Commentary

The Future Impact of Women Physicians On American Medicine

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The women of the United States, an emergent majority, are presently undergoing a period of intensive introspection, self-analysis, and role realignment. We owe much of the present realization of inadequacies in feminine health care, not to the medical establishment, but to the feminist movement. Consumer interests, as well as "developing health professional" concerns, have successfully challenged the male dominated medical profession, and forced it to begin to confront its many weaknesses and inconsistencies. While women's health centers have been waging a sort of guerrilla warfare in the nation's storefronts, the academicians of the women's studies movement have reawakened interest in the history of medicine and public health, to try to recreate the obliterated role of women healers of other times and other countries. What is behind these theoretical and practical exercises is a health constituency searching for the most effective ways of influencing public policy on behalf of their specific needs.

One major phenomenon which clearly has the *potential* for effecting change in health care is the overwhelming increase in the number of women entering the nation's medical schools; their very numbers may open the door to change. This possibility is consistent with the belief that, despite the inroads of unorthodox and lay interests, the power base of health care will continue to lie in physicians themselves, and the influence they will wield over their own institutions.

Fifteen years ago, only six per cent of incoming freshman medical students were women.[1,2] This figure began to change in 1971 with the passage of Title VII of Public Law 92-147, which prohibited discrimination in educational opportunities, and with the passage of an amendment to the Health Manpower Act during the same year. Title IX of the Higher Education Act amendments of 1972 further aided a precipitous rise, which could soon be charted graphically as a bold line going up at a 45 degree angle. By 1975, when female enrollment passed the 20 per cent mark, there were predictions that within 10 to 15 years one-half the nation's graduating physicians would be female.[3] It appears, however, to have leveled off at about 30 per cent for the moment.*

The new women entering medicine are being studied by fellow physicians and social scientists, as well as the American Medical Women's Association, which this year celebrates its 50th anniversary of advocacy for women in medicine. And they are rapidly overturning everything we thought we knew about women physicians.

A few years ago we could have summed it all up neatly.[1-2,5-10] We knew, for example, that women favored the three P's: 22 percent of pediatricians, 20 per cent of public health physicians, and 25 per cent of the child psychiatrists were women. Sixty-five per cent of all women in medicine were in the above specialties or internal medicine. Only 3 per cent of obstetrician-gynecologists were women; there were only 10 thoracic surgeons, six colon and rectal surgeons, and 43 orthopedic surgeons of the female gender in the entire United States. Almost half of the women physicians practiced in 11 states: New York, California, Pennsylvania, Illinois, New Jersey, Massachusetts, Ohio, Michigan, Maryland, Texas, and Florida, in that order. Many women physicians had parents with higher education, and professional

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*The number of women in dentistry and veterinary medicine has also been increasing. The New York State College of Veterinary Medicine at Cornell University reports that the class of 1981 is over 50 per cent female, compared with a ratio of one in twenty 15 years ago.[4] The rationalization for this shift borders on the ludicrous: it is said that with the introduction of tranquilizers, women are now capable of handling large animals!

fathers. They tended to marry physicians or other professionals, but usually made less money than their doctor husbands.[5,6] A large number did not marry, and those who did had fewer if any children, often long delayed. Women physicians, particularly unmarried ones, had relatively high suicide rates, and at a younger age, compared both to male physicians and the general population. Women physicians did tend to drop out in early child-bearing years, but lived longer and practiced longer than their male colleagues, whose drop-out rates, less well publicized, were due primarily to military duty which nipped them in their youth, and heart attacks, which polished them off when they grew old. Although 4,000 women served on teaching staffs, less than 3 per cent of full professors in medical schools were women. At this time there is still not one full-time female dean of a U.S. medical school.[11]

There was little doubt that women physicians, clustered as they were in less prestigious specialties, and with lower incomes than men, bore close resemblance to women with doctorates in other fields, who also had lower salaries, lower employment status, fewer supervisory responsibilities, and who received less recognition.[12] Although embracing a wide variety of political viewpoints, a number were sufficiently conservative to cause Vicente Navarro to suggest that, as a group, they identified more with male physicians than with other women health workers and women patients.[13]

These data are beginning to shift, and the changes appear to be significant for the future of medical practice. The new women coming into medicine are choosing more and more to go into private practice, are working longer hours, are more insistent upon recompense, and are moving into more varied disciplines, including surgery and its subspecialties. A recent study of 166 men and 95 women students at the University of Colorado and the University of California, San Diego, medical schools showed women, as well as men, ranking family practice as their first choice of specialty—followed by pediatrics, internal medicine, and psychiatry.[14]

Why are women choosing medicine? Cartwright,[15] who studied 58 female medical students at the University of California, San Francisco, found no fewer than 173 reasons given for studying medicine, of which seven predominated. Ranked in order of importance, these included: encouragement from others (57 per cent), long-standing interest (48 per cent), desire for self-development (43 per cent), altruism (34 per cent), unfavorable evaluation of alternatives (34 per cent), response to adversity (22 per cent), tradition (21 per cent), actualization of parental dreams (17 per cent), counter-striving against negative influence (5 per cent), quest for admiration, respect and status (5 per cent), financial security (5 per cent), and "other" (5 per cent). Economic and prestige factors were seldom mentioned.

There are as yet no studies to confirm the impressions I gather from talking to students—that an increasing number of women are entering medicine because of deep personal involvement in the health problems of other women, and the realization that a degree in medicine is mandatory as a power base from which to launch their own individual health revolution. As recruits from the health movement, often with previous training in another health discipline, they are dedicated to advancing the interests of women as patients.

My impression of these women is that, unlike so many of their male colleagues, they work well with other women health professionals, whose opinions and skills they are more inclined to view with respect rather than suspicion. They appear more vocal in protecting themselves from the slurs and prejudices against women which have permeated academic environments. They do not endure "cheesecake" anatomy slides gladly. They rebuke their professors when subjected to sexist remarks, and are extraordinarily sensitive to invasions of the privacy of their patients, unethical professional behavior, and the arrogance of power. They are aware of how isolated and disunited the women of a previous generation were, and establish mutual support networks to countervail the "old boy" bonding of the operating room locker rooms.[16] They appear unwilling to give up the female presence in a male dominated atmosphere, and are not flattered to be considered "one of the guys." They are not ready to sacrifice home, husband, and outside interests to a hard-driving career, but differ from their older colleagues in that they will not accept a second-class career as a compromise. In making more demands of the system to bend to what they perceive to be their legitimate needs, they have caused male colleagues to question their own attitudes, lifestyles, and career models, with the result that greater flexibility is now being sought for men as well as women.[17,18]

Do women bring to medicine a distinctly feminine world view, which makes them more sensitive, more empathic, more intuitive? If so, is it culturally or genetically determined? There are those who believe, and I suspect I am one of them, that the answer should be "yes" for one or both reasons.[19] In any event, the behavioral scientists are working on the question. Cartwright, for example, in a study of personality differences between male and female medical students, found that women were more sensitive to relationship values, more accepting of feelings, and more inclined to value independence and individuality to a greater extent than their male colleagues.[20]

If these women are going to change the face of medical practice, as I believe they have the ultimate power to do, there is a great deal they are going to have to overcome. An excellent description of the forces which throttle the capacities of women physicians to change the health care system has been provided by Heins, et al.[7–9] Trained interviewers, using two control groups, did a large productivity study as part of a project on the practice and life patterns of men and women physicians. One in three non-foreign born women physicians in the Detroit, Michigan area answered a 207-item questionnaire. They found that women moved more often than men, presumably to be near their husbands. Although they had more medical training than men, only 54 per cent of the women, compared to 74 per cent of the men, were board certified. Forty-eight per cent of the women vs. 67 per cent of the men, interrupted their training at some point (due to marriage or military service. The phenomenon of interruptions in career training has also been reported on by Cartwright.)[21] At the time of the survey, 96 per cent of the men, and 84 per cent of the women were working, but it was im-

possible to compare the hours worked, as men tended to include their "on call" hours, and women tended to overlook their informal and volunteer assignments.

More than twice as many women as men worked for someone else; 61 per cent of the women, compared to 46 per cent of the men said they were a "staff doctor." In industry, government, and medical education, 43 per cent of the men and only 10 per cent of the women held top level administrative jobs. More men than women belonged to professional organizations, and men were slightly more active in these than were women.

When asked about work overload, three times as many men as women felt that office pressures were the reason, with women attributing pressure to home and child care rather than professional responsibilities. Three times as many men as women felt they should cut down on work at the office, while nearly 50 per cent of the women felt they needed more help at home. Although 70 per cent of the women physicians reported having domestic help at least one day a week, 76 per cent said they do all the cooking, shopping, child care, and money management. Nearly 100 per cent of women physicians have the responsibility for virtually all household tasks, whereas male physicians had none.

When questioned as to stress, 36 per cent of the women and 15 per cent of the men mentioned "conflict between work and outside life." Almost twice as many women as men (94 per cent to 57 per cent) perceived conflicts between career and traditional role relationships with members of the opposite sex. However, significantly fewer women (18 per cent) than men (63 per cent) expressed general feelings of stress about working too much. Lastly, more women than men felt they needed to modify themselves in some way.

Examining the implications of these data, we find ourselves confronting recurrent and contradictory themes.

On the one hand, we have an image of the average older woman physician today: she is the aggressive product of discriminatory admissions policies; qualified, productive, yet lower paid; has slower career advancement and recognition; and is clearly committed to home and family responsibilities deemed worthy of major professional sacrifice. She is underrepresented in all seats of power, less active in the public arena, depends on someone else for her paycheck, and is politically uninvolved. She tends to undervalue her own clout, blames herself when caught in the crunch, and is still a servant to her household. There is a good-natured, self-effacing, plodding, salt-of-the-earth type image coming across from these findings. She is the kind of woman who in large numbers could easily do to American medicine what the feminization of medicine did to the countries of the Soviet bloc.

On the other hand, we have the new woman physician. She is a composite of egalitarian principles, and her husband knows which end of the diaper pin is up. A product of a role-liberating society which made her career a matter of course rather than another breakthrough, she can meet her classmates 20 years hence without having to ask them, "Did you ever get married? How old are your kids?" Because all her energies will not have been spent desperately scrounging flex-time residencies, day care, household help, self-regulated working hours, a raise, an academic appointment, tax advantages, and a piece of the power pie, she may be given an opportunity for the first time since women were admitted to medical colleges to show what she can do as a physician—not just a "woman" physician.

The question concerning us is "What is she going to do with it?" A number of factors will determine this. First, women's achievement will, in part, be dependent upon the extent of the backlash which may develop in response to the menacingly shifting equilibrium in one of men's most powerful fiefdoms. Women constituted one-fifth of the practicing physicians in Boston at the turn of the century, a representation swiftly and systematically destroyed as vengeful males reasserted their authority over a lucrative and prestigious profession through its medical schools. Walsh has pointed out that without solidarity, a secure power base, and a truce between feminism and professionalism, the gains of women doctors could be wiped out as they were 75 years ago.[22]

Another variable will be the strength and magnitude of the cooptive forces exerted upon women by a seductive profession that offers seemingly limitless opportunity for personal and professional corruption. The temptation to yield to materialistic concerns, restless upward striving, and the direct benefits of power and status have deflected many young men from their chosen path. Can we say, without blatant sexism, that women are somehow purer?

A third determinant will be the flexibility and fortitude with which women react to the above. The mass infusion of women into medicine will bring adjustive problems on a grand scale. Although we live in a world of social experimentation, only the most naive would consider that the eternal conflicts between feminine nature, upbringing, biological role, and professional aspirations are as close to resolution as some would have us believe.[23]

Assuming that the future will bring some resolution of the issues of backlash, cooptation and adaptation, one further consideration is noteworthy. As public health professionals, we realize that physicians, despite their power role, provide end-stage treatment rather than the broad-based preventive services which determine the ultimate health of the population. Paradoxically, women physicians are moving *away* from public health, and will exert their influence primarily as clinicians. How then can we hope that by their numbers and influence they will effect change that is meaningful? We have reason to believe that as a group they may be more personally aware of home and community as environmental sources to be tapped rather than ignored; more amenable to fusion of preventive and clinical services in their offices; less inclined to substitute technical procedures for human services; and more discerning of the essence of the complicated hurt that brings patients to health care personnel. They may even restore some measure of common sense to medicine's various excesses.

REFERENCES

1. Fisher-Stevens Report, American Medical Association, 1974.
2. Directory of Women Physicians in the U.S. 1973, First Edition. Center for Health Services Research and Development, American Medical Association, 1973.

3. Carlova J: Face It: Half Your Colleagues Will Be Female. Medical Economics, March 3, 1975, Vol. 52, pp. 151–166.
4. New York Times article, "Women at Cornell . . .", October 10, 1977.
5. Got Family Problems? They're worse for women MDs, Medical Economics, April 30, 1973, vol. 50, pp. 191–202.
6. Adams JW: Patient discrimination against women physicians. Journal of the American Medical Women's Association, 32:255–261, No. 7, July 1977.
7. Heins M, Smock S, Jacobs J, and Stein M: Productivity of women physicians, JAMA, 236:1961–1964, Oct. 25, 1976.
8. _____: Comparison of the productivity of women and men physicians, JAMA, 237:2514–2516, June 6, 1977.
9. _____: A profile of the woman physician, Journal of the American Medical Women's Association, 32:421–427, No. 11, Nov. 1977.
10. Finseth KA: Letter to the editor, re: suicide among women physicians. JAMA 237, No. 16, April 18, 1977.
11. Witte MH, Arem AJ, and Holguin M: Women physicians in United States medical schools: A preliminary report. Journal of the American Medical Women's Association, 31:211, 1976.
12. Finseth KA: Women Physicians, Connecticut Medicine, 40:143–144, No. 2, February 1976.
13. Navarro V: Medicine Under Capitalism. Prodist Publishing Company, New York, 1977.
14. Medical World News: Women Medical Students: Change in Specialty Preference, February 21, 1977.
15. Cartwright LK: Conscious factors entering into decisions of women to study medicine. Journal of Social Issues, Vol. 28, No. 2, 1972.
16. Finseth KA: Office for women in medicine: A model for social change. Journal of Medical Education, Nov. 1977, Vol. 52, pp. 928–930.
17. Medical World News: Mothers Liberate Specialty Training, July 13, 1973.
18. Wallace J: Part-time internships and residencies: Programs to be encouraged. Journal of the American Medical Women's Association, 24:566–570, No. 7, 1969.
19. Knight JA: Medical Student, Doctor in the Making. Chapter 11, *in* The Woman Medical Student. Appleton-Century-Crofts (paperback), 1973.
20. Cartwright LK: Personality differences in male and female medical students. Psychiatry Medicine, 3:213–218, 1972.
21. Cartwright LK: Continuity and noncontinuity in the careers of a sample of young women physicians. Journal of the American Medical Women's Association, 32:316–321, No. 9, 1977.
22. Walsh MR: Doctors Wanted, No Women Need Apply. Sexual Barriers in the Medical Profession 1835–1875. Yale University Press, 1977.
23. Nadelson T and Eisenberg L: The successful professional woman: On being married to one. American Journal of Psychiatry, Vol. 134, No. 10, October 1977, pp. 1071–1076.

Dr. R. Gerald Rice Receives 1977 Martha May Eliot Award

The 1977 recipient of the Martha May Eliot Award for unusual achievement in the field of maternal and child health is R. Gerald Rice, MD, Chief of the Bureau of Maternal and Child Health, Michigan Department of Health. Dr. Rice received the award, which consists of a $1,000 honorarium and a bronze plaque, on November 1, 1977 at a luncheon session sponsored by the Maternal and Child Health Section of the American Public Health Association during APHA's 105th Annual Meeting in Washington, DC.

Dr. Rice was recognized for his leadership among his peers over at least three decades; for bringing credibility to public service in the health care of maternal and child populations; for sustaining innovativeness, high quality, and forward thrust in planning and implementing child health activities; and for his numerous accomplishments as director of maternal and child health services in three States: Massachusetts, Pennsylvania, and Michigan. Dr. Rice was further cited for his deep commitment throughout his professional career in the practice of maternal and child health, and for his unusual ability to develop an effective understanding among state legislators in child health activities.

The Martha May Eliot Award, presented annually by APHA's Maternal and Child Health Section, was established in 1964 under a grant from Ross Laboratories. It is named in honor of the child health pioneer and former chief of the U.S. Children's Bureau.