Section: Community Medicine

Original Research Article

GENDER ATTITUDES AND PERCEPTIONS AMONG COMMUNITY MEDICINE RESIDENTS IN MEDICAL COLLEGES OF MUMBAI REGION

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ABSTRACT

Background: Gender bias remains a persistent issue within the medical profession, indirectly influencing clinical responsibilities, professional interactions, and leadership opportunities. Although the representation of women in the medical field has increased significantly, particularly in academic and clinical settings, deeply rooted traditional gender norms continue to shape institutional culture and professional dynamics. These long-lasting biases can affect careers, job roles, and the workplace. **Objective:** This study aimed to assess the gender-related attitudes and perceptions among postgraduate residents in community medicine across Medical Colleges in the Mumbai region. By assessing beliefs related to professional suitability, domestic roles, and gender diversity, the study sought to identify prevailing stereotypes and areas for intervention.

Materials and Methods: A cross-sectional observational study was conducted among 72 participants (47 females, 25 males) using a validated self-administered questionnaire. The participants included postgraduate residents in Community Medicine from nine medical colleges in the Mumbai region. The questionnaire examined attitudes toward gender roles in professional domains, domestic responsibilities, and openness to gender diversity. A Likert-type scale was used for inclusivity and rejection of Stereotypes. Data analyzed using Microsoft Excel, SPSS v25, applying frequency, Chi-square tests, and Pearson correlation.

Results: Most participants supported gender-neutral roles, with 97.2% and 90.2% viewing cardiology and pathology, respectively, as suitable for both genders. However, 19.4% considered surgery more suitable for men. A notable number of participants perceived politics (13.9%) and the armed forces (31.9%) as fields more suitable for men. While 94.4% supported shared parenting, only 48.6% firmly disagreed that rape is caused by increased male sex drive. Pearson's correlation showed a positive relationship between gender inclusivity and rejection of stereotypes ($r = 0.56$, $p < 0.001$).

Keywords: Gender attitudes, community medicine, medical faculty, gender bias, leadership roles, public health education, LGBTQIA+ Inclusivity.

INTRODUCTION

Gender norms and biases significantly influence how people interact and function within society, including in professional fields such as healthcare. These norms are the deeply rooted beliefs and expectations about how men, women, and gender-diverse individuals should behave. Unfortunately, they often lead to unequal treatment and unfair advantages or disadvantages based on gender. In the healthcare system, these biases affect medical education, career opportunities, leadership positions, and even the quality of care provided to patients. Achieving equality in healthcare requires challenging these traditional ideas and promoting gender-sensitive practices across all levels of the profession.[1]

The World Health Organization (WHO) has emphasized that gender equity should be a key part

of medical education and training. This involves helping future doctors and healthcare professionals understand how gender influences health outcomes and professional opportunities, and training them to respond fairly and respectfully to all patients, regardless of their gender identity or background.[2] However, in India, this ideal is far from fully realized. Despite ongoing reforms and policy-level efforts to improve equity, Indian medical institutions often continue to reflect patriarchal values that restrict the professional growth of women and gender-diverse individuals.[2,3] These values affect everything from who gets selected for leadership roles to which specialties men and women are encouraged to pursue. A striking example of this inequality is the continuing underrepresentation of women in surgical specialties and leadership positions, even though nearly half of India's medical college entrants are now women.[4,5] This suggests that the problem lies not in the number of women entering medicine but in the systemic barriers that prevent them from progressing to higher ranks. Gender stereotypes, such as the belief that men are naturally more confident and decisive, while women are more caring or gentle, still influence decisions around job roles, promotions, and expectations within healthcare institutions.[6] These stereotypes create invisible walls that stop women from being treated equally in the profession.

Even medical educators, who may have good intentions, can unintentionally reinforce gender bias in how they train students.[1] For example, male trainees are often rated more highly or encouraged more strongly, even when their performance is similar to that of female trainees.[7] This kind of unconscious favouritism is especially harmful because it occurs subtly and often goes unnoticed, making it harder to challenge.

In 2018, in response to growing concerns about gender bias in medical education, the National Medical Commission (NMC) released official guidelines to promote gender sensitivity in Indian medical colleges.[8] These guidelines encouraged institutions to include discussions about gender roles, discrimination, and inclusivity in their teaching. However, actual implementation has been inconsistent. Many postgraduate programs still lack structured modules on gender equity, and few provide opportunities for students to reflect critically on their own biases or the societal norms they've grown up with.[3]

This inconsistency is particularly concerning in specialties like Community Medicine, which focus on public health and the broader social factors that affect well-being. Community Medicine professionals work closely with diverse communities and often address sensitive issues related to gender, family planning, sexual health, and domestic violence. Therefore, it is especially important for them to have a clear understanding of gender equity and to be comfortable working with people of all gender identities and sexual orientations.[9]

In this context, the current study aims to explore the gender attitudes and perceptions of postgraduate students in Community Medicine departments in medical colleges in Mumbai. The study focuses on key questions: Do students believe that certain jobs or roles are more suitable for men or women? Do they think that domestic responsibilities should be shared equally? How comfortable are they with people who identify as LGBTQIA+? And do they recognize harmful myths related to gender-based violence?

By answering these questions, the study hopes to shed light on the existing gender attitudes among future public health professionals. These insights can help guide reforms in medical education and training. For example, if the study finds that many students still believe surgery is a "man's field" or that only men should lead in politics or medicine, then educational institutions may need to update their curriculum to challenge these outdated ideas. Similarly, if students are uncomfortable working with LGBTQIA+ patients or believe harmful myths about sexual violence, then structured learning experiences and exposure to diverse communities may be necessary to change their perspectives.

Ultimately, this study highlights the gap between formal medical knowledge and personal attitudes. A student may know how to diagnose and treat a disease, but if they carry hidden biases about gender, it could affect the way they treat their patients or collaborate with colleagues. Improving the attitudes of healthcare professionals toward gender and diversity is not just about fairness; it directly affects the quality of care and public trust in the healthcare system.[10,11]

By focusing on a specific group, this research in Community Medicine contributes to the broader effort of making healthcare education in India more equitable and inclusive. The findings can inform policy decisions, curriculum reforms, and faculty training programs, all of which are essential for creating a more just and compassionate healthcare environment.

Despite global and national efforts, there remains a lack of empirical data on gender perceptions among public health trainees in India, which this study aims to address.

MATERIALS AND METHODS

Study Design: Cross-sectional observational study
Study Setting: Medical colleges in Mumbai region
Participants: 72 postgraduate residents (47 females, 25 males) from Community Medicine departments
Sampling Method: Convenience sampling
Inclusion Criteria: Postgraduate residents in Community Medicine
Data Collection Tool: Validated self-administered questionnaire covering:

1. Gender suitability for professional roles
2. Domestic role beliefs
3. Attitudes toward gender diversity

Data Analysis: Data analysis was conducted using Microsoft Excel and SPSS v25. Descriptive statistics, Chi-square tests for associations, and Pearson's correlation for inter-variable relationships were applied.

Ethical Considerations: Participation was voluntary. Confidentiality was maintained.

RESULTS

Professional Role Suitability: Most participants supported gender-neutral roles, with 97.2% and 90.2% viewing cardiology and pathology, respectively, as suitable for all genders. Surgery was seen as male-oriented by 19.4%, especially among males (28% vs. 14.8%; $\chi^2 = 5.32$, $p = 0.021$). Leadership was considered gender-neutral by 88.88%, Suitable for All Genders, though military roles were still viewed as male domains ($\chi^2 = 4.93$, $p = 0.026$).

Domestic Roles: 94.4% supported shared parenting. However, 16 % of men favoured male decision-making in households.

Gender Diversity and Violence: Only 48.61% strongly rejected rape myths. 32% of males believed rape is linked to male sex drive. 29.15% believed false rape allegations are common. Female respondents reported significantly higher comfort with LGBTQIA+ individuals. Pearson's correlation showed a positive relationship between inclusivity (e.g., comfort with LGBTQIA+ individuals, support for shared parenting, belief in equal gender roles) and rejection of stereotypes (e.g., that men should dominate decisions, or that rape is caused by male sex drive). ($r = 0.56$, $p < 0.001$).

2. Beliefs about domestic roles

Statement	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
Mothers and fathers should equally share parenting	94.4	2.7	2.7	0	0
Fathers should have more say in family decisions	5.5	5.5	2.8	6.9	79.1
Hitting out is an understandable response for a man	2.8	1.4	1.4	4.2	90.3

4. Attitudes towards gender-based violence myths

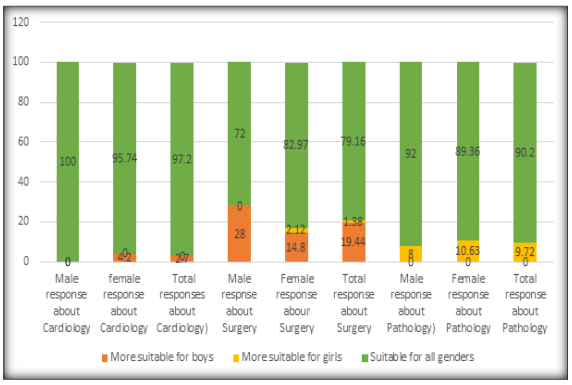
Statement	Strongly Agree (%)	Agree (%)	Neutral (%)	Disagree (%)	Strongly Disagree (%)
Rape due to male sex drive	9.7	8.3	18.1	15.2	48.6
False rape accusations are common	15.3	13.9	48.6	11.1	11.1
Can't call it rape without resistance	1.4	0	6.9	2.7	88.9

5. Comfort with LGBTQIA+ Individuals by gender

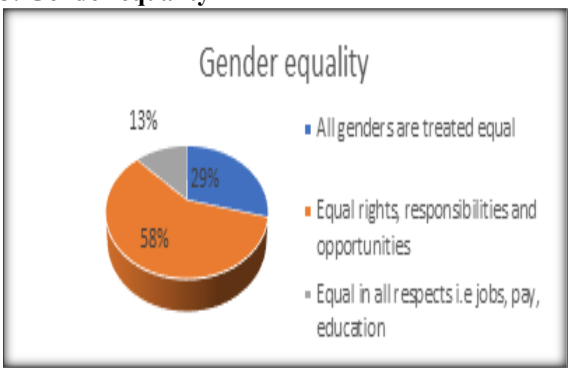
Scenario	Male Comfortable (%)	Female Comfortable (%)	Total Comfortable (%)
As part of your family	57.33	78.01	70.98
As one of your friends	66.66	87.23	80.08
As a work colleague	74.66	85.81	81.94
As your doctor	56.00	74.46	68.05

1. Perceptions of gender suitability for professions

2.



3. Gender equality



DISCUSSION

The findings of this study offer a complex and layered understanding of gender attitudes and perceptions among postgraduate Community

Medicine residents in medical colleges of the Mumbai region. While there is evidence of progress, particularly in the acceptance of shared parenting and women's participation in professional roles, deep-seated biases persist, especially regarding leadership and surgical specialties. These attitudes reflect broader societal norms and cultural stereotypes that shape perceptions, particularly among male students.[1]

One encouraging outcome is the widespread agreement on the need for shared parenting and inclusivity in workplaces. Most respondents acknowledged that child-rearing should be a shared responsibility, reflecting a shift in urban Indian families toward dual-income households and evolving gender roles.[10] This aligns with global movements that emphasize co-parenting and more equitable family structures.[19]

However, such progress appears limited when considering responses around leadership and surgical specialties. Male students were more likely to question women's competence in high-stakes or physically demanding roles. This bias reflects traditional views that associate leadership, physical endurance, and decisiveness with masculinity, values that are long embedded in medical and surgical training.[12] The gap between what students say about equality and their bias toward certain roles shows that education hasn't fully changed their deep-rooted beliefs.

Further, many residents displayed patriarchal attitudes regarding household decision-making. Even in medical settings, some participants still believed men should lead at home. This supports previous research showing Patriarchal thinking is learned early, becomes a deep habit, and is rarely questioned in professional education unless directly talked about.[16] The disconnect between stated equality values and actual belief systems mirrors similar findings among healthcare trainees in other South Asian contexts.[13]

A particularly alarming result involves myths around gender-based violence (GBV). A substantial portion of students believed GBV may be provoked or justifiable under specific conditions. This finding is troubling, considering the professional responsibility of doctors to support survivors of violence. Such beliefs may hinder victim-centered care and perpetuate stigma.[17] There is an urgent need to include GBV training in medical courses, as supported by global best practices.[18]

The study also found noticeable gender-based differences in attitudes toward LGBTQIA+ individuals. Female respondents showed greater acceptance of gender and sexual diversity, echoing studies that link higher empathy levels among women to more inclusive perspectives.[20] This is also consistent with national survey data showing more progressive gender views among Indian women than men.[14] Research suggests that intersectional education improves understanding of diverse identities and reduces prejudice.[15]

To tackle these layered biases, a multifaceted strategy is necessary. First, medical curricula must incorporate structured, compulsory modules on gender sensitivity, intersectionality, and bias. These should not be optional but an integrated part of public health and clinical education. Reflective and case-based learning has been proven effective in changing student attitudes when done longitudinally.[13]

Second, faculty should be trained to understand their hidden biases and show inclusive behaviour. Faculty attitudes shape the "hidden curriculum," influencing how students interpret institutional norms. Without systemic faculty sensitization, formal curriculum changes are unlikely to be transformative.[17]

Ultimately, institutional leadership should promote gender equity through transparent recruitment processes, support for underrepresented groups, and effective mechanisms for addressing harassment or discrimination. Unless institutions themselves embody the values, they seek to teach, meaningful change among future medical professionals will remain elusive.[12]

This study reveals both evolving and deeply held perspectives among postgraduate Community Medicine residents. While many support gender equity in principle, practical biases still influence views on leadership, domestic roles, violence, and inclusion. To bridge this gap, India's medical education system must undergo deliberate and sustained transformation that integrates gender sensitivity, structural reforms, and institutional accountability.

Recommendations

1. Integration of Gender Sensitivity in Medical Curriculum:

Medical education should include compulsory, structured modules on gender sensitivity, gender-based violence, and LGBTQIA+ inclusion. These modules must employ case-based, interactive, and reflective learning strategies to promote critical thinking and challenge deep-rooted stereotypes among students.

2. Faculty Training and Sensitization

Continuous professional development programs must be implemented for faculty to address implicit biases and promote LGBTQIA+ inclusive, gender-sensitive teaching. Faculty serve as role models; thus, their awareness and behaviour significantly influence institutional culture.

CONCLUSION

This study reveals a promising shift toward gender-inclusive values among postgraduate residents in the community medicine departments of medical colleges in the Mumbai region. Participants expressed strong support for gender equality in theory, particularly regarding shared parenting and professional inclusivity, reflecting the influence of progressive societal narratives and evolving medical training. However, the persistence of traditional

gender biases, especially concerning leadership roles, surgical specialties, and gender-based violence myths, highlights the gap between ideals and internalized attitudes.

Notably, the higher acceptance of LGBTQIA+ individuals among female respondents underscores the role of intersectionality in shaping gender attitudes. These disparities call for inclusive, empathy-driven education that addresses not just gender but also sexual orientation and identity. Without such targeted efforts, medical institutions risk perpetuating the very biases they aim to dismantle.

To close the gap between values and practice, institutional reform is essential. Structured, evidence-based gender sensitivity training, continuous faculty development, and policy-level interventions can reshape mindsets and promote inclusive leadership.

A sustained, systemic approach will not only improve interpersonal dynamics within medical institutions but also contribute to a healthcare system that is just, equitable, and responsive to the needs of all individuals.

Limitations of the Study

1. Perception-Based and Limited to Postgraduate Students:

The study captures self-reported perceptions of gender attitudes only among postgraduate students in Community Medicine. These findings may not be generalizable to undergraduates, faculty, or medical professionals from other specialties.

2. Limited Depth in Exploring LGBTQIA+ Attitudes:

While the study measured general comfort with LGBTQIA+ individuals, it did not explore specific beliefs, clinical readiness, or knowledge about LGBTQIA+ health needs. This restricts a comprehensive understanding of inclusivity in healthcare practice.

REFERENCES

1. Raj A, Kumra T et al. Reframing gender inequality in health: Reflections and directions. Lancet. 2019;393(10190):493–94.
2. George A, Iyer A et al. Gendered health systems biased against maternal survival: Preliminary findings from Koppal, Karnataka. Econ Polit Wkly. 2005;40(16):1869–78.
3. Subha Sri B, Khanna R. Dead women talking: A civil society report on maternal deaths in India. CommonHealth and Jan Swasthya Abhiyan; 2014.
4. Medical Council of India. Annual Report 2019–20. New Delhi: MCI; 2020.
5. Gupta N, Ramani S. Women in medical leadership: Barriers and facilitators in India. Indian J Med Ethics. 2020;5(2):102–106.
6. Riska E. Gender and medical careers. Maturitas. 2011;68(3):264–267.
7. Moss-Racusin CA, Dovidio JF et al. Science faculty's subtle gender biases favor male students. Proc Natl Acad Sci USA. 2012;109(41):16474–79.
8. National Medical Commission. Guidelines for Gender Sensitization in Medical Education. New Delhi: NMC; 2018.
9. Patel V, Jain S. Gender equality in Indian medical education: Time for curriculum reform. Indian J Public Health. 2021;65(3):237–240.
10. Desai M, Reddy H et al. Addressing gender bias in healthcare: Lessons from Indian institutions. Indian J Gend Stud. 2020;27(2):157–75.
11. Lim VKG, Cortina LM et al. Personal and interpersonal consequences of workplace mistreatment: The roles of gender and power. J Appl Psychol. 2008;93(5):1252–1264.
12. Banerjee S, Roy A. Gender bias in surgical training: Barriers to women's leadership in Indian hospitals. Indian Journal of Surgery. 2020;82(5):653–657.
13. Chatterjee R, Mehta K. Gender sensitivity in medical education: An emerging need in Indian medical colleges. Journal of Public Health Policy. 2020;41(2):210–218.
14. Desai S, Dubey A et al. Gender socialization in India: Insights from the India Human Development Survey. National Council of Applied Economic Research. 2020.
15. Joshi V, Patil M et al. Inclusive medical education: Attitudes toward LGBTQ+ populations among healthcare students in India. Asian Journal of Medical Education. 2022;13(1):45–51.
16. Kumar R, Singh S et al. Patriarchy and professional identity: Gendered experiences in Indian medical colleges. Social Science & Medicine. 2021; 275:113811.
17. Mukherjee P, Ghosh A et al. Medical students and myths of gender-based violence: A cross-sectional study. International Journal of Community Medicine and Public Health. 2021;8(3):1032–1038.
18. Raj A, Kumra T et al. Gender equality and health professional education: Addressing bias and equity. Lancet. 2018;393(10171):100–109.
19. Sen G, Iyer A, Mukherjee C. A framework for measuring women's empowerment and gender equality in public health research. Social Indicators Research. 2019;142(3):1105–1125.
20. Sharma N, Dey A. Gender and empathy: Understanding attitudinal differences in Indian medical undergraduates. Medical Education and Practice Journal. 2019;6(2):85–92.