of the society. In case of women, embracing western attire helps them to distinguish them from their lower-class and occupationally subservient counterparts of nurses and governesses. In addition to sartorial choice, it is the body language, comportment and a certain kind of an appearance that a doctor needs to maintain to survive in the profession. "Detached concern" (Fox 1973) has increasingly become obsolete as found from the interviews. Interns feel that being good counsellors is also a part of the profession. However, it seemed that for the female doctors, emotional bonding with the patients can make them more vulnerable about not being perceived seriously and at the same time might expose them to unwanted advances from male patients. It is the lower-class, marginalized Muslim men and women who largely constitute the patient composition in this hospital. Pertaining to this study, the attitude

of the interns towards these patients is replete with the clash of class values, apathy towards the Muslims and, the perception of the Muslims as misogynist, unclean, fierce, libidinous and parochial. There is a belief that Muslim women are fettered by the shackles of Islam which is viewed as an embodiment of patriarchy. This unequal power shared between the doctor and the patient especially the male intern and the female patient emboldens the doctor to exert greater control over these patients to construct them as docile bodies. In the light of the study it may be assumed that the lower caste position of the interns does not indicate that they will be able to identify with the biographies of their patients. It is because the privileged middle-class identity of these interns along with the temperament of medical training makes them view patients as below their position. Interestingly, the female interns are often viewed with scepticism and the attitude of the patients is such that given a choice, they would choose female interns. Thus, there is a humble attempt to argue that within the medical profession, it is both the female interns and female patients who have to endure countless instances of symbolic violence, latent violence as well as manifest violence. However, it has also been found that male interns have to shoulder many forms of invisible labour like fetching tea during duty hours for the unit, going for remote outdoors locations during bloodbank duties, sleeping on the floor as against sleeping on the bed for female interns during night duties and the possibility of having more night duties than their female peers. Thus, these experiences of the male interns can be attributed to the societal expectation of men being strong and fierce, and hence are allocated such responsibilities on such contours. An examination of the intimate lives of the interns talks about the impact of medical school experiences and personal accounts in playing a deciding factor.

Conclusion

This study was an attempt to delineate the entry of women into the realm of institutionalized medicine and the circumstances that curtailed and regulated their occupational mobility. Another major concern of the study was to examine the discourse of science and medicine to understand the constituents, essence and power of medical socialization with a focus on gender. The study was conducted with the belief that medical socialization is not limited to the principles of biomedical science but is shaped, nurtured and informed by the social context of gender[126]. It also made an attempt to explore gendered underpinning and epistemic violence that produces and perpetuates a culture of medical patriarchy and leads to gendered choice of specialties[127]. From the outset, the study was grounded in feminist criticism of science, medicine and health.

Since antiquity, women have been pushed to a largely pernicious treatment in the world of medicine. The relations of women with the male-centric ideals of medicine are fraught with stress and strain. When women were incorporated into the medical profession it was out of several compulsions rather than an acknowledgement of the agency and occupational autonomy of women. Medical education and training objectify

[126] Along with Gender, other social indicators like class, caste, religion, doctor-patient interaction, position in the professional structure and so on and so forth have emerged in some of the narratives and during textual analysis.

[127] See Riska 1989, Hinze 1999, White 2002, Creed *et al* 2010, Bhadra 2011 and, Davis and Allison 2013.

and vilify women through medicalization and scientific detachment. The ideals of the profession are often in dissonance with femininity and as a result of which "feminine" is denigrated within the medical profession (Ehrenreich and English 1979 and Wajcman 1991). The aim of the study was to link the present gender hierarchy (through personal interviews with the interns) and gendered socialization with the historical relations of women with the medical profession[128] and the larger context of the epistemological tenet of science and biomedicine (secondary data research). In the US context[129], it was only with the increasing entry of women into the medical profession along with the feminist critics of male-dominated medicine and medical institutions that research started focusing on the influence of gender differences and ethnic status. It was found that the medical schools are not completely homogenising institutions (Gabe *et al* 2004: 171).

The narratives from the fieldwork were smeared with gendered moorings and connotations. In the climate of robust feminist ideologies, praxis and activism it was evident that the interns were able to identify the checks and balances, gradation and levelling and, horizontal and vertical occupational mobility within the medical profession that determined their life-chances and prospect. Possibly because of this, female interns of this research were predetermined about choosing feminist life partners otherwise staying away from marriage.

The chapters have been arranged into key themes--- gender hierarchy that integrates textual view and field data (emerged out of personal qualitative interviewing), gendered medical socialization which is completely based on a critical review of selected

[128] See Mandelbaum 1978, Ehrenreich and English 1979, Shuttleworth 1990, Treichler 1990, Annandale 1998 and Gupta 2000

[129] See 'Key concepts in Medical Sociology (2004), the chapter on professional socialization

literature and thirdly examination of gendered medical socialization that is contingent on field data (micro/rapid ethnography and personal qualitative interviewing).

The first chapter outlines the "masculinization" of the medical profession that can be witnessed in Europe through witch-hunting craze that have been believed to be a ploy to dismantle the power enjoyed by the local female healers who mostly belonged to the peasant class, the establishment of obstetrics that purged the authority of the midwives in birthing practise and initial obstacles of women's entry into the field of medicine. Even when women were incorporated, the culture of patriarchy posed challenges and hardships. The inauguration of the nursing profession was based on the principle of female nurses performing the task of caring and nurturing whereas the male doctor diagnosing and performing intellectual labour (Ehrenreich and English 1979, Iyer *et al* 1995 and Connolly and Rogers 2005). In the Indian context female physicians entered the medical profession during the British colonial role (Burton 1996, Ramanna 2008, Bhadra 2011, Sehrawat 2013, Ray 2014 and Singh 2005) but were entangled in double day labour and had to prove their mettle with the benchmark set by their foreign counterparts and also native male doctors (Ray 2014).

The data that emerged from my fieldsite in Kolkata show that male physicians are imagined as compatible to the temperament of the medical profession. However, owing to the high status and community-oriented outlook, medical profession has been preferred by both the female and male participants of this research endeavour. The "feminization" of the profession as noted by scholars (Reichenbach and Hillary 2004 and Lechien *et al* 2017) was not visible in respect to my study. Out of 250 male medical students there were only 65 female medical students in the batch of 2012-2018 (the participants of the study belong to this batch). All the female interns I interviewed aspired to pursue gynaecology which is subsumed in the less-prestigious specialty

(Riska 1989, Hinze 1999, Bhadra 2011 and Davis and Allison 2013). They believe that female interns choose specialization assessing the duration of higher education, the inflow of patients, market for the specialty, prospect of balancing family life with career, and also the nature of the specialty[130]. One narrative brought out the aspect of "purity" and "pollution" like handling the deadbodies in forensic lab and less grotesque nature of ophthalmology and dermatology compared to other specialties playing a key role in the choice of careers for women. The male interns believe that most of their female peers lack the grit to survive in the medical profession and that certain specialty is compatible for men. It was also found that the female interns resonate with this view therefore indicating that they have internalized the male centric worldview about their abilities.

Chapter 2 discusses on the discourse of biomedicine having immense power in disciplining and scrutinizing the bodies of women by subsuming the different stages and phases of the reproductive health of a woman under biomedical control. Medicalization of women leads to the gendered construction of illness (Riessman 1992 and, Gabe *et al* 2004, Inhorn 2007) that has been largely debated and lambasted by radical feminists. Socialist feminist critics have shown the confluence between medical patriarchy and the capitalist market economy that have reduced women as consumers in the medical market (Annandale 1998 and Riska 2003). It is also one of the reasons that gynaecology is believed to be a safety-net speciality by the interns (based on data elicited from fieldwork which has been discussed in chapter 1). In this spirit, women's

[130] The nature of each of the speciality has been discussed in Chapter 3 under the theme 'Medical school experiences'.

health and a verbose discussion on their representation were also imperative[131]. It is because it is an outcome of medicalization of the bodies of women (Riessman 1992, Riska 2003 and Inhorn 2009) and also the location of women with respect to her caste, class, race, ethnicity, age, etc or differential position in distribution to power that shapes her experiences[132] (Landrine and Klonoff 2001). It is because every aspect of a woman's biological life has been imbued with medical meanings, pathologized, and legitimized the surveillance and intervention of biomedicine (Annandale 1998, Gupta 200 and White 2002). Becoming a doctor entails learning such distorted notions about the bodies of female. Excelling in the medical profession is also about learning the traits of being acquainted with uncertainties within the profession, "detached concern" (Fox 1979), learning to act and behave like a doctor, developing a medical gaze and normalizing the instrumentalist approach to human bodies especially towards female patients (Candib 1973, Good and Good 1993 and Subha Sri 2010).

Sometimes the medical textbooks deploy misogynist language and perpetuate the existing gender power imbalance through objectification of the female patients. This nature of scientific knowledge often remains unquestioned by the medical students believing in the superlative objectivity of science. This is also remnant of Harding's (1992 and 2005) exhortation on "strong subjectivity" that needs to be incorporated and

[131] See Literature review the section on 'Medical science and distorted/negative image about women's bodies: Feminist critique', Chapter 1 the section on 'Women's health and stratification' and Chapter 2 the section on 'Feminist polemics on medicalization'.

[132] See Chapter 1 the section on 'Women's health and stratification' and Chapter 2 the section on 'Feminist polemics on medicalization'.

consolidated into the biomedical literature in order to amend those sexist and decontexualized knowledge being passed on in the name of science.

Chapter 3 comprises of the semi-structured face-to-face personal interview (the second section of chapter 1 also consist of empirical narratives pertaining to the context of gender hierarchy within the medical profession) conducted in this backdrop, show that medical students are shedding off inhibitions when it comes to the human body and there is a more healthy exchange of words regarding the human body in a co-educational setting. Medical training in a public teaching hospital entails maintaining the front that means playing the role of the doctor according to the consensus of the society. In case of women, embracing western attire helps them to distinguish from their lower-class and occupationally subservient counterparts of nurses and governesses. In addition to sartorial choice, it is the body language, comportment and a certain kind of demeanour that a doctor needs to maintain to survive in the profession. Such a demeanour has been found to be elitist, exist and classist by feminist scholars (Candib 1973).

Within the medical profession, it is both the female interns and female patients[133] who have to endure countless instances of "symbolic violence[134]" (Bordieu 1986), overt violence as well as covert violence. However, it has also been found that male interns have to shoulder many forms of invisible labour that can range from going for remote

[133] See Chapter 3 the part on 'Internship phase' and also conclusion of the same chapter.

[134] According to Bordieu (1986) the symbolic power of an individual or group ensued through education, cultural practices and position in the society. This symbolic power also known as soft power allows an individual to exert violence which are not manifested or tangible but they play in subtle ways. For example dressing in certain may render an individual to feel like an outsider by the body language of the members of a group or community.

outdoors in bloodbank duties to the possibility of having more night duties than their female peers. These hardships endured by the male interns often go unrecognized because in a patriarchal culture, apparently physically demanding tasks and arduousness are considered to be male domains. This may indicate that medical patriarchy also pushes men to victimization and compel them to bear the burden of masculinity.

The narrative in regard to the experience of a female intern during her duty in the emergency ward buttresses that despite the status ensued from the medical profession, female physicians are perpetually doubted about their abilities and performance especially in gruelling and onerous departments in hospital both by the male and the female patients. The narratives that emerged, also underline the differential nature of illness impinging men and women like the nature of orthopaedic male and female patient.

Gender and class segregation and distinction becomes prominent in the differential body language, comportment and demeanour of the doctors and the patients. For the female patients this sartorial choice is imbued with the gendered connotation to distinguish themselves from the nurses, governesses, female workers and female patients and maintain the hierarchy. For the female interns safeguarding this hierarchy with their patient is vital for being taken seriously as doctors in an overarching male-dominated profession and also to demarcate the boundaries with their patients in order to earn their obedience in the exercise of duties. The client-dependant characteristic of the medical profession informs the interns about the prospect of their speciality choice. In addition, they also realise that each specialty demands to master a range of hard skills and soft skills that is embedded with gendered meanings. In turn, it guides them

regarding what to expect from each specialty and exchange that knowledge among the peers and transfer to the juniors in the field and the others (non-medical community).

I found that the participants irrespective of their gender identity were unable to perceive the medical profession as has been analysed by feminist critics of science, medicine, and health. This also underlines the conflict of interests or clash of ideals between the disciplines of critical social science and natural science. The data from the field reinforces the existing theory about the gendered choice of specialties and is in congruent to existing literature. However, there is a humble attempt to locate the interplay of the several axes of social stratification that regulates and informs the lifeworld of various social actors or stakeholders of the medical profession. I feel that there is a need to embrace more ethical, grounded and egalitarian approaches by the doctors towards their patients especially the marginalized female patients whose biographies of poverty, illiteracy, gender violence and ideological subjugation from the medical community as a whole and the doctors at large (in this case the interns) make them the most vulnerable in the medical profession.

Finally, I want to argue that earning the MBBS degree is not limited to securing pass marks in the examination. It involves developing a new self, a self that learns to distinguish herself/himself from the others (non-medicos) and attain clarity about one's life map---the direction of the possibilities, expectations and role-play of a doctor and family life a doctor. These gender subjective experiences and interpretations intersect with the objective world of medical science[135] and produce new embodied individuals who define what it is to be a doctor. Thus, in my understanding, gendered medical

[135] Gabe, Mary and Elston (2004) in the section on 'professional socialization' raise the issue that what is the connection between formal pedagogy and informal modes of influence in the construction of a professional.

socialization is a continuous process in the lives of doctors and is not restricted to the hospital setting. Once on choosing a medical career, it continues to operate throughout one’s life.

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