

When Most Doctors Are Women: What Lies Ahead?

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The profession of medicine is becoming feminized: The number of women enrolled in medical school and residency programs has increased dramatically over the past several decades. Some researchers have examined how women are faring in the profession, but few have considered how feminization of the profession will affect patient care and health care systems, as well as the profession itself. We predict that notable changes may emerge in 4 domains: the patient–physician relationship, the local delivery of

care, the societal delivery of care, and the medical profession itself. We also consider the potential positive and negative consequences of a predominantly female physician workforce on these domains.

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The profession of medicine is becoming feminized: The number of women enrolled in medical school and residency programs has risen dramatically over the past several decades. In the United States, women make up more than 50% of matriculating medical students and 25% of practicing physicians (1). This striking change prompted us to explore how the increased proportion of female physicians may shape the future of the medical profession. What are the implications of a physician workforce in which the number of women equals, or exceeds, the number of men?

Over the past several decades, studies have compared female physicians with their male colleagues on the basis of practice characteristics, advancement in academics, and attainment of leadership positions in institutions and professional associations (2–7). Some researchers have examined how women are faring in the profession, but few have considered how feminization of the profession will affect patient care and health care systems, as well as the profession itself. Our insights into this issue are informed by literature from medicine and from business and law, which have experienced similar changes in demographic characteristics of the workforce. We predict that notable changes may emerge in 4 domains: the patient–physician relationship, the local delivery of care, the societal delivery of care, and the medical profession itself.

THE PATIENT–PHYSICIAN RELATIONSHIP

The Institute of Medicine articulated the importance of striving to provide patient-centered care that “encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient” (8). Two dimensions are inherent to this definition: Physicians should engage each patient in a process of making health care decisions, and they should demonstrate emotional sensitivity toward each patient’s circumstances.

Evidence suggests that women are well-equipped to satisfy both of these elements of patient-centered care in their one-on-one relationships with patients. A meta-analysis of 26 communication studies found that female physicians are more likely than their male counterparts to en-

gage patients as active partners in their care (9). Women typically adopt a democratic style of communication that fosters collaborative relationships. They discuss treatment options, elicit patients’ preferences, and engage patients in making decisions. Also consistent with the principle of patient-centered care, female physicians’ communication style tends to be sensitive not only to patients’ biomedical concerns but also to their emotional concerns. Female physicians offer more emotional support, encouragement, and reassurance to their patients and engage in more psychosocial discussion than male physicians (9). Despite these positive communication behaviors, studies do not consistently show higher patient satisfaction with female physicians (10).

The tendency for women in medicine to provide patient-centered care has important implications for the profession. First, women are likely to be receptive to the new and evolving criteria for measuring competencies in this arena. Standard-setting organizations, such as the Accreditation Council for Graduate Medical Education, now require that physicians demonstrate effective communication skills. As we suggested earlier, female physicians are likely to meet or exceed these standards.

Second, the strengths that women demonstrate in patient-centered care may lead to important improvements in effectiveness and outcomes of care. Studies have demonstrated that patient-centered communication between physicians and patients can enhance outcomes of care, including patient adherence to treatment recommendations, biological outcomes in chronic disease, and patient satisfaction (11–13).

In contrast, feminization of the workforce raises an interesting question regarding care for male patients. Some patients prefer a provider of the same sex or ethnicity as themselves (14). Indeed, outcomes may be better when patients and providers are of the same sex (15, 16). The preponderance of female physicians in some primary care settings may make it difficult to obtain care from a male physician (17). Some men may be unable to find a male primary care physician, and this could affect their willingness to seek care, satisfaction, or other health outcomes.

LOCAL DELIVERY OF CARE

Models of health care delivery at the local level are changing rapidly toward a multidisciplinary team approach to patient care. Leadership is required not only to build these teams but also to help them function effectively. According to the Accreditation Council for Graduate Medical Education, the ability to effectively work with others in a health care team or medical professional group is a crucial skill (18).

Female physicians may be ready to meet the challenges of practice, which emphasizes a team approach. Several recent studies of leadership style indicate that women empower other team members to develop their potential, act as role models by gaining the trust and confidence of colleagues, and take an interest in the personal needs of their staff (19, 20). These components of “transformative leadership” may increase the effectiveness of medical teams and have positive implications for the local delivery of care.

Emerging evidence suggests that a team approach to chronic disease management is associated with improved patient outcomes (21, 22). We conjecture that the democratic and transformational view of teamwork held by women is likely to enhance chronic disease management; it may also support an open forum for discussion of patient safety, a related topic about which there is growing concern. Both of these areas require a systems-based approach, which depends on all members of the health care team providing their perspectives on best options for care and on willingness to openly analyze problems when they occur.

SOCIETAL DELIVERY OF CARE

At the societal level, we have a more ambivalent view of the implications of the increasing number of women in medicine. On one hand, female physicians are willing to work in less well-compensated medical positions and are more likely to practice in primary care specialties. On the other hand, their work patterns may aggravate problems related to patients’ access to health care.

The values of female physicians are congruent with the equitable use of health care resources; this position may steer the medical profession toward assuming responsibility for the care of underserved populations. Studies investigating the attitudes of medical students and practicing physicians have found that women are more likely to serve uninsured patients and to support single-payer national health insurance (23, 24). Female physicians are also more likely to work as medical directors of community and migrant health centers, which serve poor and underserved communities (25).

Regarding specialization, it is widely acknowledged that women tend to complete their residency training in the lower-paid, primary care specialties. A senior female colleague recently described female physicians as the “housewives” of the profession, that is, those who take responsibility for the profession’s “grunt work” in their

careers as general internists (Gantzer HE. Personal communication). Many of the tasks performed in these roles are arduous or may lack prestige; some are even altruistic. This situation is not unlike what is observed in the legal profession. Female lawyers are overrepresented in government and public-interest law, areas in which remuneration is minimal (26, 27). Although the optimal balance between primary care and subspecialty physicians is controversial, it is clear that primary care will be essential to the management of the increasing number of aging patients and patients with chronic disease.

Regarding work patterns, studies in the United States and Europe demonstrate that women work fewer hours per week and take time off for child rearing (2). At the same time, women stay in the workforce longer and retire later in life (28). Thus, the overall size of the effect on the workforce is not yet clear. In addition, women prefer to practice in urban rather than rural settings (3, 29). In rural settings, female physicians may experience professional isolation, lack of privacy, and lack of work opportunities for their spouses.

How, then, will a feminized medical profession affect society? The recent charter on medical professionalism (30) asserts physicians’ professional responsibility to improve access to medical care and to eliminate barriers to access. The willingness of female physicians to practice primary care and to serve less advantaged populations may support this commitment. However, female physicians tend to work fewer hours. To compensate may require the training of more physicians and the design of new programs to support medical care, particularly in rural areas. In essence, society may reap lower returns for its investment in medical education.

THE MEDICAL PROFESSION

We contend that women are changing the profession itself. Effects can be seen in the work–family balance, in leadership positions, and in the status of the profession in society. Women in medicine have forged new pathways to allow physicians to balance career and family responsibilities. There is widespread recognition that academic medical centers and health care delivery systems must accommodate the needs of their workforce. Academic medical centers have developed parental leave policies for trainees and have adjusted their time-to-tenure rules to allow faculty leaves (31, 32). Large physician practices and managed care organizations have developed policies to allow women to work part time. We speculate that the increasing presence of female physicians will continue the pressure on policymakers to foster flexibility to enable a balance between professional and personal life, helping both male and female physicians meet responsibilities to their own children, aging parents, and themselves.

Women are underrepresented in leadership positions in academic medicine, practice settings, and professional

medical organizations (33). This is similar to the legal profession, in which women are underrepresented as partners in law firms, and to the business world, in which women are less likely than men to be corporate executives (34, 35). The reasons for underrepresentation are not clear. Some argue that this is a cohort effect and that women will increasingly assume leadership roles as they mature in the medical establishment (4).

However, studies in academic medicine refute this argument by demonstrating that women continue to be considerably less likely than their male counterparts to occupy senior ranks (4, 7, 36). We have observed that many of our female colleagues who are qualified to apply for leadership positions choose not to do so. Either they believe themselves unlikely to be successful in the competition or they do not want to assume such roles in an environment where most of their colleagues would be men. In addition, unspoken fears that the culture of the profession is too competitive or even cutthroat may subtly lead women to shy away from these jobs. We suggest that as the proportion of female physicians continues to grow, the profession will need to encourage and support women in leadership. Otherwise, it will deprive itself of the diversity of work styles and values that women bring to the profession, as well as much of the capable pool of candidates to effectively fill such important positions.

A controversial speculation about the effect of feminization of the medical workforce is a decline in the status of the profession. In Russia and Estonia, where medicine has long been dominated by women, the profession is considered a low-status occupation (37, 38). It may be erroneous to conclude that a similar loss in prestige will result in North America without also heeding possible contributory factors, such as distinct cultural, political, and historical differences between societies. Granted, in the past 2 decades, during which the number of women in medicine has increased, the status of physicians has eroded in the public's view. However, the reasons for this decline are complex and multifactorial and pertain to trends in society far beyond the medical profession itself. In short, the phenomenon has not been adequately analyzed to make a prediction.

Instead, we speculate that the increasing number of women, particularly in leadership positions, may jeopardize the status of the profession in several other ways. As in most professions, women tend to command lower salaries than men in comparable positions (6, 39). To the degree that compensation is correlated with social status, increasing the number of female physicians with less earning power may lead to reduced status of the medical profession and less generous compensation for the profession as a whole. However, while this may result in the loss of a subset of medical school applicants for whom money is a priority, the remaining applicants may be more predisposed toward improving health care and other aspects of the medical profession.

Women are also often considered to be less aggressive negotiators in business matters. Less favorable negotiating on behalf of a practice or group may adversely affect both compensation and working conditions. In addition to a potential decrease in physician salaries, if women tend to "settle for less," there may be undesirable consequences for patients. For example, a physician may be required to see an increased number of patients per day in some health care settings; this may compromise patient satisfaction and quality of care. However, it is unclear how the balance of women's skills in negotiation, teamwork, and leadership might mitigate these undesirable outcomes.

CONCLUSIONS

We have shared our reflections in order to describe some of the potential effects of feminization of the physician workforce on the patient, the profession, and society. We explicitly do not contend that women make "better" physicians than men. Rather, we have highlighted some of the potential advantages and disadvantages of a physician workforce that more closely mirrors the gender balance in our society. To date, the data suggest that increasing numbers of women may differentially affect some specialties and care settings. While there are as yet few data with which to predict long-term effects, by anticipating the possible effects of these changes, we may be better positioned to capitalize on the advantages and prevent the disadvantages.

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