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MEDICINE AND SOCIETY

The Feminization of Medicine

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Out of the mouths of the medical establishment has come the term, "the feminization of medicine." The increased number of women in medicine is cited as the cause of the changing face of medical practice. We need to acknowledge the real reasons for much of this change, namely the shift in societal values, bureaucratic control, and the lack of adequate resources to provide timely care. We need to welcome women into the leadership network that has been historically all men. As physicians, both men and women need to work on an equal basis to ensure that the public receives the care it needs despite ongoing reform in the delivery of health care.

Women comprise 50 to 60 percent of medical students in Canada and the US today. Compare this to my year of graduation from the University of Alberta Medical School in 1974, where I was 1 of 20 women in a class of 100, or to the year 1953, when 4 of 50 graduates were women. It is predicted that by the year 2020 in Canada, women physicians in practice will outnumber men physicians.

What makes the thought of the increasing number of women in medicine a worry to many? The Medical Women's International Association identifies the threat of medicine becoming a "pink collar profession," losing the status and influence and monetary compensation traditionally attached to the practice of medicine. When you compare medicine to the more-women-dominated professions of nursing and education, the difference in status, influence, and monetary compensation is readily apparent. Inside the profession of medicine, one sees that the woman-predominant specialties are often lower paid. This is due, in part, to the fact that women choose specialties that allow more flexibility and therefore ability to balance their lives; the fee schedule for these specialties is not as great as for other specialties that are male-dominated. Another factor in lower pay for women physicians is that women often practice differently, spending more time with patients. In a fee-for-service setting fewer patient visits equals less money. If one glances further afield to the former communist countries such as Russia, where women have dominated the profession for many years, the fear of loss of status escalates.

Medicine has always been considered a man's job. Even when the number of women in medical schools was small, there were mutterings of what a waste of time it was to train women. It was felt that once trained, they would marry and drop out of the workforce. The unspoken thought was that they would deprive dedicated

young men of the opportunity for training, on the presumption that men would contribute more time to the practice of medicine than their women counterparts. However, this has not proven to be true. It is true that some women work part-time in clinical practices or in salaried jobs while raising their children, but they often return to full-time practice and involvement in organized medicine once their children are raised. When men physicians reach the stage of their career when they are decreasing their working hours, women physicians are increasing theirs and working for more years than the men.

Concurrent with the increasing enrollment of women in medical schools, the attitudes of society have changed. As a consequence, medical students of today prefer to work for a living rather than living only to work. This is equally true for men as for women. They have demanded and obtained a better balance to life. They want reasonable hours of work, more sharing of responsibility, time for family and recreation, and a good income.

If this change is to be blamed on more women in medicine, should they be congratulated or rebuked? Is it indeed such a bad change?

Personally, I feel that women physicians should be congratulated. Some of the changes in medical practice that are attributed to women have been long overdue and are equally advantageous for men as for women. Such changes are more flexible residency training programs, part-time work, maternity and paternity leave, and tax benefits for daycare costs. All these changes contribute to making more time for family life and leisure activities, which benefits both women and men physicians. Women's influence on medicine has made it acceptable for physicians of both sexes to refuse to work to the point of physical and mental exhaustion. Having a balance between work and home often reduces physician burn-out.

Those entering medical school still have that inner passion and altruistic vision that they are contributing to society in a positive way. When you compare medicine to professions such as accounting and law, the average physician works the same number of regular hours. New physicians acknowledge the need for 24/7 medical care, but they are unwilling to be always available. In many cases these physicians' expectations have changed the way medicine provides 24/7 coverage. One example of this change is the increasing use of hospitalists, salaried physicians who do regular shifts to care for hospitalized patients. Another example is the demise of the solo practice family doctor and the birth of large groups where physicians work shifts to provide coverage. New physicians are not willing to shoulder the burden of family practice with responsibility that is never-ending while their counterparts do a shift in the walk-in clinic for better remuneration and defined working hours. Such changes in practice have been accompanied, however, by the loss of personal touch in medical practice.

One of the criticisms of women physicians is that they do not take their share of leadership roles. This is not always by choice. Not all women physicians are

content to limit their role to the practice of clinical medicine. Many medical organizations pay lip service to wanting more women on their boards because doing so appears politically correct. However, once a woman shows that she has ability and appears to be headed for a role normally earmarked for a man, she encounters the very real glass ceiling that stops her from reaching her leadership potential.

Those who worry that medicine might become devalued as a "pink collar profession" should instead recognize all physicians—women and men—who have leadership potential and mentor them now for their future leadership roles. My second suggestion is that we acknowledge the positive changes in medical practice that happened as more women have entered the profession and move beyond blaming women physicians for the unpleasant changes. We must recognize other causes for these changes that reduce physician autonomy such as the lack of resources and third-party control. My third suggestion is that we move beyond the insistence that the new graduates work as we have always worked. We must admit that their way may be better than ours. Let us move on to finding ways to deliver health care that will meet the needs of both the public and the physician. Bright minds are not going to be attracted to a profession that fails to provide job satisfaction, status, influence, and monetary reward.

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