

Medicine, Gender and Asian Families

Text by Audrey Ng Shian Ting

"Oh, you are a girl ah... Got male student or not? Or can I see a male doctor?" The words landed like a punch to the gut. The simulated patient was harrowingly good at his role – his tone carried the sobriety of a man past his prime, his shoulders were rolled forward as he slouched in the chair like a beaten soldier.

Getting around cultural norms

For a first-year medical student, the task of obtaining a patient's sexual history loomed large, and as someone rooted in conservative upbringing, it posed an even greater challenge. Navigating the labyrinth of "*coitus*", "*intercourse*", "*sex*", "*making love*", "[redacted]" felt like trying to read a language I had never been taught. Growing up, my parents had made no effort to bridge that gap for me – movie nights with raunchy scenes were always punctuated with awkward silences, conversations were carefully tiptoed around, and as my mother once said, "I didn't even know the *thing* could stand!" In a world of unspoken innuendos and taboos, I was somehow meant to figure it out all on my own.

Unfortunately, my situation is pervasive in Asian culture. A systematic review revealed that due to attitudes rooted in traditionalist culture and

religion, Asian parents often expressed reluctance to engage in conversations on sexual health.¹ Such hesitancy can impede efforts to promote sexual health education and open dialogue. Additionally, such cultural norms can also manifest as challenges in healthcare. A study has also highlighted the need for sexuality education programmes with emphasis on cultural backgrounds.²

Healthcare professionals need to have salient awareness of such nuances when discussing sexual health with patients from all walks of life.

After the session, I was reminded that I could be more receptive to non-verbal cues, and that I could have shared more sensitivity and warmth. Additionally, I needed to be present not just physically, but emotionally as well. The facilitator introduced me to the mnemonic "NURS":

- Name the emotion
- Understand the feelings
- Respect and reassure
- Show support

While such mnemonics (think SPIKES, SOCRATES, ICE...) are simple in practice but much harder to execute in real life, such a clinical communication scenario was a good learning opportunity to

experience how consciously setting aside ingrained cultural inhibitions is highly effective in creating safe spaces for patients to share their concerns, ultimately building trust in the doctor-patient relationships. That being said, adaptability and empathy go hand in hand in promoting good clinical care and communication.

Appreciating the impact of gender roles

Yet, another concern lingered in my mind long after my team and I left the consultation room – my role as a *female* medical student and future doctor.

While it is perfectly natural for male patients to have some reservations when discussing sensitive topics, I could not help but wonder if my ability to provide adequate care would be inherently limited solely due to my gender. Would my phenotypic differences, somehow, make me seem less competent in their eyes? Would my legitimacy as a doctor be nullified simply because these patients could not instinctively see themselves confiding in me – a woman? These were questions that clung to me tightly. Though such a roleplay scenario may not necessarily reflect society as a whole, it would still be naive to dismiss the

lingering conservative qualms that persist within Singapore.

Across cultures, particularly in more conservative settings, studies dating all the way back to 1997 have shown that gender plays an unspoken, yet undeniable role in shaping patient preferences.³ Such attitudes are amplified in matters of intimate health, such as the consultation scenario I was tasked to work on. The hesitation may not always be vocalised, but it is omnipresent – the averted gaze, the crossed arms, the brief responses. Sadly, the battle between legitimacy and perceived competence for women in healthcare is a longstanding one. Reports have also elucidated that female doctors in male-dominated specialties, such as urology and surgery, often admit having to work harder to prove their aptitude.⁴ A lingering notion prevails where male patients would be better served by male doctors, not necessarily because of superior skill, but simply because of shared experience – a perceived understanding that transcends clinical knowledge.

And so, the paradox emerges. The Hippocratic Oath binds us to a singular duty: to heal, to serve and to prioritise the well-being of our patients above all else. But what happens when patients, bound by their own cultural or personal reservations, see our gender before they see our expertise? When their comfort with a same-gender physician outweighs the urgency of objective medical care? When deeply ingrained beliefs about who “should” be providing care lead to the exclusion of those who are fully capable of doing so?

The intersection between gender and healthcare is a delicate one. Medicine is a discipline of necessity. Regardless of who performs these tasks, a broken bone must be put back in place, a bacterial infection must be treated with a course of antibiotics, and a life-threatening illness must be diagnosed. However, it seems that time and time again, the weight of cultural norms – deeply rooted in the segregation of gender and sex, holds greater sway than the very oath we as doctors swear to uphold. For all the objectivity and empathy that we

strive for in patient care, such societal expectations dawdle, dictating who is most apt to provide that care.

Fostering the right environment

However, my teammates and I were taught that there are ample ways to reclaim legitimacy and navigate such delicate boundaries. For instance, the clinical communications facilitator highlighted that establishing professionalism through body language and active communication can help reinforce one's authority, establishing my role as a medical student in ensuring comfort and an open conversation. Additionally, there are also unique strengths that we are equipped with as women in healthcare. Studies have shown that female doctors often excel in patient-centred communication,⁵ which may be crucial when discussing sensitive topics such as sexual and mental health. Some male patients also feel more comfortable discussing emotional or mental health concerns with female practitioners as there is less pressure to maintain a stoic front or conform to traditional norms of masculinity in the presence of other men.⁶ It is also worth acknowledging the converse – many female patients may feel more at ease and inclined to confide in female healthcare providers for the very same reason.

If medicine is to remain a field governed by logos, pathos and ethos, then it cannot be shackled by the arbitrary constraints of gender norms.

And yet, the challenge remains: how do we, as future doctors, uphold our commitment to patient-centred care while also confronting the biases that threaten to undermine it?

Perhaps the answer lies in the roleplay scenario itself. Just as navigating conversations on sexual health required a conscientious overlooking of cultural inhibitions, addressing gender biases in patient care demands self-awareness, adaptability and resilience. The onus is on us as medical professionals to foster environments where openness prevails over silence, and competence triumphs over prejudice.

But one thing remains clear – if the oath we take as medical students holds weight, then our ability to heal must not be determined by the bodies we inhabit, but by the hands that wield the scalpel, the minds that diagnose and the hearts that choose to care. ♦

References

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