



The Feminization of Family Medicine:

How is the Health-Care System Influenced?

Preconceptions of women in medicine have persisted for centuries. This article examines both the positive and negative gender biases female physicians continue to face.

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Women in medicine is a subject I decided to study, when, after many years in practice, I re-entered academia and learned once again how to research and critically appraise the literature. Like most women in family medicine, I found that 85% of my patients were female and all of them had come looking for “a female doctor.” What was this

animal — “female doctor” — patients were choosing, and why? What role did simply being born female have on influencing my own career path and practice choices?

Women in medicine cannot be generalized as a single entity or “animal.” They are, in fact, more different than similar, but a number of attributes are projected on female physicians as a group. Collectively, women are labeled as a single entity and this is difficult to avoid. This is not the intention of this article. Rather, this article will describe how the literature portrays female physicians based on averages and summaries of the studies done.

Gender preconceptions have perfused society and influenced us overtly and covertly in our career paths. This article will present some of the statistics showing the current reality.



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It is interesting to begin with an overview of some of the preconceptions out there. Imagine yourself in the eyes of female patients. What do they believe about female physicians? They choose female doctors because they feel they are better “understood” or “listened to.” Male physicians may ask “What about us? We do the same listening!” This may be true, however, the practices of female physicians are filled before those of their male counterparts.¹ Preconceptions of colleagues may be that women will “not to carry the full load,” due to maternity leaves. Preconceptions of department heads and hospital chiefs may be that women will not fulfill “academic criteria” or cover “clinical load.” What about manpower needs with the increasing number of women in the profession? Preconceptions of professional associations are that women are not interested in joining the political process. This article will examine the data supporting these arguments.

Preconceptions of women physicians are that they are carrying the full load of the emotional and social burden of their patients’ lives. Women physicians feel as though they are providing preventive care for their patients, their children and their parents, and their accomplishments often are not measured or even noticed. Evidence supports this belief.² Female physicians are in the lowest paid, lowest status fields.^{3,4} Wellness or satisfaction of patients is not even considered.

These preconceptions have influenced all women physicians and the profession must find constructive ways to effectively respond.

Different is Neither Better nor Worse

Patient choice. Patients are choosing female physicians over male physicians at a rate of 1.5 to 1.¹ Female family physicians (FPs) see an average of

Summary

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- Patients are choosing female physicians over male physicians at a rate of 1.5 to 1. Female family physicians see an average of 65% to 90% female patients, as compared to their male colleagues who see 54% to 60% females.
- Female physicians are alleged to be “better listeners” than male physicians. The literature demonstrates this to be true when it comes to patient preference studies and measures of time spent per patient.
- Overall, the salaries for female physicians are 58% to 70% lower than those of males, despite a system that mainly charges fees for service.
- Family medicine has jumped from having 32% female to 47% female residents in the past 10 years. Meanwhile, pediatrics and obstetrics are comprised of 65% and 67% female practitioners respectively.
- Even with so many women in medicine, only about 10% are involved in academics, medical education, administration and research.

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65% to 90% female patients, as compared to their male colleagues who see 54% to 60% females.⁵

Prevention. Female physicians have done more counselling and psychotherapy, have provided more preventive care services and billed almost double the lab costs of male FPs.⁶⁻⁸ This is likely because of the fact that women physicians saw a different profile of patients and did more women's care, including Pap smears, cervical cultures and mammograms.

Thirty-six per cent of family medicine faculty staff are women. Discrepancies occur, however, when examining how many women attain full professor status.

Hours worked. Female FPs work fewer hours than male FPs.⁹ The 1996 Canada census found that female doctors worked 83% of the hours of men overall, but this gap is narrowing over time as women increase and men decrease their hours of work.¹⁰ Married women in one report worked 36 hours per week, as compared to 45 hours per week for single women.¹¹ Breaking the numbers down, it is evident having children influences these numbers in opposite directions for men and women. The Canadian Medical Association (CMA) physician manpower survey showed married women with children work 37 hours on average. Single mothers, however, work 44 hours. Married men with children work the longest at 51 hours, and single men with children work 48 hours, an average of four hours more than single mothers.⁹

Time per patient. Female family physicians saw fewer patients per hour, yet had more visits per patient per month.^{6,7} Because female doctors

see more female patients and female patients demand more preventive services, more prescriptions and more return visits, this can be construed as costing the system more per patient.

Listening. Female physicians are alleged to be "better listeners" than male physicians. The literature demonstrates this to be true when it comes to patient preference studies and measures of time spent per patient.¹³ The themes of gender difference in medicine reflect theories of maternalism and paternalism.^{14,15} In the literature, female physicians are described as more consensus-building, better listeners and more empathic than males.^{4,8} Males and females have different attitudes toward medical practice, sex roles and women's issues.¹⁶ Patients also have different expectations from their male and female physicians. Female physicians are expected to fulfill all of the roles outlined above. This projected "female" ability, whether real or perceived adds stress to a female doctor's day, especially when patients with greater emotional needs seek a doctor simply because she is female and, therefore, will listen. There is good reason to identify these patient preferences and teach them to all doctors.

Some Differences Remain

Salaries. Overall, the salaries for female physicians are 58% to 70% of those of males, despite a system that pays mostly fee for service.⁷ Data taken from a 1996 Canada census show female FPs earn an average \$74,200, as compared to men whose average is \$109,200. By removing from these figures those people who work less than 40 hours per week, this changes to \$79,200 *versus* \$113,900 for full-time work. Further analysis shows this to break down to an hourly wage of \$37.54 for women and \$45.17 for men.¹⁰

Women seem to have a bimodal peak, with their top income from the ages of 55 to 59 years at

\$99,400. Little is known about how the different lifespans of women and men will play out, with differences in career choices made in senior years. This perhaps will be determined by a cohort of women in medicine as they mature.

Practice patterns. In one year, 62% of women doctors were general practitioners (GPs) or FPs. That same choice was made by only 48% of their male colleagues. Only 33% of women residents chose a specialty field, as compared to 48% of men. Women chose more primary-care fields — general and pediatric. Fewer women chose surgical specialties, for example. More women chose salaried positions, public health, or community clinic settings, and more women chose private practice over in-hospital care.^{3,6-8,12}

Productivity. Depending on what is considered “work,” childcare and housework contribute to large discrepancies in productivity between the sexes.¹⁷ Professional productivity goes beyond counting acts billed, hours worked, or lab costs. Men and women both have been known to do full-time work in 75% of the time needed. The hours of work that are harder to quantify include working through lunch, evening work, work done at home, administrative and committee work, mentoring, teaching time, travel time, *etc.* Should productivity include how well we keep our patients? Or how much preventive work and counseling is done?

Demographics and history. These differences affect the entire health-care system. Some have argued there is a chicken-and-egg phenomenon pertaining to demographics and the history of women in medicine. This is due to a denigration of primary care as more women enter medicine with less relative power, money and status, compared to their male counterparts.⁴ What came first? This article will present an overview of the historical context for this belief.



Burnout issues apply to all physicians, however, the issues creating them may differ. While men have had longer work hours, the issue of multiple role demands is a main cause of burnout in women.

Career Choices

Summary of the current situation. Some believe no gender imbalance exists anymore and such a discussion is a theme from the 1960s. There already has been a 270% increase in the numbers of female physicians. Less than 20% of physicians were female in 1987 it is projected that the figure will reach 45% by 2025.^{6,18}

Academics. Even with so many women in medicine, only about 10% are involved in academics, medical education, administration and research.^{3,19}

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Sheer numbers don't tell the whole story. The era of equality in medicine is yet to come. Recent statistics from the U.S. outline the number of female medical school applicants, enrollees and graduates over the years, and 42% of graduates were women in 2000.²⁰ Acceptance data for men and women over the years shows the number of men applying has fallen by 15% in the last two years, while the number of women has dropped by 5%.²¹ Family medicine has jumped from having 32% female to 47% female residents in the past 10 years.²² Meanwhile, pediatric and obstetric groups are comprised of 65% and 67% female practitioners respectively. Many other internal medicine specialties have similar numbers. This is the same phenomenon seen in numbers from the Association of Canadian Medical Colleges.²³

Leadership. Thirty-six per cent of family medicine faculty staff are women.²⁴ Discrepancies occur, however, when examining how many women attain full professor status. In the U.S., women make up 17% of full professors of medicine, but only 10% of women faculty are professors *versus* 30% of men. Data from the Gender Issues Committee of the Council of Ontario Faculties of Medicine show the proportion of female and male faculty classed as full professors *versus* assistants and lecturers at all of the Ontario Medical Schools, and the University of Ottawa is similar to the provincial average. Here, the ratio of full to assistant professors is 20:80 for women and 60:40 for men.²⁵

The terms "glass ceiling" and "leaky pipeline" have been coined to describe what is happening to women in leadership positions in academic medicine. The barriers to entry and then to progression up the ranks are sometimes blatant, but more often quite subtle. The lack of females in higher academic positions creates an absence of role models outside of the traditional career choices for women. The dearth of female faculty also ulti-

mately influences curriculum, policy and guideline development at the university level. The case of women in medicine is paralleled by the situation for ethnic minorities. Cultural diversity of faculty is lacking, and it is lacking more at the higher ranks.^{24,28}

Learning From History

Women have been there forever. There are references to women healers in the Bible, and there is evidence of women learning alongside men in the great Egyptian medical schools.^{26,27} Isis was the goddess of medicine, with magnificent temples devoted to her and priestesses who were regarded as healer/physicians who drew their powers from her. The first evidence of a women's medical school was in 1,700 BC. From all accounts, the women in this era were educated as surgeons, anatomists and healers equal to the men.

How many of us know Pythagoras? How many know that the first book on child welfare was written by his wife and daughters in the 6th century BC? We all know Aristotle. How many know his wife, Pythius, who co-wrote an encyclopedia of physiology histology embryology and biology (350 BC).

Aristotle's obstetric school was open to all. We hear of Philista, however, who is forced to lecture from behind a screen because her incredible beauty was too great a distraction.

During the witch hunts of the 13th to 18th centuries, women were edged out of the medical profession and lost access to formal education. By the 17th century, even midwifery was lost to women, although women were allowed to assist as subordinates to physicians.

Dr. James Barry, a brilliant, if somewhat crude physician, was nominated inspector general of Hospitals of Upper and Lower Canada in 1857. A graduate of University of Edinburgh in 1812, he was considered particularly eccentric. He was a

pioneer of many health reforms, in between political run-ins, and remained very private about himself. It was only after his death that his true female sex was realized. His secret allowed him to study medicine. The university would never have accepted a female student in 1809. The very idea of it was preposterous. In 1873, one Harvard professor named Clark wrote that studying medicine would cause women to grow monstrous brains and puny bodies. This fits with theories of women's health of the time, which reflected the belief that women had a certain amount of life energy needed for reproduction, and if that energy was diverted to the brain, the reproductive organs would suffer.

Similarly, in Canada, institutes of learning were for men only. It was believed female students would be bad for discipline and medicine would "soil their modesty" and be too difficult to understand.

In an age when many women wouldn't see doctors because being examined by a man was considered immodest, Elizabeth Blackwell (1821) fought for entry into medicine for women. Refusing to disguise herself as a man, she was denied entry by most schools. She slipped in at Geneva Medical College in New York. Upon graduating, she was barred from practising in New York hospitals, was ignored by colleagues and was mistaken for a prostitute when doing house calls in the evening. In her mission to overcome these obstacles, she later founded the New York Infirmary for Women and Children. This was a hospital run and supported financially by women and was the first of many of its kind. Johns Hopkins was founded in 1893 by Mary Elizabeth Garrett. In a historic agreement, its opening became conditional on equal access to men and women, the first model of co-education in medicine.

The down-side of co-ed schools was the impression of equality they gave. Once women were allowed to attend men's institutions, there seemed no need for women-only schools. By the turn of the

century, all but one of these schools closed. The irony was that the "feminization" of medicine was blamed for the economic downturn for physicians. An 1898 editorial in the *Journal of American Medical Association* (JAMA) stated: "The profession is overcrowded to the starving point." The presence of women in medicine was blamed for the drop in salary and in prestige. One by one, the medical schools reduced and then stopped accepting women's applications or set up more subtle barriers to their attendance. Women graduates at Johns Hopkins fell from 33% in 1896 to 3% in 1910.

Women's roles over history have ranged from deities, to respected colleagues, to alleged witches, to intruders into the male medical establishment, and back to respected peers once again.

In Canada, medical schools had agreed reluctantly to a limited enrollment of women (University of Toronto in 1870 and Queen's in 1880). The atmosphere was hostile and ultimately, these attitudes led to bans on women students in 1883. The quotas of the late 1800s persisted until the late 1960s.

Emily Stowe was the first woman to practise medicine in Canada. She was not able to study in Canada, as women were not allowed into Canadian schools, nor was she able to get a qualifying year in Canada for her license, so she practised illegally. She and her sisters later founded the women's medical school affiliated with the University of Toronto. Stowe's daughter, Augusta Stowe, was the first woman to graduate from a Canadian program in 1883. That same year, Dr. Jennie Trout founded the Kingston Women's

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Medical College. The school was designed to give women separate, but equal, medical education. They also created a separate place to sit through awkward lectures, such as obstetrics, so they wouldn't be seen blushing.

How much has really changed? It was not until the 1970s that things started to change. The rise of feminism and affirmative action are considered the reasons for the improved atmosphere for women in medicine. In 1960, 5.8% of incoming students were female. In 1971, this increased to 14%, following the Equal Opportunity Act. By 1990, one in five students was female.

Women's roles over history have ranged from deities, to respected colleagues, to alleged witches, to intruders into the male medical establishment, and back to respected peers once again. History has alternately helped and hindered women over time, as social, religious and scientific ideologies have evolved to what they are in Canada today.

A Look To The Future, Educated By History

We have yet to see the impact of women in family medicine. Women are more likely to spend their younger years raising children and then to subsequently re-enter the workforce. New parental leave policies may influence men to do the same.

Burnout issues apply to all physicians, however, the issues creating them may differ.² While men have had longer work hours, the issue of multiple role demands is a main cause of burnout in women. Choosing a "lifestyle" is not a gender issue, but may result in an equalization of hours worked over a career span.

It is fascinating to use history to guide the future. Elizabeth Blackwell coined a principle she called "conscious responsibility."⁴ One hundred years ago she described the importance of

women's potential for exorcising the demons of the old order. In 1889, she wrote: "Methods and conclusions formed by one half of the race only, must necessarily require revision as the other half of humanity rises into conscious responsibility." If we are proactive, history need not repeat itself. This conscious responsibility described over 100 years ago, and rewritten for today by Achterberg, is still very relevant.⁴ Changes expected to the health-care system in Achterberg's view, from women following Blackwell's descriptions of conscious responsibility, are outlined in the following quotation:

- Differences in the nature of medical education and in the practice of medicine itself;
- A shift from the hierarchy of a power-based health system to one of more egalitarian proportions;
- The elevation of women's professions to higher levels of competency, respect and responsibility;
- More attention to larger systems of health, including the ecology of the earth;
- The inclusion of therapeutics that treat the mental and spiritual aspects of health within the mainstream of health care; and
- A more human-centered healing system, which will be assured if the feminine nurturing voice is included.⁴

How far have we come on that path?

Conclusion

Women FPs must be doing something right to have gained their level of public and patient support. The perceived gender gap has been qualified and quantified by studies presented. The actual differences in career choice, practice patterns, promotion and pay are still very obvious. If true equity is ever found between men and women in medicine, or if we can bridge the gen-

der gap in the approach to patients, discussions such as this one will no longer be necessary. Hopefully, we will attain a more balanced profession in the future. CME

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