Women in Medicine: The Path Forward (for Medical Students)

Committee on Physician Health and Wellness ◆ Providing Education for Medical Students

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Learning Objectives

Upon completion of this activity, physicians should be able to:

1. Analyze the masculine culture of medicine and assess specialty-gender disparities,
2. Examine factors that contribute to role strain for female physicians and medical students;
3. Identify ethical goals to promote the leadership of women in medicine;
4. Evaluate the difference between patient care and mentorship given by female physicians and male physicians, including attendings;
5. Recognize the behaviors consistent with gender discrimination and harassment, and the ethical conflicts they pose; and
6. Employ strategies to effect cultural change in medicine.

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Focus

This activity examines factors that contribute to role strain for women in medicine. It evaluates the difference between patient care given by females and males in medicine and also discusses gender discrimination and harassment, and the ethical conflicts they pose. The activity addresses strategies to effect cultural change in medicine.

Target Audience

Medical students

I. Demographics, Gender Differences, and Workplace Issues

History of Women in Medicine

1849 — Elizabeth Blackwell, MD (New York): first female physician

1876 — Sarah Hackett Stevenson, MD (Illinois): first female physician to join the American Medical Association

1998 — Nancy Dickey, MD (Texas): first female president of AMA

Throughout the history of medicine, women have been instrumental pioneers for the field. Some of these pioneers started with forging their own medical education.

Born in London, Elizabeth Blackwell graduated first in her medical school class at Geneva Medical College in Geneva, New York. She was admitted after the administration left the decision up to the entering class. The student body believed the administration was playing a practical joke and voted unanimously to accept her. After her admission, both the administration and student body made efforts to hinder her education and training, limiting her access to resources because the information was deemed inappropriate for women. She managed to prevail despite these efforts and throughout her life tirelessly pursued advances in women's health as well as the inclusion of women in the field of medicine in both the United States and England. In 1868, she opened the Women's Medical College at the New York Infirmary for Women and Children, where she served as the chair of hygiene until her departure to England. There she founded the London School of Medicine for Women. (About.com, Women's History, at http://womenshistory.about.com/od/blackwellelizabeth/a/eliz_blackwell.htm accessed Sept. 8, 2016)

Sarah Hackett Stevenson was the first female physician to join AMA in 1876. She was a delegate from the Illinois State Medical Society. She opened doors in organizational medicine that eventually led

TEXAS MEDICAL ASSOCIATION
Physicians Caring for Texans

to the election of the first female president of AMA, a family practitioner from our own state, Nancy Dickey, MD, some 122 years later.

Workplace Equality

1965 — Title VII Civil Rights Act
1970 — National Organization for Women Class Action Suit Against Medical Schools
1971 — AMA identifies need for more women in medical schools
1975 — Resolution by AMA House of Delegates in opposition of sex discrimination in medical institutions
1990 — Policies (AMA) in medical institutions

Title VII of the Civil Rights Act prohibits discrimination in the workplace on the basis of gender and race/ethnicity. Unfortunately, organized medicine was slow to incorporate these protections, and in 1970, the National Organization for Women filed a successful class-action lawsuit against every U.S. medical school to ensure compliance with the civil rights legislation.

In 1971, the AMA House of Delegates adopted Board Report O: Physician Manpower and Medical Education, which identified the need for more women physicians, issues specific to women physicians and necessary changes to increase the number of women physicians.

In 1975, the AMA House of Delegates passed a resolution that opposed sex discrimination in medical institutions, including academic ones, focusing on payment disparities, hiring, and promotions.

After launching a national campaign, Women in Medicine Month, in 1990, the AMA House of Delegates adopted Women in Medicine Panel policy that tackled issues related to maternity leave, child care, and sexual harassment prevention. The AMA Office of Women's and Minority Health was established in 1992.

Changing Demographics

- About 50 percent of entering medical students are female
- About 30 percent of practicing physicians are female
- Percentage of female practicing physicians varies by specialty
- The percentage of female medical school faculty has shown a modest increase.

The most recent Association of American Medical Colleges (AAMC) Physician Specialty Data Book reported that women represent about 50 percent of graduating medical students and 46 percent of residents/fellows, but only 30 percent of all practicing physicians. This is a large increase from 1965, when women constituted less than 10 percent of the accepted graduating class.

Recent data from AAMC showed an increase of female medical school faculty from 29 percent in 2001 to 37 percent in 2012.

Understanding female physicians' choices to pursue careers in academic medicine will help address the gap regarding academic medicine as a practice option.

(Bauman 2014; Bruce 2015)

Culture of Medicine

- Culture of medicine remains male-dominant
- Male approach: "Find the disease and eliminate it." (assertive and agentic)
- Female approach: "Support the person in coping with the illness." (communal and nurturing)

Given historical roles and discrepancies in numbers between men and women in medicine, there are environmental pressures for women to ascribe to an existing "culture of guyness." Although changes have been made, there continues to be a "gender learning curve" for female medical students as they enter their clerkship rotations to incorporate more stereotypical male work roles. They perceive the culture of medicine as valuing male characteristics more than female characteristics, thus leading to a "masculinization" of sorts.

Female doctors often find they are met with less respect and confidence and are given less help than their male colleagues. In the doctor-nurse relationship, female physicians often are asked and expected to do more for themselves. Female nurses do fewer tasks for female physicians than for their male counterparts. In an attempt to dissipate the tension created by status differences between female nurses and physicians, female physicians often prioritize their personal relationships with nurses above their professional relationships.

Various authors have studied the differences in treatment approaches between men and women, generalizing these characteristics as either "masculine" or "feminine." More feminine qualities included engaging the patient as an active partner in their treatment and communicating in a more sensitive manner. Female communication styles are shown to improve health outcomes, lessen disenrollment in managed care plans, and decrease malpractice litigation.

(Bertakis 2012; Bruce 2015; Jerant 2013; Sandhu 2009)

Workplace Discrimination

Despite increased numbers of female physicians, they have:

- Lower salaries
- Slower rates of career advancement nationally
  - 69 percent of assistant professors/ instructors are women.
  - 18 percent of associate professors are women.
  - 12 percent of full professors are women.

When President Kennedy enacted the Equal Pay Act in 1963, women earned about 59 cents for every dollar earned by men. Progress has been made since then, but the pay gap persists, with women earning about 81 cents for every dollar earned by men.

Women are slower to achieve leadership positions in medicine, as indicated by these statistics.

(Despande 2011; Essary 2014)

Eliminating Discrimination

- Collaborate effectively with women through education
- Encourage mentorship
- Promote leadership training
- Exhibit transparency in pay criteria
- Offer flexible training

Educating administrative, clerical, and nursing staff can help eliminate discrimination in the workplace. To be most effective, continuing education on gender equality should reach inpatient, administrative, clerical, nursing staff, physicians, teachers, and students.

Providing mentorship from females outside and within medicine, as well as leadership training, improves female physician success. Women with strong leadership skills have decreased susceptibility to gender discrimination.

AMA adopted a report that details gender disparities in physician income and advancement, and makes specific recommendations for improvement, including greater transparency in pay

Civil Rights and Resources

- Title VII
- Title IX
- AAMC professionalism and intervention for faculty misconduct
- AAMC GWIMS
- AAMC questionnaire (MS2 and graduates)

As noted above, Title VII of the Civil Rights Act prohibits employment discrimination on the basis of race, color, religion, gender, and national origin. Title VII prohibits sexual harassment in places of employment. Title IX of the Civil Rights Act, the Education Amendments of 1972, prohibits discrimination on the basis of gender at educational institutions that receive federal funding. Title IX has broad implications; however, and the most recent emphasis has been on sexual violence and its prevention.

Students should use their local/campus resources for Title VII and XI reporting, and be informed about:

- Sexual harassment and sexual violence federal information and resources;
- AAMC professionalism and intervention for faculty misconduct (systematic innovation and prevention);
- AAMC Group on Women in Medicine and Science (GWIMS) resource guide — Title IX, gender equity, and the like;
- AAMC graduation questionnaire tracking student mistreatment, sexual advances, assault, and other issues; and
- AAMC Medical School Year Two Questionnaire (Y2Q) tracking student adjustment, stress, learning environment, and the like. AAMC administers this online questionnaire annually to all active, second-year medical students. It asks students to share their thoughts on a variety of topics, such as learning climate, adjustment to medical school, and career plans.

II. Sexual Harassment

Case Study No. 1: Dr. Martha
Sexual harassment of a female resident

- Dr. Martha, resident physician, assists a surgeon
- Groped while preparing for surgery
- Action taken to address sexual harassment

As a resident physician, Dr. Martha was assisting a surgeon. While they were preparing for surgery, he reached out and groped her as they passed. After a brief recovery from the shock, Dr. Martha waited until an appropriate time arrived when, as she passed him in the surgical hall, she told him, firmly, that they needed to talk in private. He agreed to do so.

Shortly thereafter, in a private room, Dr. Martha told the surgeon she was advising other female staff members that they should immediately inform her of any such behavior. She said she would take the reports from the two of them to the state medical board, which likely would cause him to have to answer to the board and might place his license in jeopardy.

At a later time, several female staff members reported to Dr. Martha. They wondered what had happened since the surgeon had changed his behavior toward all female staff and now behaved quite professionally. Dr. Martha later told the surgeon that she had not told her husband about the incident since she did not want him to be jailed for assault.

Definition of Sexual Harassment

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitutes sexual harassment when submission to or rejection of this conduct explicitly or implicitly affects an individual's employment, unreasonably interferes with an individual's work performance, or creates an intimidating, hostile, or offensive work environment.

Sexual harassment is prohibited under Title VII of the Civil Rights Act of 1964 and under Title IX in academic environments. Sexual harassment may be physical, verbal, or visual. The response of the victim determines whether a particular conduct is harassment.

(www.eeoc.gov/facts/fs-sex.html. Accessed Sept. 16, 2016)

Nuances of Sexual Harassment

- In the workplace (Worse during training due to power differential and hierarchy)
- In the patient-physician relationship

"Microinequities" are continuing small instances of gender discrimination and may include events, conscious and unconscious, such as the following:

- Being left out of informal networks of communication or information about opportunities for advancement because of negative presumptions about the individual's dedication;
- Invisibility, as when a woman's suggestion at a meeting is initially ignored and only validated when spoken by a man;
- Exploitation, as in assigning women a disproportionate clinical and teaching role; and
- Inaccurate attribution, when a woman's expressed idea/work is attributed to a male colleague.

Sexual Harassment: Protection

- School/Clinical setting: chaperone, door ajar/seating, setting limits
- Home: security and caller ID, unlisted number, do not give out pager/ Facebook/Twitter information
- Personal:
  - Professional dress, exam gloves
  - Attention to personal space

The underlying problem is abuse of power by the perpetrator rather than provocation by the victim.

When being sexually harassed by a patient, the student's appropriate actions could be:

- Having the confidence and courage to leave the exam room, even if it means walking out without any explanation for the departure;
- Refusing to provide further or ongoing care;
- Notifying appropriate supervisors or agencies as might be necessary (such as regulatory bodies);
- Wearing a coat and being more businesslike and controlling, which may successfully overcome the inverted power differential the patient is trying to create;
- Having a chaperone in the room when conducting an exam; and
- Redefining the situation as social rather than a personal problem.

Case Study No. 2: Ms. Alison
Sexual harassment of a female medical student

- Older married woman with three grade-school children
- Fourth-year medical student in internal medicine rotation
- Upper-level resident approaches her for sexual favors

Sexual harassment has been a long-standing problem in a system where the hierarchy of power puts medical students at the bottom, interns and residents in the middle, and attending physicians over them. Women are more likely to endure such harassment than men in a similar position. Consider this scenario.

Ms. Alison is an older married woman with three grade-school children. She is a fourth-year medical student responsible for patients in her internal medicine rotation. Ms. Alison's upper-level resident will not allow her to go home until she has checked out with him. He hints daily that she could leave sooner and with less hassle if she would give him sexual favors. Additionally, Ms. Alison can hear men laughing in the background when the resident makes a crude remark to her on the phone. The resident is in a position to give her a good or poor recommendation, and his evaluation may affect her grade and her future residency.

What should happen in this situation?

Key Ethical Challenges

- Autonomy: physician and patient
- Justice: equality
- Beneficence: The doing of good
- Non-maleficence: do no harm

Perceived autonomy is related to job satisfaction. Male physicians report higher levels of perceived autonomy than female physicians. Patient autonomy requires patients to take action when making decisions regarding their health care, which female physicians encourage more often.

Continued gender pay gaps and career advancement disparities speak to the principal of justice, revealing inequality and a need for policy adjustments to advance women in medicine.

Beneficence and nonmaleficence often are considered together and support striving for net best. Based on the knowledge we have that the "feminine" leadership/relationship style achieves improved health outcomes, it is a matter of ethics that we continue to strive for equality and the advancement of women in medicine.

(Bruce 2015; Essary 2014; Jerant 2013)

Ethical Dilemma

Sexual harassment and gender discrimination are wrong: We all have an ethical responsibility to work to remove them from our profession.

Women physicians report greater numbers of female, psychosocially complex, and frustrating patients, given the same levels of medically complex patients as the male physicians. They also report more time pressure than men with both new and follow-up patients. Both patient mix and time pressure are factors that contribute to physician job stress and, therefore, to the risk of medical errors. Poor collegiality and respect between female physicians and female nursing staff may result in inability to get the work done, delay, and inappropriate treatment. Gradually, the female physician may suffer decreased self-esteem and a sense of failure, which may affect her ability to work with staff and colleagues, and further compromises patient care.

Female physicians may experience poor patient satisfaction scores that can affect perception of their productivity. This is because patients may see them in authoritative roles despite the fact that they are perceived as being more patient-centered.

(Hall 2011; Jerant 2013; McMurray 2000)

Ethical Responsibilities

- The medical community has an ethical responsibility to recognize female physicians as equal members.
- It is important that women in medicine exercise responsibility and capabilities within the medical community.

III. Balance Dilemmas

Finding Balance

- Lifestyle and career choices (D, FM, MG, OB-Gyn, PTH, PD, P)
- Family planning and career trajectory
- Seeking balance

The fundamental challenges facing women during their medical careers remain unchanged since the mid-1970s, despite the increase of the numbers of women in medicine. It is expected that the proportion of female medical students will continue to rise — to two-thirds of the medical school class in the next decade.

According to the Association of American Medical Colleges, there are seven specialties in which women represent more than half of all residents in training: dermatology (D), family medicine (FM), medical genetics (MG), obstetrics-gynecology (OB-Gyn), pathology (PTH), pediatrics (PD), and psychiatry (P).

Female physicians often feel guilty for taking time off to have children, and many choose to delay pregnancy until after training.

Female physicians note that their main struggle is in achieving balance between their personal and professional lives. Failure to do so was accompanied by emotional distress. "If we're 80 percent good at everything, 80-percent good mother, 80-percent good doctor, and 80-percent good wife, add it all together — that's working 240 percent of the time instead of just 100 percent. ... [I]n my household, I do carry a bigger weight of the child care, of wife-ing, of mothering, getting the groceries, doing the laundry."

The majority of part-time female faculty is between age 40 and 60, with an average age of 45. Some 25 percent of all female part-time faculty are younger than age 40, but only 2 percent of all male part-time faculty are younger than 40. Five percent of female part-time faculty is age 60 or older, while 67 percent of male part-time faculty is age 60 or older. This means women use part-time status for family reasons, while males use it as a bridge to retirement.

(Carr 2015; Dunn 2007; Mobilos 2008)

Lifestyle and Career Choices

- Specialty
- Alternative work schedules
- Pregnancy and parental leave (FMLA)

Female physicians often choose certain specialties that are more family-friendly and have better work hours, such as pediatrics, family practice, medical and pediatric subspecialties, and psychiatry. Female physicians also choose not to enter surgery

or inpatient settings, where the schedules are strenuous and demanding. However, certain hospitalists can work set hours, making this more attractive to women.

Increasing numbers of female physicians are working part time and reporting higher job satisfaction and productivity, equal or better performance, and greater patient satisfaction. Other options for female physicians include flexible hours and extended residencies. However, part-time physicians also report negative consequences such as negative perceptions of part-time physicians' work ethic and commitment to medicine, lower rates of tenure and promotion, less mentoring, and less research support compared with full-time physicians.

Female physicians face a special challenge. Their pregnancy and childbearing years coincide with their time as residents or junior attendings. Family leave policies therefore have been developed at institutional and national levels. Most teaching hospitals provide parental leave (often paid leave) and the American Board of Medical Specialties has developed relevant regulations for such leave. In 1993, Congress enacted the Family and Medical Leave Act (FMLA), which dictates that covered employers (those with more than 50 employees) allow eligible employees up to 12 weeks of unpaid leave during any 12-month period for the birth or care of a newborn child, adoption or foster care of a child, care of a seriously ill family member, or care of a serious health condition of their own. Many female residents and physicians use this law during their childbearing years to allow them to adequately balance their work and family responsibilities without fearing loss of a residency training position or a job.

(Carr 2015; Gunn 2014; Harrison 2009; Mobilos 2008)

Gender Diversity Initiatives

- Emergency medicine
- Orthopedic surgery
- Radiology

Women in medicine should be able to balance career and family successfully. Many specialties are attempting to train, recruit, and retain more female physicians.

A recent workgroup addressed promotion of supportive workplaces for women in emergency medicine. It recognized gender disparities in salary, advancement, and resource allocations. The group recognized the need for emergency departments to implement individual approaches to policies and practices; culture change to eliminate bias; equitable compensation; and family-friendly policies. This workgroup also emphasized networking; mentoring; and specific policies addressing pregnancy, lactation, and family leave.

Despite near equal ratios among men and women in medical school, the women represent 14 percent of students entering orthopedic residency. The negative perception among medical students of the lifestyle workplace culture and a lack of exposure has been to blame. Since 2012, the Perry initiative has focused on recruiting and retaining women in orthopedics through its Medical Student Outreach Program, which has reached more than 300 students in its first three years (2012-14).

It is interesting to note that women are largely underrepresented in the field of radiology compared with other male-dominated medical specialties. The three most common reasons attracting medical students to the field of radiology are income, job flexibility, and interest in acquiring a broad knowledge base. It also should be noted that female medical students have significantly less preclerkship exposure to the radiology field than do their male counterparts. This disparity may lead to female medical students' misperceptions concerning the amount of physics involved in the field, as well as to women's lack of awareness regarding radiology subspecialties, which involve more direct patient contact.

(Choo 2016; Lattanza 2016; Zener 2016)

Case Study No. 3: Dr. Phyllis
Employed physician seeking life balance

- 35-year-old married female
- Pregnant with second child and in third-year group practice
- Life balance dilemma

Dr. Phyllis is a 35-year-old married woman, pregnant with her second child and in her third year of group practice. She appears happy when she announces the news to her peers, but resentment ensues. She goes to the medical director, who recommends that she take a leave of absence. She agrees, and the medical director suggests FMLA. However, she still needs to complete call requirements. She worries about competency, childcare, and return-to-work issues.

How can Dr. Phyllis achieve life balance?

After Dr. Phyllis delivers a healthy baby, her mother-in-law helps with childcare. In addition, her husband takes on more household responsibilities, which allows her to complete CME requirements.

After 12 weeks at home with the baby, Dr. Phyllis is welcomed back into her practice part-time.

Family Planning and Career Trajectory

- Dual physician marriages
  - 85 percent of female surgeons marry professionals, 50 percent of whom are physicians
- Pregnancy
  - Complications
  - Guilt
  - Sacrifices
  - Hours and income
  - Defer to husband's career

About 50 percent of all married women physicians are part of a dual-physician couple. Dual-physician couples have higher household incomes. But women in such families may have more challenges such as dual call schedules and more home responsibilities. Dual-physician couples do not believe both careers can have priority; they suggest that the couple plan in advance which partner's career will receive precedence. Female physicians frequently report problems associated with pregnancy and childbearing (particularly during residency). These include guilt, sacrifices, loss of hours and income, lack of support from faculty and resident peers, complicated schedules, and problems obtaining child care. Positive impacts of having a physician partner were reported as someone who understands the rigors of medical practice and provides help, support, and an in-home medical consult.

In a study of family physicians (FPs), 86 percent of family physicians were married; 16 percent of these married other physicians. Having a physician partner significantly reduced hours devoted to professional practice: Female FPs in physician-physician marriages worked five hours less per week than other female physicians, and male FPs worked three hours less per week than other male physicians.

In a national survey of American Board of Surgery-certified surgeons, women surgeons (9.4 percent) were much less likely to have a homemaker partner than men surgeons (56.3 percent). More women than men surgeons were married to another surgeon or to a professional. Female surgeons were less likely to have children (64 percent versus 91 percent) or to have their first child later in life compared with male surgeons. The partner was the child's primary caretaker for 27 percent of women surgeons, compared with 79 percent of men surgeons. More female surgeons than male surgeons thought maternity leave was important (68 percent versus 31 percent) and that child care should be available at work (87 percent versus 70 percent).

A survey of 7,905 members of the American College of Surgeons found that 90 percent of surgeons had a domestic partner (DP). Half the DPs did not work outside of the home, 16 percent were physicians, and 35 percent were working nonphysicians. Surgeons in dual-physician relationships more often experienced career conflict with their DP than surgeons whose partners were working nonphysicians. Surgeons in dual-physician relationships were more likely to be depressed and have low mental quality of life than those with homemaker partners.

(Dyrbye 2010; Schrager 2007; Troppman 2009; Woodward 2005)

Barriers to Balance

- Increased risk for burnout related to decreased control in work setting
- Rate of female physician suicide
  - 250 to 400 percent higher than general population
  - 2-3 times greater than women population
- Role strain
  - Home versus work
  - Caring for other dependents (sandwich generation)

Sources of stress on female physicians are problems related to minority status, discrimination, lack of role models and mentors, and role strain. Junior female faculty members often feel supported, but they feel the impact of gender discrimination as they become more senior. Mentors are needed to review promotion and tenure criteria and to encourage women to make choices that will lead to career advancement. Unfortunately, women faculty often report the absence of mentorship. The limited number of women in senior positions leads to fewer available mentors for young women physicians. Junior female physicians may hesitate to ask senior males to mentor them for fear that the relationship may be open to misinterpretation.

Suicide accounts yearly for 32,000 deaths in the United States and is the seventh leading cause of death in men and the fifth leading cause of death in women. The rate of suicide in male physicians is 70 percent higher and the rate in female physicians is 250-400 percent higher than the general population. We should pay special attention to female physicians because of the large incidence of completed suicide among that population.

Men may help or assist, but women bear primary responsibility for childrearing and home tasks. Women report role strain between their personal and professional responsibilities, resulting in stress and burnout. Women physicians also have substantially more responsibility for other dependents such as aging relatives compared with male physicians (adjusted means 21.1 for women versus 11.9 for men).

(Bauman 2014; Bruce 2015; Schernhammer 2005)

IV. Physician Marriages and Divorces

Dual-Physician Marriages

- As a couple
  - Earn less money than individually by choice
  - Each plays greater role in childrearing
  - Have more children
  - Achieve career and family goals as frequently as other couples
- The wife
  - More likely to interrupt career for childrearing
  - Works fewer hours and earns less money

When two physicians are married to each other, the marriage has both additional challenges and benefits. Each of them will make less money individually and spend more time with children. They also tend to have more children than other couples and to achieve their career and family goals just as successfully. The wife, however, still will be more likely to interrupt her career for childrearing and will work fewer hours than her husband.

(Woodward 2005)

Dual-Physician Marriages: Benefits

- Higher total income than nonphysician couples
- Interpersonal support
- Shared work interests
- Both work less than peers
- Couples talk more/have more to negotiate
- Partner is a colleague

The benefits of physicians marrying each other are numerous. Their total income is higher than that of other couples, and they offer each other interpersonal support due to their shared interests. They actually work less than their peers and talk more because there is more to negotiate with two work and call schedules.

(Woodward 2005)

Dual-Physician Marriages: Strains

- Physician couples have complicated schedules
- They must have reliable help at home
- They must make a conscious effort to discuss topics other than medicine
- They must make sacrifices for the other's career or for children
- Dual-physician marriages result in working fewer hours, which forces institutions to reexamine their policies

Because physician schedules can be quite complicated, these couples often find it helpful to have reliable help at home. At times, these couples talk so much about medicine that they should consciously choose to discuss other topics. They also make sacrifices for the other's career and for the children. Because the number of dual-physician marriages continues to rise as more women enter the profession, it is

What Matters?

MOST IMPORTANT	LEAST IMPORTANT
Amount of time spent together	Similar interests
Mutual respect	Sex
Children	Financial circumstances

perhaps time for those who hire doctors to start recruiting two at a time — couples rather than individuals.

Dyrbye 2010 surveyed members of the American College of Surgeons and found that surgeons in dual-physician relationships had more career conflicts and work-home conflicts than surgeons partnered with nonphysicians. Surgeons whose domestic partners were fellow surgeons faced even greater challenges in these areas than surgeons partnered with nonsurgeon physicians.

(Dyrbye 2010; Schrager 2007; Woodward 2005)

Shanafelt reported that the amount of time spent awake with their physician partners was the dominant characteristic associated with partner satisfaction with the relationship. When physicians were surveyed as to what mattered to them most in their marriages, they reported that mutual respect and children are most important.

Similar interests, sex, and financial issues are of comparatively small concern.

(Lowes 2000; Shanafelt 2013)

Physician Divorce

- Rate in physician marriages (29 percent), which is less than the general population
- Highest in surgical fields (33 percent) and psychiatry (50 percent)
- Lowest in pediatrics, pathology, and internal medicine (22-24 percent)
- Higher in marriages prior to medical school

The marriages of physicians, men and women alike, have a lower likelihood of ending in divorce than the rest of the employed population, including professionals in law and related high-status professions. A greater proportion of female physicians are divorced, but this difference reflects the higher prevalence of divorce among employed women. Among **employed** women, in fact, physicians are particularly **unlikely** to be divorced.

Couples must be cautious that medicine does not consume their lives totally, yet appreciate the rewards of being able to share in a profession that demands much time and energy and still results in a gratifying marriage. The lack of time for other pursuits was seen as a major disadvantage in a medical marriage.

Physicians and their partners tend to stay in unsatisfying marriages because of financial security or social status.

(Shanafelt 2013)

V. Goals for Cultural Change

AAMC Ethical Goal

"Only institutions able to recruit and retain women will be likely to maintain the best house staff and faculty. The long-term success of academic health centers is thus inextricably linked to the development of women leaders."

(Morton 2007)

Case Study No. 4: Ms. Sam
Female-to-female interaction

- Samantha "Sam," fourth-year medical student, surgical rotation, female attending
- "Masculinization" of female attending, Dr. Jill, due to male-dominated surgical subspecialty
- Healthy communication and mentorship despite initial difficulties

A fourth-year medical student in her surgical rotation, Sam was interested in becoming a surgeon. Her attending, Dr. Jill, continually placed excessive demands on her that she was unable to meet, which had her reconsidering her choice of surgery.

Fearing a bad evaluation, Sam requested a meeting with Dr. Jill, where she was given the opportunity to voice her concerns. Dr. Jill listened and acknowledged she had been acting harshly, explaining how difficult it was during her training, how it continues to be challenging as a female in the male-dominated world of surgery, and that it was her hope to toughen Sam up and better prepare her for a career in surgery by piling on the work.

By the end of the meeting, both Dr. Jill and Sam were encouraged. Dr. Jill respected Sam's ability to speak up and realized she needed to be more positive and nurturing role as an attending and the importance of female mentorship to recruit and retain more women in surgery.

Do you see this happening in your environment? Can you see how this approach is beneficial for the advancement of women in medicine?

Goals for Cultural Change

- Ask women what they want
- Promote personal and professional well-being
- Foster a culture of mutual concern, safety, professionalism, and confidentiality
- Involve families of all structures
- Cultivate methods of personal renewal
- Establish mentoring programs
- Provide confidential support groups
- Furnish annual well-being retreats on company time
- Provide membership in a fitness center
- Require all physicians to have their own primary care physician

The medical profession needs a cultural shift from the belief that the physician's call transcends family life. Medical marriages are changing, with an increase in women physicians and dual-physician marriages. Practice styles are changing along with the demographics.

Those who are training and those who are hiring physicians may improve our current medical culture in several ways. We should ask women what they want and develop a system that promotes both personal and professional well-being. The work environment should be one that fosters mutual concern, safety, professionalism, and confidentiality. Consideration of the physician's family should include attention to partners of either sex, recognition that the partner also may be a physician, and inclusion of children as well.

To appeal to the changing social norms, county medical alliances should incorporate nongender- specific programming, including topics of interest to a multicultural demographic, offer meeting times that accommodate working people's schedules, and encourage family participation in alliance events and activities. Likewise, county medical societies should address topics of mutual interest to male and female physicians to accommodate member needs. Including nongender- specific programming in alliance and county medical society meetings will increase the likelihood of robust memberships.

Other beneficial changes are listed here. Mentoring programs are especially helpful for women who find medicine to be a "good ol' boys' club." Confidential support groups for those both in and out of training provide outlets for fostering goodwill and emotional well-being. Hospitals and group practices might plan annual wellness retreats, provide memberships in a fitness center, or arrange on-site day care programs. Employers also should insist that every physician have his or her own primary care physician.

(Bauman 2014; Bruce 2015)

Additional Goals for Cultural Change

- Develop CME related to leadership
- Offer flexible scheduling, part time, sabbaticals, and shared positions
- Extend tenure clock to account for leave of absence
- Alert medical students to risks of divorce by specialty choice
- Make available and encourage use of marital counseling during medical training
- Recruit couples to accommodate dual-physician marriages
- Increase work productivity, mental health, and job satisfaction by offering flexible and reasonable work hours
- Incorporate more on-site child care
- Restructure residency programs to be more family friendly

Because women are underrepresented in academic medicine, we should ask for more continuing medical education courses that develop leadership skills. Both men and women need more access to flexible scheduling, sabbaticals, and shared positions. Medical boards need not be punitive to those physicians that take time off for bearing children, and tenure assessments need to allow for leaves of absence.

While we're about changing the medical culture, we need to do more to prepare students for the realities of medical practice. Certain specialties are more likely to contribute to marital stress and divorce. We should not only advise students of these realities but also encourage them to engage in marital counseling, beginning in the training years.

Organizations that hire physicians already should be focusing half their recruitment efforts on couples. If hospitals, clinics, and practices will incorporate some of the suggestions mentioned, they may hope to see better work productivity, better physical and mental health, and greater job satisfaction. An on-site, 24-hour child care facility is a very attractive bonus to physicians with families, to female physicians, and to couples wherein both are physicians.

Assertiveness is essential for success in medicine. Leadership positions also require expertise with assertiveness. Traditional ideas of women being deferential instead of being assertive are slowly changing.

Looking Toward the Future

Things are getting better …

The family structure is evolving. Medicine is more inclusive and moving away from the dominant masculine culture of medicine.

"If society will not admit a woman's free development, then society must be remodeled."

— Elizabeth Blackwell, MD

Elizabeth Blackwell lived from 1821 to 1910 and is the mother of every woman in medicine today. She persevered and inspired many other women to follow in her footsteps.

Let us not only allow women to practice medicine but also encourage their development into leaders, contribute to the welfare of their marriages and families, and promote their well-being. Both the profession of medicine and patients will enjoy the benefit.

The PHW Committee hopes this activity is useful educational information and welcomes your suggestions regarding these or other educational materials you think should be made available to Texas medical students.

Disclaimer

VI. Bibliography

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PHW Topics Available for Medical Students:

Creating and Maintaining Student Life Balance; Challenges of Professional Boundaries; Challenging Patient Encounters; Medical Student Stress and Burnout; Preventing Medical Student Suicide; Social Media: Ethical Dilemmas and Boundaries; Women in Medicine: The Path Forward