

Women in Medicine

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Physicians have often been agitated by the demands of women to be admitted to the practice of medicine. It cannot be denied that feminine mental faculties suffice for the acquisition of medicine. On the other hand, only a few girls will take up the study, and these few will be those who are not really fitted for their maternal duty. Thus medicine, like the women, will not derive much benefit from these efforts. It will not amount to much.

Male Physician, Early 1900s

The error in this physician's projection is obvious. One hundred years ago and in the context of a culture which embraced more traditional gender roles, this prediction was reasonable, not insensitive or sexist. It is true that before 1960, ninety five percent of physicians were male. Women occupied supportive roles, at home, in the office and hospital. In 2003, the number of women applying to medical school outpaced men for the first time. Today, more than half of students entering medical school are women. It is projected that by the year 2010, a full third of practicing physicians will be women.

While great strides have been made in terms of the absolute number of women in the field, they continue to be a minority in positions of leadership and remain underrepresented in some specialty areas. Most studies assume a gender based preference to account for the high numbers of women choosing primary care specialties. However, early in medical school, women show interest in all specialties in proportions similar to male students. Where things change is later in training, as women perceive difficulty in combining family and career and in the context of limited mentorship in some specialties.

More women enter primary care and work part time, likely reflecting efforts to integrate personal and professional roles. According to the Medical Colleges Association, in academia, only five percent of department chairs are women and 10% are deans. Finally, only 15% of full professorships are held by women.

Disproportionate gender representation in clinical arenas cannot be explained by specialty choice alone. Fewer women, compared to men who apply to surgical residencies match successfully. The factors contributing to these observed disparities are complex. While much has been done in the last two decades to eliminate inequities stemming from gender bias and discrimination, sexual harassment and role conflict, these factors continue to influence the lives of women in medicine.

Although the compensation gap is narrowing for "younger" (i.e. less than 45 years old) physicians, women continue to earn on average, \$22,000 less per year than their male colleagues, even when such factors as hours worked, practice setting and specialty are controlled. In academia, female and male reviewers are more critical of the grant proposals submitted by female applicants. Women in academic arenas receive less institutional support (e.g. funding and administrative assistance) relative to their male colleagues. Female faculty members with children publish less, experience reduced career satisfaction and perceive themselves as less successful.

Gender discrimination may also manifest in the form of conscious or unconscious slights based on stereotypes. In an anonymous survey of male medical students, thirty percent believed that women of childbearing age pose a significant risk to the optimal functioning of a department. Nearly fifty percent of this same survey group agreed with the following statement: Women who spend long hours at work were neglecting their responsibilities to home and family. The lingering notion that women are not as serious or fitted for certain medical careers because they choose to incorporate motherhood into the mix, is an example of gender bias that can interfere with a female physician's consideration for promotion.

The medical profession has become more sensitive to issues pertaining to sexual harassment. According to a Women Physician Congress survey conducted in 2005, 49% of members reported experiencing sexual harassment in their careers. Circumstances have improved dramatically in the last decade. However, more subtle forms of sexual harassment, (i.e. staring, suggestive looks) persist and are difficult to prove. Recipients report that such covert harassment is as distressing as overt behaviors including groping or frank sexual advances. The prevalence of sexual harassment is higher in subspecialties dominated by men. The literature continues to support that the vast majority of female trainees and practicing physicians who encounter this behavior are unlikely to report it. The reasons include "no energy beyond keeping up with the demands of training" to fears of retaliation. It is significant to note that sexual harassment in the workplace can be an important predictor

of depression for female physicians. Role conflict is another factor which can impact a female physician's career satisfaction and success. Pregnant physicians frequently encounter resentment from colleagues who inherit extra work in order to accommodate the new mother's "medical leave." A colleague of mine once likened her expanding waistline to "A scarlet letter; the ultimate betrayal to the house of medicine." It is not uncommon for postpartum physicians to experience a degree of cognitive dissonance while celebrating a new birth and simultaneously contending with feelings of guilt or disloyalty related to imposing on colleagues.

More women than men make changes to accommodate children's needs. For example, one survey (N=1248) revealed that on average male physicians interrupted their careers for one month compared to female physicians who interrupted their careers for 8.5 months, to address child care issues. Female physicians are more likely than male physicians (85% vs. 35%) to change their career plans to accommodate children.

Female physicians continue to be responsible for the lion's share of other domestic work. Even in two physician marriages, traditional role divisions predominate, leaving women with a far more complex juggling act. Female physicians who lack family support for their work role are at an increased risk for depression. Finally, family obligations compete with those networking opportunities (for example, national conferences) which are more likely to provide an early career physician exposure to superordinate female role models.

Discriminatory practices aside, most experts agree that a combination of biological hard wiring and early gender role socialization contribute to the prevailing differences between the sexes in terms of the way we think, feel and behave. Unfortunately, ultra sensitive gender politics has made it difficult to fully acknowledge, if not embrace and capitalize on those unique masculine and feminine traits that contribute positively to the practice of medicine.

Numerous studies reveal that parents, consciously or otherwise, interact differently with their sons and daughters. A child's behavior, influenced by gender role socialization, can be reinforced by teachers, television, books and even the religious beliefs we subscribe to. Researchers have found that from preschool on, teachers, including female teachers, praise boys more than girls and are far more likely to accept a male student's comments in the classroom.

Additionally, more (overt) expressions of aggression are tolerated in young male students. In contrast, girls are conditioned to be more relationship oriented and emotionally responsive to others. This kind of traditional gender shaping can contribute to a girl's tendency to avoid situations which risk disapproval or involve conflict. Carol Gilligan, PhD, has written extensively about how boys tend to "play by the rules or get out of the game," whereas girls are apt to change the rules to accommodate and/or avoid conflict. Finally, adolescent girls receive messages that competence and competition can pose liabilities, at least in terms of evolving relationships with the opposite sex. Sometimes, being too smart or outperforming male peers is not considered attractive. In this context, teenage girls can become self-conscious about their academic abilities.

The legacy of these childhood experiences manifests in the different expectations men and women have in the workplace. Very recently, Columbia University researchers examined men and women cross sectionally, in a broad variety of jobs. They found that women overwhelmingly put a high value on the congeniality of coworkers and the friendliness of their work environment. Men tended to place a higher value on issues pertaining to compensation and workplace control.

Deborah Tannen, PhD, has written extensively about how women are more likely to downplay their certainty and men their doubts. Men are more likely to attribute successes to their abilities and failures to task difficulty or other external variables. On the other hand, women are prone to internalizing failures (i.e. "I am not competent"). Finally, assertiveness studies reveal that most men experience relief after asserting themselves whereas for the majority of women, anxiety is heightened. Dr. Beth Vanfossen has observed that men talk more in public and are comfortable interrupting others. Women are more likely to allow themselves to be interrupted.

UCHSC Medical Students 1986: 124 total 76 male & 48 female 2006: 122 total 66 male & 56 female continues on page 13 . . . Male traits, such as a placing a premium on decisiveness and lack of equivocation create an advantage in the business world. Autonomy, competition and goal-directedness are not inherently stressful. It makes perfect sense that more men than women are comfortable with hard negotiations, competition and instrumental relationships.

Feminine traits, including a tendency to be other directed and consensus-oriented, translate well into the examining room.

Several studies show that both male and female patients tend to prefer female physicians for their primary care needs. Research has shown that female doctors spend more time with their patients and have good listening skills. Malpractice experts believe that this particular communication style confers some protection against malpractice suits. Female physicians are less likely to be sued by their patients compared to male physicians, even after adjusting for specialty.

Recently, Colorado Physician Health Program (CPHP) reviewed physician client data accumulated since 1986 to determine whether any obvious differences existed between our male and female physician client populations. In general, the problems physicians presented with reflected gender differences observed in the general population. For example, more men present with substance use disorders and behavioral problems, whereas women physicians endorsed more depression and anxiety.

We found that while male physicians are more likely to be mandated for evaluation, Top 3 Specialties for the vast majority of women present voluntarily. This supports the notion that women UCHSC Female Residents tend to be more help seeking and help accepting, obviating the need for forced evaluations. This finding is also consistent with the gender differences observed in present-1986: Pediatrics, Internal medicine problem or diagnosis. Physicians engaging in disruptive behavior and/or who Medicine & Psychiatry suffer from substance use disorders are less likely to voluntarily seek treatment. 2006: Internal Medicine, In our preliminary examination of physician client data, CPHP also observed an age-Pediatrics & Ob/Gyn based trend. Before the age of 50, women surpass men in seeking CPHP assistance by a large margin. In the over-fifty cohort, male clients predominate. Perhaps this reflects how early career role diversity can be stressful, but ultimately pay off.

Female physicians with multiple roles tend to report higher levels of health and happiness. Women with children have lower odds of burnout (40% less), provided they have the support of colleagues and spouse or significant other. Career satisfaction has a linear relationship to the number of children in a family. Historically, medical training conditioned physicians to adopt an impossibly demanding philosophy: Complete devotion to medicine at the exclusion of all else. This narrowly defined identity and linear progression of achievement creates vulnerability for the traditional male doctor. He may experience more crises in terms of conceptualizing life after medicine or considering other definitions of success.

Physician health research is in its infancy. Most of the physician health information we have today has been derived from surveys, questionnaires and cross sectional rather than prospective studies. The Colorado Physician Health Program is committed to examining physician health data more scientifically. Delineating gender differences and respective needs will likely enhance our provision of services to our physician clients. For example, women physicians have a 60% greater likelihood of having symptoms of burnout and the risk of burnout increases significantly (1-15%) for every 5 hours over forty hours worked per week. Research also shows that the suicide rate for female physicians is four times the national rate for women. While theories have been proposed to account for a higher suicide rate in physicians, no longitudinal studies exist to support them or guide Physician Health Programs toward more definitive preventive measures.

In 2005, CPHP embarked on a pilot project with Colorado Permanente Medical Group. Representatives from both agencies met over a several month period and developed a workshop which was offered to a selected group of women physicians. So far, the feedback has been positive. CPHP is introducing similar support to women physicians throughout Colorado via a series of presentations beginning this year. Our goal is to provide education to these physicians as well as obtain their input for developing specialized, gender sensitive services for our physician health program participants. We look forward to outreaching women physicians in this endeavor.

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