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Women in Medicine: Recognition and Responsibility

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In the mid-1960s, only 6 percent of the students enrolled in U.S. medical schools were women [1]. By the mid-1970s, the number of women graduating from U.S. medical schools had risen to only 16 percent [2]. By the 2004-2005 academic year, women represented 50 percent of applicants, 49 percent of matriculating medical students, 47 percent of graduates of U.S. medical schools, and 42 percent of residents and fellows [3]. While obvious disparities remain for women in medicine—especially as one looks higher up the institutional ladder—the gains, so far, have been solid and enduring.

Prior to 1968, approximately 2.5 percent of American physicians were African American (and virtually all were trained at Howard or Meharry) and less than 0.2 percent of medical students were Mexican American, Puerto Rican, or American Indian/Native Alaskan—this at a time when minorities represented, depending on which resource one cites [4, 5], between 12 and 12.8 percent of the general population. Underrepresented minorities finally reached 12.1 percent of the 1999-2000 first-year medical school class, but, by then, according to U.S. Census Bureau 2000 estimates, African Americans, American Indians and Alaska Natives, and Hispanics represented 25 percent of the U.S. population [6]. Even more troubling, however, is the fact that, as of 2005, racial and ethnic minorities (black, Hispanic, Native American/Alaska Native, and Native Hawaiian/Other Pacific Islander) still accounted for less than 10 percent of all U.S. physicians and surgeons [7].

Fortunately, as the number of women applicants to medical schools has grown, the numbers of racial and ethnic minority women applicants have also steadily increased. Among minority women applicants, black women have made the greatest gains. In 2004, black women accounted for nearly 70 percent of all black applicants to medical school [8]. This statistic defines a trend across many racial and ethnic minorities; men have not fared as well as women. Between 1995 and 2000, minority matriculation for men at medical schools dropped by 15 percent [9]. Thus, despite efforts to reach more equitable minority representation in medicine, most minority groups remain underrepresented, whether as graduates of medical schools or as practicing physicians.

What does this latter, disturbing set of statistics about underrepresented minorities have to do with the question of sex and gender in medicine? More than one might

initially appreciate. As the victims of entrenched prejudice in business and academia (foreshortened ladders, glass ceilings, closed doors—the usual suspects) women, despite accounting for 50.7 percent of the population, know only too well—and first hand—the effects of prejudicial thinking and behavior. Members of racial or ethnic minority groups who are women have more experience in applying strategies for obtaining what they want from the majority culture—hence the gains by racial and ethnic minority women mentioned above. Sure, women still have an uphill battle despite being the majority sex, but, pragmatically speaking, wouldn't the struggle be a bit easier if *the rest* of our underrepresented minorities—that is, not only the remaining underrepresented female minorities, but the *males* too—were included? And, pure pragmatics aside, isn't it simply “the right thing to do”?

Medicine—like any other social institution—is always, in large part, a reflection of the culture in which it exists and, historically, racism and sexism have, unfortunately, been endemic to U.S. culture. I submit that this is an artifact based largely on an erroneous assumption; namely that, for the most part, culture is—and rightfully ought to be—perceived and understood through some dominant, monolithic viewpoint. But cultures are pluralistic; there are nearly as many conflicting and competing values, interests, and goals as there are persons within a culture. Moreover, it does precious little good to replace one dominant, monolithic viewpoint (i.e., white male) with another, whatever its stripe. The way out of such zero-sum game thinking is to recognize and celebrate differences as strengths, not weaknesses.

Differences are strengths because they force us to develop more rigorous and inclusive intellectual habits that serve as means to the shared twin goals of justice and respect for individuals. Just as binocular vision is a vast improvement over monocular, hearing about a problematic situation from multiple perspectives will nearly always enlighten our own understanding of it and reveal the existence of a much broader, richer range of “live options” available to us for crafting an equitable solution with more sensitivity and respect for all relevantly affected.

Long before the relatively recent interest and scholarship in what has come to be called “feminist ethics,” John Dewey, in his 1919 essay, “Philosophy and Democracy,” declared:

Women have as yet made little contribution to philosophy. But when women who are not mere students of other persons' philosophy set out to write it, we cannot conceive that it will be the same in viewpoint or tenor as that composed from the standpoint of the different masculine experience of things [10].

For Dewey, women's philosophical writing would be a *good* thing, a breath of fresh air. What makes democracy vibrant and rich with promise is the recognition and celebration of such differences. A single philosophy or perspective must never be permitted to “overcome” or “replace” another; rather, it should be welcomed as one more intellectual tool for crafting respectful, equitable solutions.

So, this underrepresented minority philosopher takes your leave by way of the three questions (often explicit, but always there—even if hidden from view) Plato raised in his famous dialogues via his protagonist, Socrates:

- Where have you/we come from?
- Where are you/we going?
- How will you/we get there?

The answer to the first question is as diverse as the numbers of persons asking and answering—and that’s a *good* thing. The answer to the second question stems from the commonalities that unite us—our human nature and our basic drive to develop our interests and talents to the greatest extent possible.

The answer to the third question is not “out there somewhere,” waiting to be found; it is not imposed “by nature” or from within. Rather, it is hammered out in the course of engaged and respectful dialog by those with different points of view. And, even in the singular, where this question is posed as an internal “dialog” with oneself, what we are really doing is posing, in our mind’s eye, a hypothetical “other” with whom we can critically rehearse a defense for a favored point of view.

If women answer this all-important third question by trying to impose a “new” perspective for the field of medicine—not an unusual outcome when groups finally acquire power—then one form of domination will merely have been replaced by another. But if the women of medicine can wield their relatively new and increasingly powerful influence to transcend difference by bringing everyone to the table, by listening with charity to everyone’s points of view, and by discussing the strengths and weaknesses of various viewpoints, they will truly transform both medicine and its individual practitioners.

As an underrepresented cousin in the field of philosophy, I eagerly wait to see how women in medicine go about answering that all-important third question.

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