Dear Members,

We are proud to present to you our third issue of the MWIA bulletin. A lot of things have been going on in all our lives, and we are happy that we have this networking opportunity to share our experiences in our medical lives with each other.

A few changes and new columns have been filled with amazing female doctors that should set an example and inspire any one of us.

This issue will mostly deal with the topic of gender sensitive science, and even though it may seem to you that it is clear to us what this entails, let us tell you, there is lots to be learned.

We hope you enjoy reading and feel inspired to contribute the next time!

Sincerely,
Charlotte Röhrborn
Secretary yMWIA

Pamela Verma Liao
Editor in Chief

Gender and Science – the Final Frontier
Young Women from Across the Globe Take on the Issue of Science & Gender

www.mwia.net
Gender sensitive science – What do we need to know??

Many of us have heard the term gender sensitive science, yet few of us really know what lies beneath. Is it women’s health issues? Is it biological? Is it political correctness? Really, it is all of the above. We will start with assuming that men and woman are different. Now we all know the popular hypotheses on how different men and women are, and we all know a lot of examples where we have found the same thing. But the differences that matter most are subtler than what we perceive in our daily lives. Those differences are what gender sensitive science and medicine looks at.

Let’s begin with some simple definitions: Sex and gender are often used synonymously, but they are not the same thing: Gender is a term used for the differences that we find in male and female creatures through culture and lifestyle, sex is a term that describes our biological differences: Essentially, XX vs. XY.

So, let’s get started with science: Several objectives are raised in this field from a gender-educated point of view: For one, in past times most animal models were conducted with mixed animals, but not analysed for sex. It is quite startling that for proper analysis, so many factors are being considered, but never sex? Other studies, for example drug trials, used animals of only one sex, as you will learn below. Not considering the differences between men and women may seem a bit simplistic to us, but really, these are recent ideas! Now we start to understand that this is the beginning of where gender sensitive science is needed. Several analyses have shown that, genetically, you are more closely related to a female chimp than you are to any male human. Now, the chimp will be treated differently from you, but you will be treated the same as your peer. The medical treatment both of you receive is more likely to have been tested on the male chimp, his relative, making it clear that perhaps your treatment is not completely suitable for you. Isn’t this an easy model to understand why it starts with animal experiments, and ends in clinical treatment?

It is common knowledge that boys and girls exhibit different numbers of sudden infant death syndrome; that boys are more prone to cancer at a young age than girls; and generally, 100 male infants surviving oppose 133 female infants surviving. This quite obviously hints at differences being not only being behavioural, but rooting in our physiology and pathophysiology, and while large parts of the 70s were spent trying to elucidate that women and men are essentially the same, one came to find that although some things are the same, a whole lot differs as well. At the same time, still, women are often excluded from clinical trials and treatment evaluation, even though there are several obvious factors that play into, for instance, pharmacokinetics: Women have a higher rate of adipose tissue, less muscle mass, and a different fluid distribution. This suggests that women and men should be regarded as separate assays in dosage finding for instance.

Now, when we take a step further and look into clinical medicine, we see not only that women treated with the same drugs show completely different results, but they have different occurrences of diseases themselves. To begin with the first question, do women have a different set of diseases, apart from the obvious set regarding Gynaecology? The answer is, yes, they do. Takotsubo - cardiomyopathy is far more common in women than in men for example. Women have more heart attacks, but less cath labs- where does this make sense? Apparently, women have a different image of themselves and their health. Even though they see doctors more frequently and generally have a more health-care aware lifestyle, they seem not to be able to express their complaints in a manner that leads to further examinations. To be quite frank, my own grandmother was first diagnosed with psychosomatic chest pains before she was taken to see a cardiologist and the cath lab revealed a RIVA stenosis. In this case, all went well, but in many others, women are misdiagnosed multiple times before the right differential is made, if at all. And why is that? Quite simple: Because women exhibit different symptoms. If you recall.
your medical school education, you may remember the
days of your own cardiology rotations, and remember
that symptoms of acute MI differ widely between the
sexes. That raises the question why this should only
apply to MI, why not to cholecystolithiasis, or to
Crohn’s disease, or whatever other diagnosis you can
come up with’?

Back to cardiology as our primary example: Women
have more heart attacks, women also show significantly
less improvement under certain medication; for
instance ASS as primary prevention of MI, where they
have no benefit up to the age of 65, but seem to benefit
in the prevention of strokes, which, of course is also
nice, but not what we were aiming for. Nonetheless,
they are still treated with the exact same dosage of
the same drug as men. Very apparently there is a logic
error here, but thus far, few studies have been released
that suggest other guidelines for medication in female
patients.

Couldn’t the reason why woman have more and
recover worse from cardiac incident be not because of
their frail health but because they are mistreated?

But let us not only look on the dark side. It has been
proven by an easily accessible parameter that women
seem to have biological advantage of some kind: The
age of women in the developed world is approximately
4 years higher than that of their male counterparts at
the time of their death. Women are less prone to
several types of cancer. Their advantage is probably not
only caused by their healthier lifestyles, and better
primary prevention, they also seem to have genetic
dispositions that result in longer lives, but not with
fewer hospitalisations. On the other hand, more
women are ridden by multiple sclerosis and several
other diseases autoimmune diseases, allergies included.

Now, we shouldn’t start to suspect a male plot against
women’s health, that men were out to ameliorate only
their own healthcare and to keep women’s healthcare
out of the list of priorities, that is not the case: Women
are definitely harder to integrate into trials than men,
given the fact that they have oscillating hormonal
stages, making comparability infinitely more
complicated, and also, the obvious option of a woman
becoming pregnant during the trial. Embryotoxicity is a
danger that is not easy to evaluate, and of course, the
newborns life and health cannot be put at risk in a trial
with a new drug. This mixture of care and practicability
actually led to the Contergan/Thalidomide scandal: pregnant
women were not included in the trial, leading to catastrophic
results, which we are all aware are of. Pregnant animals were
not tested in the studies, so embryotoxicity couldn’t be
evaluated.

All of the above said, still, pharmacology is a field where
differences seem to be of the utmost importance. All
of us have studied the concept of hepatic elimination of
drugs, and have learned about the CYP-450 System. Now, let
us refresh that knowledge, and add some details: Taking the
CYP3A4 enzyme as an example, the most ubiquitously
expressed enzyme, we see that women express higher levels
of CYP3A4, of which common substrates are
methylprednisolone, midazolam, nifedipine and verapamil,
resulting in lower plasma levels of these drugs in women due
to more rapid elimination.

CYP2D6, as the next example, is the metabolizer of beta-
blockers, a drug that is so commonly used in the developed
world, and is of such value to patients’ health, that we would
never suspect that there might still be a fault in the way it is
administered: Women, after a dose of 100 mg, show 40 %
higher plasma levels. At the same time, they have more
difficulties with side effects of beta-blockers that are
eliminated through the CYP2D6 system, and much less with
varieties that are not CYP2D6 dependent.

The list goes on and on, with especially striking findings in
psychopharmacology: Women react in completely different
manners to their psychopharmacological regimens: They
 seem to have much better outcomes with SSRIs in
comparison to tricyclic antidepressants, and does that seem
startling? Not if you know that major depression does not
only occur with different symptoms in men and women, but
is associated with different genes!

Another very startling difference: Female physicians seem to
conduct themselves and their treatments differently then
male physicians, even though there are only limited data
regarding the influence of physician gender on drug therapy.
It has been shown, for example, that female physicians tend
to adhere more closely to guideline-recommended
pharmacotherapy compared to their male counterparts. In
some medical conditions where drug therapy is one among
various components of a complex interplay of therapeutic
regimes (e.g., diabetes, cardiovascular diseases, depression,
pain management), female physicians seem to achieve better
overall intermediate outcomes and some studies suggest
that “better” drug therapy is provided by female physicians.
The reasons are various and beyond the scope of our understanding as of now: Of course it is impossible to distinguish between the individual contributions of drug- and nondrug-related influence on such improved outcomes and thus to determine whether they are due to unconfounded physician gender effects on drug therapy. There is, however, until now no evidence giving rise to the assumption that a patient will consistently receive higher quality of care by beginning to see a female doctor.

Of course, this is just a very short run through some striking differences, don't think this is all there is to learn.

When the first scientists and clinicians described their findings in term of sex differences, they were met with quite a lot of skepticism, as are all pioneers, really. We as the generation of young clinicians are the ones that have the chance to include this knowledge in the way we are trained and as we make our first medical steps, we don’t have to rethink, we can incorporate all of these differences into our day-to-day practice. Let’s all take the chance and learn about gender and sex sensitivity for the benefit of our (future) patients.

FURTHER SUGGESTED READINGS:

GENERAL

Discrimination by good intention: gender-based medicine.

Glezerman M. Handbook of Experimental Pharmacology
Volume 214, 2012, pp 3-22

Sex and Gender Differences in Clinical Medicine

Vera Regitz-Zagrosek, Ute Seeland

Obstetrics & Gynaecology

The association between stillbirth and fetal gender,

Fetal gender and pregnancy outcome.

Melamed N, Yoge Y, Glezerman M.


PHARMACOLOGY AND DRUG THERAPY


Haack S et al. Sex-specific differences in side effects of psychotropic drugs: genes or gender?

Handbook of Experimental Pharmacology
Sex and Gender Differences in Pharmacology
Editors: Vera Regitz-Zagrosek

CARDIOLOGY


Japanese yMWIA was formed in October 2012 as a part of activity of Ms. ACT, which stands for student Japanese MWIA. We are now starting to prepare for the presentation we will have in Seoul next year, and glad to take contact with other members of internationally.

President: Ayaka Iwata (Tokyo university); Vice President: Atsuna Matsumoto (Tokyo Dental and Medical University) & Haruna Akiba (Tokyo Medical Women's University); Special advisor: Dr. Mariko Fujikawa (administrators of Japanese Medical Women's association, Ms.ACT.)
Starting medical school is often not easy for students without exemplary grades in their final exams. For me, living and studying abroad seemed like a great alternative to the wearisome process in Germany. After inquiring with an agency in Münster, Westfalia, that connects students with foreign universities, suddenly things happened very fast.

Riga, a city that fascinated me, one application, and 8 days later, a binding offer for a place at the university, led me to leave my hometown in January of 2009, with heavy baggage, leaving behind a worried set of parents, loyal friends and doubtful relatives. I gained upon arrival, within one week, interesting international friends, a start into my dream future, freedom, a new language, and satisfaction.

With cheap flights it was fairly easy to bridge my old and my new home, and due to the low rental prices, it was easy to find a nice place and feel at home in Riga. From now on, I was finally a medical student. The first glance at my future university buildings left me a bit shocked, but I quickly learned that age old is easily transformed into brand new, and in many places I found a renovated, modern university.

The teaching situation was unique, classes only held 8-10 people, and in the beginning my entire semester consisted of 20 students. A remarkable privilege, compared to the size of German universities.

Our professors fit a wide range, from stern and serious to strict, but very sympathetic. The teaching language is English, which was not at all an obstacle as most teachers were not native speakers themselves.

Studying became completely day and night filling. We had weekly lab tests, colloquia and oral exams, spread out over the entire semester, an incredibly effective atmosphere was created, that converted even the laziest of students into a studious bookworm. It also led to everybody looking for great past times, and the possibilities were endless: fitness, paintball, opera, theater, ocean-side activities, singing, playing poker, partying, eating, surfing, shopping, and mostly, sleeping.

The weather in Riga is a rather extreme situation: mild summers, the city and it's parks and the nearby ocean-side being a wonderful whereabout, and exactly the right time to fall in love with the city, then without that love, you may not make it through winter. Your morning wake up at -25 degrees Celsius and being at school at 8.00 a.m seemed impossible, just like the dawn at noon and the street lights being illuminated just a few hours after.

Living standard of the Riga people is quite a bit lower than in Germany, and takes some getting used to, but it also has the advantage of very low rental prices for us. Food and clothes however are basically similarly priced to the rest of Europe.

Looking back, I would never want to miss the experiences I have gained, and without finally getting a place at a German medical school closer to my family, my alternative would have definitely been staying in Latvia and finishing medical school there. In the future, I would love to compare my old Latvian school, and my new German school, the Charité Berlin.
The problem of sexual harassment relates to the roles, which are attributed to men and women in social, economic life, which in turn directly or indirectly affects women position in the labour market. Women of all ages are been harassed physically, verbally or sexually. It may be severe, affects working conditions, and can create a hostile work environment. It has been recognised as unruly and demoralising organisational problem. It is sexual actions that make a staff feel embarrassed, uncomfortable, threatened, humiliated, and unsafe and creates an aura of intimidation. Women are more likely than men to encounter sexual harassment at the workplace.

INTRODUCTION

In today's world, women are increasingly participating in the realm of the workforce, yet they are facing many obstacles on their way. Sexual harassment is one of those obstacles. It could happen to anyone but women are the targeted victims. The problem of sexual harassment relates to the roles, which are attributed to men and women in social and economic life, which in turn directly or indirectly affects women’s position in the labour market. Women of all ages are been harassed both at work and outside work. They are harassed physically, verbally or sexually. Sexual harassment has been a fixture of the workplace since women first began to work outside the home. Although true epidemiological studies do not exist, large scale surveys of working women suggest that approximately one of every two women will be harassed at some time during their academic or working lives. Sexual harassment has been identified as universal factors that can affect performance and work productivity in any health care facility. Any conduct of a sexual nature that makes the employee uncomfortable has the potential to be sexually harassed. Junior doctors are sexually harassed more by the senior colleagues and hospital administrators and managers. Sexual harassment is considered as an occupational hazard and a violation of the right to work with dignity. Internship and residency are pivotal and exiting times in a physician's career. Sexual harassment at the workplace is underestimated in professional environments and probably even more so in private life. Sexual harassment at the workplace can happen in all social and economic classes, ethnic groups, jobs, and places in the community. The medical setting is not left out and male doctors are sexually harassing female doctors. Men harass women workers because of entitlement to achieve sexual dominance, for personal pleasure and to discipline women as workers. Sexual harassment at the work place can happen to both man and women and the harassers can be fellow students or employees, teachers, principals, supervisors, and co-workers. Even as women enter medicine in large numbers, they may still encounter impediments including harassment.

WHAT IS SEXUAL HARASSMENT AT THE WORKPLACE?

It is unwelcome or uninvited behaviour of sexual nature, which is offensive, embarrassing, intimidating, and affects an employees work performance, health, career, or livelihood. Any conduct of a sexual nature that makes the employee uncomfortable has the potential to be sexually harassed. The United Nations Development Fund For Women defines sexual harassment as “unwelcome or unwanted verbal, non-verbal, physical or visual conduct based on sex or of a sexual nature, the acceptance or rejection of which affects an individual’s employment.” It has been recognised as unruly and demoralising organisational problem. Unwelcome behaviour is the critical word and does not mean involuntary therefore sexual conduct is unwelcome whenever the person subjected to it considers it as unwelcome. It includes actual or attempted rape, unwanted pressure for sexual favours, unwanted deliberate touching, leaning over, pinching, unwanted sexual looks or gestures, unwanted letters, telephone calls, unwanted pressure for dates. Unwelcome conduct is not invited, unsolicited, the victim has done nothing to incite it and the victim views the conducts as undesirable and offensive. It is sexual actions that make a staff feel embarrassed, uncomfortable, threatened, humiliated, and / or unsafe and creates an aura of intimidation.

PREVALENCE OF SEXUAL HARASSMENT AGAINST FEMALE RESIDENTS

Abuse and harassment during residency continues to be commonplace and is underreported. In a study by Li et al, their
male colleagues had sexually harassed 23% of female doctors. Sexual harassment at the workplace could happen to anyone but women are the targeted victims. Physicians are susceptible to experiencing and perpetrating abuse and discrimination, which may be subtle or overt, intermittent or pervasive. Abuse and discrimination may negatively affect the ability of physicians in training to learn. Abuse in medicine has been recognised in various settings. Cook et al reported that significant number of female respondents than males stated that they have reported events of sexual harassment to someone. A few widely publicised cases have made of sexual harassment a salient subject in the 1990s. Sexual harassment is a widespread phenomenon affecting 42% of women and 15% of men in occupational settings, 73% of women, and 22% of men during medical training and lower percentages in other educational settings.

In a study conducted in dental offices in Washington 26.3% of respondents had personally experienced one or more forms of sexual harassment in their setting. 54% of the harassed respondents all women indicated that they had been harassed by male dentists and employers. Sexual harassment of female doctors appears to occur frequently and it is therefore an important topic in medical school and professional development. Because such a resident’s future career may depend on a possible evaluation from her supervisor, she like any employee is vulnerable to the supervisor’s power. Sexual harassment affects women regardless of age, relationship, disability, physical appearance, background, or professional status and takes place in all countries in the wold. It seems to be increasing however; the issue of sexual harassment at the workplace is often difficult to prove because the woman is believed to be lying even when she reports to female doctors. Sexual harassment occurs in residency programmes with alarming frequency. Victim of sexual harassment are usually women show that this is a society in which women generally lack power relative to men. Sexual harassment may start as a seemingly innocent gesture. Despite strong statements against sexual harassment in medical literature, it still occurs especially in countries without policies against it. Even as women enter medicine in large numbers, they may still encounter impediments including sexual harassment. It is acknowledge in thought, policy, and statute that harassment is an exercise of power that may produce unawosome effects. In a study by Frank et al, more than one third of the female physicians reported having been sexually harassed. Women physicians are significantly more likely to report being harassed while in training in medical school, internship, residency, and fellowship than in practice. Despite large and increasing numbers of women physician in practice, experiences of sexual and gender based harassment remain widespread. One survey revealed that 75% of residents in anaesthesiology, family medicine, internal medicine, obstetrics-gynaecology, paediatrics, psychiatry, and surgery reported having experienced discrimination based on sex. Sexual harassment of residents is not limited to training programs. In a study by Berlin L, unwanted sexual contact was experienced by 13% of residents, and explicit positions by 6.5%. Most of the responding female residents indicated that the sexual harassment was generated from a supervising physician. 50% of resident’s experiencing sexual harassment stated that they told someone about it, most often another resident, or friend. 14% were afraid to report sexual harassment because it would adversely affect their evaluations and 13% believed that such reporting would not be kept confidential and might result in punishment. A survey among psychiatry, internal medicine, and obstetrics-gynaecology residents disclosed that sexual harassment and abuse are prevalent in medical training programmes. 32% reported that their physician supervisors told them inappropriate details of their private lives, 24% asked about details of the residents private lives that made them feel uncomfortable, 12% touched them inappropriately and nearly 8% asked them directly for a date. More than 31% of residents reported that a supervisor unfairly favoured another trainee because of a personal relationship with that trainee and 25% of the trainees reported that a supervisor had doted a fellow trainee. A survey of Argentinean residents disclosed that 10% of female residents were subjected to sexual harassment; attending physicians were the perpetrators of this harassment in 14% of the cases. In another study by Stratton et al 93% of women and 83% of men reported encountering sexual harassment during their residency program. It was found across all specialties more women than men experienced sex discrimination and sexual harassment during residency. Many African women experience unwanted sexual advances in their workplace or study. Women in surgical and emergency medicine reported a higher prevalence of sexual harassment in a study by frank yet al. As these fields may particularly tolerate or even value hierarchy and authority. Such historically more male dominated and prestigious fields also have fewer women to demonstrate that being female is compatible with success in these fields. In the same study by frank et al, more than one third of female physicians reported having been sexually harassed.

**MAGNITUDE OF THE PROBLEM**

Sexual harassment at the workplace speaks more to power relationships and victimisation that it does to sex itself. It suffers from a misuse of power.
Perpetrators of sexual harassment are traditionally employers, supervisors, or co-workers. Any person who feels affected by the offensive nature of the act can make a charge in countries, which have policies and laws on such issues. The conduct becomes sexual harassment when it is forced upon a recipient against his or her will and even though the recipient makes it clear to the harasser that she does not approve of the behaviour, the harasser persists. Many victims of sexual harassment do not have the courage to report it because they have little cause to be believed and more so they do not see how the perpetrator would be prosecuted. There is a vacuum in the law of most developing countries, thus those accused of sexual harassment may go unpunished. One major problem in dealing with sexual harassment in organizations is its perceptual nature. Men and women generally differ in what they perceive to be sexual harassment. Sexual harassment at the workplace is usually an attempt by one person to exert power over someone else. It is emotional abuse and creates an unhealthy unproductive atmosphere in the workplace. Present thought characteristics sexual harassment primarily a manifestation of power rather than sexual attention. The profession of medicine particularly in academic settings may be especially prone to harassment because of the importance of hierarchy. This may account for the higher prevalence of harassment found in training environment and the somewhat lower prevalence experienced among women physicians once they in practice in a typically higher place of hierarchy. The majority of incidents are between supervisors and his subordinate. Power is central to senior registrar /consultants’ harassment of a registrar/ senior registrar. As a result, a victim of sexual harassment is more likely to submit to and less likely to complain when the harasser is a superior colleague. Because of the workplace hierarchy, the sexually harassed women are unlikely to complain. Studies have shown repeatedly that very few individuals report their experiences or lodge an official complain. Sexual harassment is about the abuse of power and status rather than merely being about sex per se. Sexual harassment can occur regardless of whether the harasser considers the behaviour offensive or not. Sexual harassment is difficult to gain a true picture of the extent of sexual harassment because of levels of under reporting are extremely high with a large number of workers preferring not to pursue a formal complaint. Female doctors may be harassed for a variety of reasons. Sometimes because they appear to belong to an underrepresented group or because of some other factor. Sexual harassment at the workplace often reflects an abuse of power within an organisation, where members of one group or people yield greater power than others generally. Sexual harassment at the workplace has been found to be prevalent in certain work situation and medical specialties especially where there is at unequal sex ratio where there are large power differentiation between women and men. Perpetrators of sexual harassment are generally male and often in a position of power compared with the person, they are harassing. A key characteristic of sexual harassment is that it is unwanted by the recipients. It is for each person to decide what behaviour is acceptable for or her and what they regard as offensive. Sexual harassment can take different forms. A characteristic of many harassers is that tend to read or interpret acts of friendly nature in a sexual manner, which was not the intention of the individuals they then harass.

**KINDS OF SEXUAL HARASSMENT**

There are two kinds of sexual harassment at the workplace namely the quid pro quo and hostile environment. Quid pro quo harassment closely translated as something for something occurs when an employee is required to choose between submitting to sexual advances and losing a tangible job or educational benefit. This kind of harassment usually occurs between a supervisor and subordinate. Hostile environment harassment is unwelcome conduct that is so severe or pervasive; it changes the conditions of the victims’ employment or educational situation and creates an intimidating, hostile, and or offensive work environment. Hostile work environment harassment is not limited to sexual advances and includes sex-based actions such as display of sexually explicit materials.

**COPING WITH SEXUAL HARASSMENT AT THE WORKPLACE**

Women need to be protected. In most instances at the workplace, women are vulnerable to sexual advances and manipulation. The level of intolerance for sexual harassment varies from culture to culture. When a female doctor is sexually harassed, make it open to the harasser that his sexual advances are unwelcome and not making you feel uncomfortable. Never compromise. This may be difficult in some countries where it is believed a lady should not tell a man no when he comes with his sexual desires. Carefully assess which co-workers that can be trusted with your confidence. Some of the co-residents may laugh, mock and turn down the victim of having childish behaviour. Some may tell the victim to be happy and fortunate to be admired by a senior colleague. The abuse is humiliating so the victim is motivated to keep it secret especially in countries without policies against it. There may be retaliation against the victim complaining about sexual harassment or for participating as a witness in an investigation of sexual harassment. Senior colleagues will always want to look for every avenue to get the victim queried and kicked out of the establishment in countries especially in countries with loose laws. The victim may be told to forget about the case while your image is been tarnished and rubbed. The perpetrator will be seen as a hero. The woman may be told that she is not supposed to announce to the world that a man is chasing her even when there is attempted rape. There are cases in which a female resident has
received threats from the perpetrator to the extent of taking her to the law court while the senior colleagues and hospital management just look on without doing anything and blame her to be the cause of the sexual harassment. The senior colleagues and hospital administrator sometimes tell her that it has never happened in the establishment so they are surprised about such claims. Instead of the female resident to appreciate what they are doing for her she says, a senior colleague wants her in bed. What is actually happen to this learned profession called medicine? Are the elders and hospital management and administrators not supposed to protect the junior especially when it comes to harassment yet we give medical reports to rape victims when they come to us to give the law enforcement agents and even have to give testimonies in the law court? This causes such unwelcome behaviour to continue as the perpetrators go free and the victims are the ones that are punished after being sexually harassed. Retaliation and backlash against a victim are very common particularly a complainant. Victims who speak out against sexual harassment are often labelled as troublemakers who are looking for attention. Women are not necessarily sympathetic to female complainants who have been sexually harassed. Most establishments do little or nothing to protect female residents and other female doctors. Except instances of violent abuse, the harassers are not penalized. It is quite easy for men to harass women without fear of retribution when they hold the positions of power. All types of physical and verbal sexual harassment make women workers feel extremely uncomfortable. Most women try to avoid those who harass them, whether it comes from their supervisors or fellow co-workers. Victims may be told there are many relationships going on in the hospital among the single and married so why is she should be making so much noise because a senior colleague is making sexual advances and request from her. Some hospital administrators and senior colleagues will make you feel ashamed, guilty, fearful, depressed, sad, introverted, do not want to talk to anybody, find it hard to focus on things and can no longer concentrate at work. What is important is how the woman handles the issue and not what others say about it.

Some things to do when sexually harassed:

1. Make it clear to the offender and / or to a person in authority that such action has occurred and is unwanted. Employees who are harassed may also wish to contact their residents union or association. In extreme cases, the offenders spouse should be informed although establishments may frown.

2. Do not blame yourself and never compromise. Any kind of harassment is an abuse of power and authority. The victim is not to blame for being targeted for this misuse of power. Rumours of a sexual nature may be said about the victim.

3. Do not allow others to minimise your experience or to convince you that it is not really sexual harassment.

4. Ignoring sexual harassment will not make it go away. In fact, it will likely get worse if you try to ignore it.

5. Document your experience including a list of events with times and dates, what happened, when it happened, where it happened, what was said or done and who said or did it.

6. There may not be any witness or evidence to claims. This does not rule out the fact that there was sexual harassment.

CONCLUSION

Everyone should be treated with dignity and respect at work. In countries with policies against sexual harassment, it can cost significantly if the resident decides the employers have not done enough to prevent it. Creating a work environment, which is free of sexual harassment, is every member of staff responsibility. It is acknowledged in thought, policy, and statute that harassment is an exercise of ill effects including reduced productivity, morale, and job satisfaction 6. As physicians must update their understanding of appropriate practice for patient care, they must also update appropriate practice for professional interactions 6.

Sexual harassment is a complex social concern that needs to be addressed as a serious priority and with appropriate measures for prevention of sexual harassment and protection of women need to be addressed at all levels 1. Sexual harassment is above all a manifestation of power relations. Failure on the part of an organisation to correct unwelcome sexual behaviour that is having a disruptive effect on a resident is not worth it.

REFERENCES

7. Sabitha M. Sexual Harassment Awareness Training at Workplace: Can It Affect Administrator’s Perception? JOAAG. 3 (2): 1-16
8. www.undp.org
19. What Is Sexual Harassment Retrieved From www.bbc.co.uk

Book Release:
Dr Omiepirisa Yvonne Buowari, a Nigerian member of MWIA Young Doctors and Medical Student Forum young doctors and medical students forum has coauthored a chapter entitled “Physical and Psychological Aspects of Pain”, in the book “Pain in Perspective”. The book can be assessed at www.intechopen.com. She is also a member of the editorial board of EMWIA, the official journal of MWIA.
One to look up to: Rebecca Lancefield

Many of us know the Lancefield classification, or lets say, we should all know about it, and some may have heard of Rebecca Lancefield. We certainly all know, much to our dismay, about Streptococci. When I spent this fall in bacteriology classes, I read in a small footnote the name Rebecca Lancefield. And as always when I read a woman’s name in a medical textbook, I looked her up. I am always curious who these women were- the medical women of the past century, long skirts and upswept hairdos, a picture that looks a little out of place, sitting in front of an ancient microscope, mostly with a small smile and generally a rather stern look on their faces. Rebecca Lancefield, as we learn, is just that.

Rebecca was born in 1895 as Rebecca Price Craighill in Fort Wadsworth, Staten Island where her father was stationed as a member of the army. Moving around a lot since an early age, she was introduced to many educational situations; public schools, governesses, private schools. In 1912, she entered Wellesley College, with the ambition of majoring in French and English literature, but had a change of mind when she noticed her roommates class in zoology. After this initial introduction into biology, Rebecca decided to change her major to zoology, trying to fit as many biology classes into her schedule as the regulations for a BA would allow her, and, and this is a point where all of us should definitely see her as a role-model; found she needed fundamental knowledge in the subject of chemistry, dedicating almost the entirety of her last two years at Wellesley in obtaining it. She graduated in 1916.

Initially, like it was considered suitable for a non-married academic, the post graduate took a position teaching at Hopkins Hall, a boarding School in Virginia but, was soon offered a scholarship supported by the Daughters of the Cincinnati for daughters of army or navy officers. Rebecca was concerned when she read the class catalogue that the Teachers College didn’t offer the bacteriology and genetics classes she was interested in, but apparently she was able to take any class offered at Columbia as long as she was matriculated. Upon arrival, she joined Hans Zinssers at the department of bacteriology at the college of physicians and surgeons. 1918 was quite an eventful year for Rebecca: She earned her Master’s of Arts and married.
her classmate Donald Lancefield, whom she had met in the "fly room", the genetics department of T.H. Morgan at Columbia University.

It was through her husband that she obtained her next position: at the beginning of WW2, Donald was called into service, beginning at the sanitary corps unit at the Rockefeller Institute for medical Research, taking a class taught by O.T. Avery and A.R. Dochez, who, though being mainly interested in their research on pneumococcus, made time for investigations on streptococci after bringing back 120 cultures of streptococci from Texas army camps. Rebecca, who was now already experienced in bacteriology through her work for Zinsser, applied for a job as a technical assistant, and started work immediately, focusing on what would be her life-long objective: rheumatic fever.

At this time, the world of streptococci was exactly how we still perceive it in our first classes; not knowing the intricate systematic: a huge mess. There were tests available for streptococcus viridans, but none were specific enough, since in one instance, 50% of the control sera would exhibit the pathologic reaction in rheumatic fever patients, despite coming from healthy patients. One of the reasons for this was the fact that in the beginning of the research, S. haemolyticus was not the prime suspect, it was S. viridans.

When Rebecca joined the Zinsser department, he suggested that she find a position with the department of H. Swift, who was just starting his studies on rheumatic fever. Rebecca joined the group, and worked meticulously on typing S. viridans for two years, trying to find a suitable antigen. After three frustrating publications on the unsuccessful attempts to phenotype S. viridans with certainty, the research objective was refocused, and Rebecca, at the very least, got her PhD out of this error in 1925: "The immunological relationship of the streptococcus viridans and certain of its chemical fractions".

The new focus would found her actual route to fame and success: the research on the hemolytic streptococcus, S. haemolyticus, risen to new fame when it was recognized that it had a much larger connection with rheumatic fever than was first acknowledged. Avery found evidence of the pneumococcus polysaccharides, making typing of bacteria possible, and since their labs were across the hall from each other, the spark ignited: Rebecca Lancefield was able to lay the groundwork for all her following projects, as she identified the polysaccharide common to all group A strains; the C molecule, c standing for carbohydrate, allowing specification of the streptococcus.

Shortly after, the M-antigen was identified, a groundbreaking discovery, since the M-antigen allowed typing of streptococci, determining the immunity of the host against infection with streptococci of each individual type. As both M- and C antigens appeared to be immunogen, thus mounting a heavy immune response in passively and actively sensitized guinea pigs, they appeared to be haptens, also a major discovery.

E.W. Todd, during his stay as a research fellow of the British Medical council and Lancefield discovered the cross-links between his interpretations of matt and glossy colonies and the type specific M-antigens, the M actually standing for matt. Their work resulted in a lifelong friendship and fruitful collaborations.

In 1935, "A serological differentiation of human and other groups of hemolytic streptococci" was published, in which Lancefield depicted the methods of producing streptococcal antigens and antisera for use in precipitation tests. She noted that "the results of this study are of interest not only from the theoretical viewpoint of establishing an orderly grouping of these microorganisms, but also from an epidemiological aspect in providing means of identifying the probable origin of a given strain." She then demonstrated the classification of 106 strains of streptococci from various sources, the ones she had studied in the group of Avery and Dochez all being of human origin and all forming the A group. All next nine publications dealt with refining these descriptions and problems in typing streptococci.

When Lancefield became aware of the work of Fred Griffith in London who described the slide agglutination test while doing epidemiological studies on London schools and identifying 30 types of streptococci himself, she instantly made contact. A new cooperation ensued, and the ocean-crossing journeys of patients’ sera began. Lancefield used the precipitation method to characterize Griffith’s patient sera, finding that their classifications matched meticulously, which was of course true proof of each others findings.

In 1940 Rebecca delivered the Harvey lecture titled
"Specific relationships of cell compositions to biological activity of hemolytic streptococci". In her speech, she gave a historic overview, beginning with Louis Pasteur's description in 1879 to Schottmüller in 1903, and finishing off with her own work. Not only positive outcomes were viewed, but she also shed light on all the experiments that had gone awry, e.g. the fermentation experiments. At this point, Lancefield had characterized or contributed to groups A through H, K (later dropped) and M.

Asked on her view on the discovery on antibiotics; she responded that she was glad to be freed of the many practical responsibilities of streptococcal responsibilities and could pursue her initial objective, the connection between A-streptococcus and rheumatic fever.

Three years later, Rebecca Lancefield became the president of the American Society of Bacteriologists, the second woman in history to bear this title, and a few years later, the first woman to claim the title of president of the American Society of Immunologists.

During her years as a researcher her primary objective was always the study of rheumatic fever, but she was never quite able to elucidate the connection between S. hemolyticus and the disease. One of the groups conquers was the fact that before the therapy with antibiotics was possible, each recurring attack seemed to be caused by a different strain, whereas under antibiotic therapy, this no longer held true: The recurring attacks were mostly caused by the same strain. Much of the work in this field was contributed by physician Ann G. Kuttner with whom she shared an informal, but immensely fruitful, collaboration. Kuttner contributed greatly to the research, and was a joint author with Markovitz and Gordis, of the first edition of "Rheumatic fever. Diagnosis, Management and Treatment", and when the second edition was dedicated post-mortem to Kuttner, Rebecca Lancefield wrote the preface.

In more recent years, she turned to the study of the R-antigen, originally thought to be the M-antigen of type 28, but Rebecca, together with Gertrude Perl, soon found out that the R-antigen had no effect on virulence or protection against streptocooci when it was present in the organism. Also, group B streptococci were researched, interesting not only from the theoretical viewpoint of bringing a systematic into the world of streptocooci, but also from it's pressing clinical implications, that being meningitis in neonates.

This overview of her research tells us what a broad spectrum Rebecca covered, and also, that it has taken a lifetime to achieve this systematic, without actually reaching her goal, to finally link the streptococcus hemolytics to rheumatic fever with direct molecular proof. From our perspective we know that it would not have been possible whatsoever: Rheumatic fever is a complication of streptococcal infection, but is not directly associated with the bacteria itself.

The later years Rebecca spent not only researching but also earning the recognition she deserved; several honorary lectures, prizes, for example the New York Academy of medicine medal in 1973, and the Achievement award from "Medicine" and from the Alumnae Association of Wellesley College, also in 1973.

Her most outstanding achievements: Her election into the National Academy of Science in 1930, at that time holding only 10 women and In 1973 she was awarded the Honoris Causae from the Rockefeller Institute.

Despite her fame, Rebecca Lancefield was said to have been very generous with her time and encouragement towards young doctors and researchers, inspiring them to investigate and look deeper into their objectives. She was supportive of women in medicine and women's rights, but stated in a very cautious manner, that she often times found young women wanting too much; and that it would often be very difficult to combine a family and a career. These words, in context of all the work and all the acknowledgement above, seem overly modest, given the fact that she herself was a mother to a daughter, with whom she spent every summer. All these sides of her draw a portrait of a truly unique personality, a gifted mind, and in combination, a very serious woman.

Rebecca Lancefield worked up to a few months before her death in March 3rd, 1983. She left behind her daughter and husband, a legacy of research that has yet to be topped, resulting in over 50 publications in 60 years, all published in high ranking journals, (e.g. Journal of Experimental Medicine), and also, an outstanding recipe for egg nog, filed under "applied bacteriology".
News: Next Generation University (NGU) and Medical Women's International Association (MWIA) and Launch Joint Project to Provide Global Access to Obstetrics & Gynaecology Education

Globally, there has been an identified need to produce more health care providers for the growing population. In attempts to meet this need, Dr. Erica Frank developed Next Generation University. This is a freely-accessible online university that uses only peer-reviewed content. Through a combination of web-based resources, coupled with activities requiring local, mentored supervision, trainees in vast areas of medicine are able to receive certifications in their fields of interest.

A natural partnership formed in 2009 when the need to produce high-quality training in Obstetrics and Gynaecology was identified. The Medical Women International Association is one of the oldest professional group's in the world. Following their most recent in

We are currently recruiting course authors. We provide detailed, easy-to follow instructions with many template to base the courses on. Course authors will be responsible for identifying appropriate learning materials to meet pre-determined learning objectives.

Exceptional candidates include those with a strong interest in any domain within Obstetrics or Gynaecology.

For more information, please contact meverton@nextgenu.org or visit http://www.nextgenu.org/

Photo: Drs Pamela Liao (MWIA Young Form/NGU Course Coordinator), Shelley Ross (MWIA Secretary General), Erica Frank (NGU Founder), Wendy Norman (UBC/Canadian Contraception Access Team) (left to right) (Credit: Kate Tairyan).
Make a difference  - Exchange Ideas

Submission for the next issue of the Young Forum’s Newsletter are currently being accepted.

Please send news items, articles, commentaries, school exchange reports, local MWIA activities to our editors.

Reports must be carefully proof-read prior to submission.

Please include author name, country, email, photo, and articles not exceeding 500 words.

Submit to yMWIA Secretary: c.roehrborn@googlemail.com.