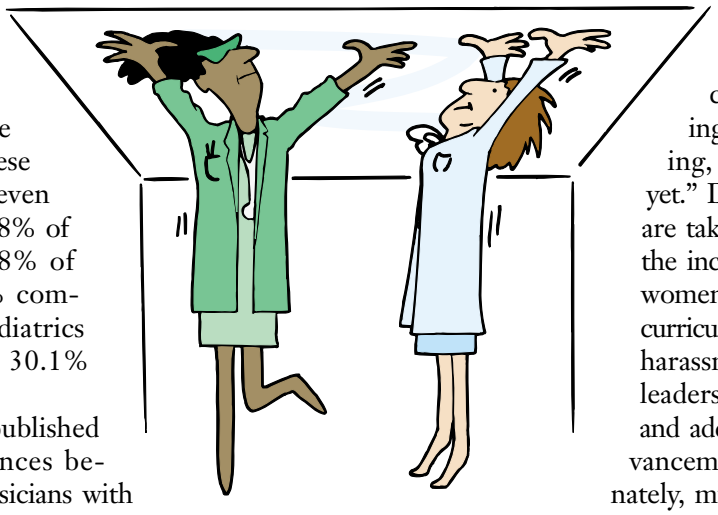
Cracking the glass ceiling

May Cohen, MD

In 1997, 26% of physicians in active practice in Canada were women. This proportion will continue to increase: in the academic year 1996–97, 50% of medical school enrollees were women. Although there has been an increase in the number of women entering virtually every specialty, the percentage of women trainees still varies widely from field to field, ranging from 66% in obstetrics and gynecology and in pediatrics, to 53% in family medicine, 40% in general internal medicine, 12% in neurosurgery and 7% in urology. On the basis of graduating students' first choices in the Canadian Resident Matching Service for 1997, we can expect these differences to persist and even to become more marked: 9.8% of women as opposed to 26.8% of men chose surgery; 10.7% compared with 5.5% chose pediatrics and 39.9% as opposed to 30.1% chose family medicine.



Many research articles published in 1997 examined differences between male and female physicians with respect to practice organization, time spent on professional and other activities, modes of remuneration, attitudes toward the health care system, rates of preventive interventions, utilization of diagnostic imaging, responsiveness to patient attitudes, rates of medical liability suits, the impact of gender on marriage, child-rearing and academic advancement, and the effects of sexual harassment and discrimination.

The Association of American Medical Colleges[1] reported that the number of women selected for academic leadership positions is not keeping pace either with the availability of talented female faculty members or with the need to achieve gender balance. This phenomenon was attributed to a complex combination of factors, including isolation, cultural stereotyping, sexism, lack of mentors, the difficulties of combining career and family responsibilities and the inflexibility of a system that was created decades ago to reflect the realities of men's careers. The situation is similar in Canada. There are no female deans in our 16 medical schools. However, a woman was appointed acting dean for 6 months in 1997, and committee membership lists of the Association of Canadian Medical Colleges suggest that there are now roughly 15 female associate deans.

The number of female clinical department chairs ranges from 0 to 2 per specialty, except in family medi-cine, where there are 4. Two chairs of women's health have been appointed. One department chair stated, "We are knocking up against the glass ceiling, but we haven't broken it yet." Despite this, women faculty are taking the lead in promoting the inclusion of a broad range of women's health issues within the curriculum: combating sexism and harassment, enhancing women's leadership roles, and identifying and addressing barriers to the advancement of women.[2] Unfortunately, much of the activity undertaken by women faculty is not well documented, nor are outcomes and the factors critical to success clearly identified.

Organized medicine has begun to recognize the importance of appropriate female representation in its decision-making bodies. The CMA is concerned that its future membership will decrease if women do not perceive the organization as responsive and relevant to them. Accordingly, the association has been trying to attract more women at all levels and has undertaken some important initiatives. These include annual leadership conferences for women in medicine, the publication of *Women in Medicine: the Canadian Experience*,[3] and the inclusion of issues specific to women physicians in its draft policy on physician stress. MD Management Ltd. has studied and responded to women's investment profiles and supports

many activities of women physicians. The CMA Gender Issues Committee has developed a template against which the organization can analyse proposed policies with respect to the gender of both physicians and patients. However, the organization is still unclear as to the most effective ways to introduce an awareness of gender issues into all policies and activities, and women are still under-represented on the CMA board and on most divisional boards.

Organized medicine in Canada lags behind the US in promoting and responding to the concerns of women physicians. The American Medical Association is extremely active in this regard and can serve as a role model. It has developed guidelines on maternal leave, child care, sexual harassment and gender-neutral language, sponsors an annual Women in Medicine month, and recently established a congress for women physicians.

Female representation and leadership is slowly increasing in Canadian medical organizations. The Royal College of Physicians and Surgeons of Canada recently appointed its first female director, and the Canadian Medical Protective Association has appointed its first female physician executive member. Currently, 4 of the provincial or territorial college registrars are women and, in the last year, women served as presidents of several professional organizations, including the CMA, the College of Family Physicians of Canada (CFPC) and the College of Family Physicians of Ontario. Unique among our medical organizations is the Federation of Medical Women of Canada (FMWC), which was founded in 1924. It actively promotes the role and status of women physicians. Many of medicine's current leaders honed their leadership skills through the Federation. This year, a number of women physicians have been recognized for a broad range of medical, social and political achievements and have provided leadership in responding to women's health needs.

Although the doors into medical school are now wide open for women, challenges remain. In the US some enduring differences between the experiences of male and female students have been reported.[4] Unfortunately, similar nationwide surveys have not been conducted in Canada. At the postgraduate level, the under-representation of women persists in some fields. This poses a potential risk to any specialty if it cannot attract and retain the best candidates *regardless* of sex. It is essential that we understand *all* the factors that influence specialty selection: not only the characteristics of learners, but the availability of role models and mentors, the attitudes of teachers and the prevailing attitude of the specialties toward women.

We must examine the practical and attitudinal barriers to women's advancement in the academic world and in organized medicine and find ways to overcome them. We *know* the difference that women leaders make in professional education, research and women's health care. However, we must be more rigorous in defining and understanding the factors that influence the impact that women make, including their leadership style.

Organized medicine must ensure that gender issues are addressed in its policies and planning. It must be more sensitive and responsive to the concerns of women physicians with respect to their professional well-being and the health of their patients. Women physicians are very concerned about the impact of health care reform on their patients, including very early discharge after mastectomy or childbirth or the assumption of the burden of care by women in the community (Dr. Judith C. Kazimirski, past president, CMA: personal communication, 1997). Regional boards must not fail to accommodate differences in practice patterns between men and women in their credentialing decisions. Organized medicine, in its extensive debate over health care reform, has failed to highlight such issues.

More research is required on the differences in practice patterns between men and women physicians; through longitudinal studies we can determine if these differences change over the course of the physician's career. How do differences in patient populations contribute to differences in practice? This information is essential for appropriate resource planning. Finally, we need a regularly updated, centralized source of information to track our progress in addressing the challenges that continue to face women in medicine.

References

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Dr. Cohen is Professor Emeritus in the Department of Family Medicine, Faculty of Health Sciences, McMaster University, Hamilton, Ont.