FMWC Report to the House of Commons Standing Committee on the Status of Women (Women in non-traditional careers):

Dr Kathleen Gartke, Dr Janet Dollin

Women in medicine have come a long way since Emily Stowe opened her practice in Toronto in 1867. It would take her 3 years before she was even allowed to earn her Ontario medical license. Her daughter, Augusta would be the first woman to graduate from a Canadian medical school. In the 1970s, less than 25% of Canadian medical students were women, but by 2009, more than 50% of students attending Canadian Medical Schools were women. In many schools this number is over 60%, reaching as high as 70%.

With the increasing numbers of women in the medical workforce there have been many positive changes in the way medicine has evolved. It was the increased presence of women that led to a greater focus on women's health and, more specifically, on gender as a determinant of health. It led to more advocacy for women's reproductive rights, for the prevention of violence against women, more support for qualitative research and more attention to work-life balance in medicine. These are changes which we work alongside our male associates to address and which hopefully will benefit both men and women in medicine. Patients have responded to the increased number of women in medicine by describing increased satisfaction with communication styles that are more inclusive, with more time spent per patient, and with more preventive services being offered. Women are making changes to the basic practice of medicine. They are also choosing very specific fields of practice.

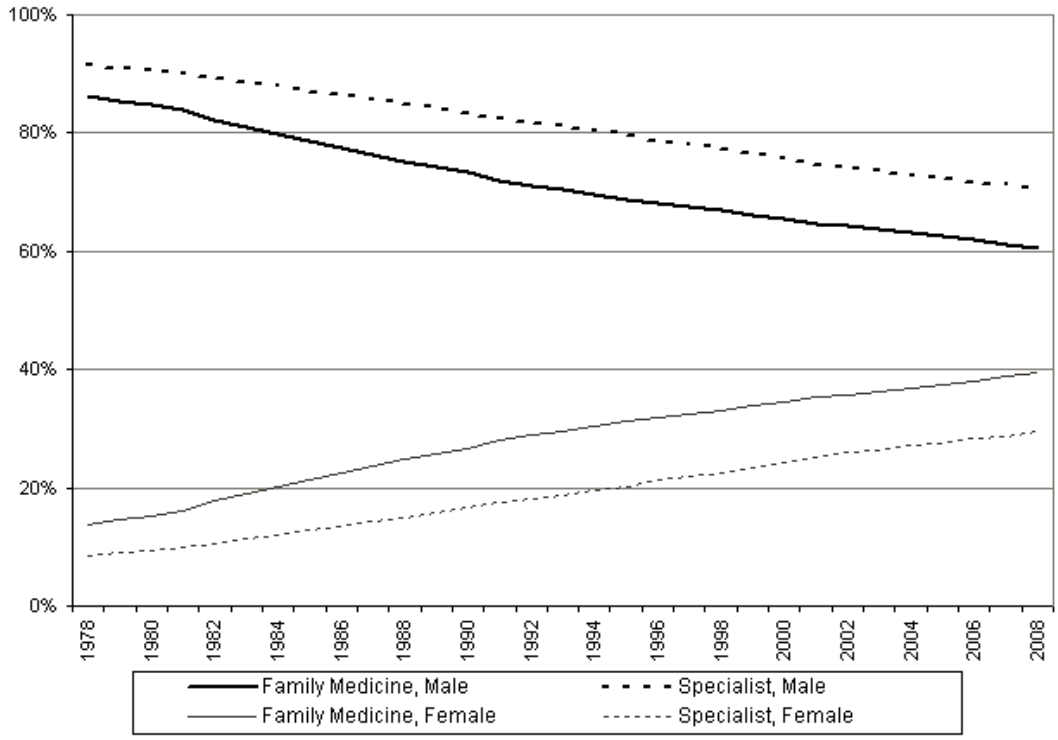
Women are predominantly choosing primary care specialties such as family medicine, OB/Gyn and Pediatrics. While it is not surprising that the overall percentage of women pursuing specialty training is also rising, it is striking to note the distribution of women into specialty vs family practice in 2008 compared to 30 years ago. CIHI's data (see figure1 below) show that Family Physicians were 85% male:15% female in 1978 and in 2008 are 60% male:40% female. Specialists during that same time span went from 95:5 M:F to 70:30 M:F. What is noteworthy about this change over time is that the curves remain parallel. This is despite the fact that women are beginning to outnumber men in some specialties. (In OB/GYN for example, that translates to 87% female trainees as we will see)…. To maintain the same overall parallel ratios over time with such significant bulges in a few specialties means that certain specialties are remaining significantly underrepresented. We have to ask ourselves: why? Is it some inherent characteristic about women's abilities or interests or are there other factors in play?

.

.

Figure 1:

CIHI (Canadian Institute for Health Information)
Gender Distribution of Physicians, by Physician Type, Canada, 1978 to 2008



In particular, let us consider the surgical specialties. In 1998, according to CMA data, 12% of physicians practicing in surgical specialties were women. By 2008, this had only risen to 19.2%, despite the fact that more than half of the medical school graduates were women over the same time frame. This will not correct itself over time without some attention to the causative factors. In other words, it is not simply a “pipeline” effect.

Figure 2

Système informatisé sur les stagiaires post-M.D. en formation clinique
Ottawa, Canada Téléphone: 613-730-1204 Fax: 613-730-1196

CAPER

Canadian Post-M.D. Education Registry
caper@afmc.ca http://www.caper.ca

Table A-3
(Visa Trainees Not Included)
FACULTY OF MEDICINE PROVIDING POST-M.D. TRAINING
BY
GENDER
2008 - 2009

Faculty of Medicine Providing Post-M.D. Training	Female		Male		Total	
	Count	Row %	Count	Row %	Count	Row %
Memorial University	119	52.7%	107	47.3%	**226**	**100.0%**
Dalhousie University	240	54.5%	200	45.5%	**440**	**100.0%**
Université Laval	409	64.9%	221	35.1%	**630**	**100.0%**
Université de Sherbrooke	323	65.8%	168	34.2%	**491**	**100.0%**
Université de Montréal	591	65.3%	314	34.7%	**905**	**100.0%**
McGill University	327	52.3%	298	47.7%	**625**	**100.0%**
QUEBEC SUBTOTAL	1650	62.2%	1001	37.8%	**2651**	**100.0%**
University of Ottawa	337	52.3%	307	47.7%	**644**	**100.0%**
Queen's University	164	44.4%	205	55.6%	**369**	**100.0%**
University of Toronto	918	52.7%	825	47.3%	**1743**	**100.0%**
McMaster University	326	51.3%	309	48.7%	**635**	**100.0%**
University of Western Ontario	275	47.9%	299	52.1%	**574**	**100.0%**
Northern Ontario School of Medicine	39	60.9%	25	39.1%	**64**	**100.0%**
ONTARIO SUBTOTAL	2059	51.1%	1970	48.9%	**4029**	**100.0%**
University of Manitoba	163	41.4%	231	58.6%	**394**	**100.0%**
University of Saskatchewan	133	49.6%	135	50.4%	**268**	**100.0%**
University of Alberta	313	46.0%	368	54.0%	**681**	**100.0%**
University of Calgary	289	52.0%	267	48.0%	**556**	**100.0%**
ALBERTA SUBTOTAL	602	48.7%	635	51.3%	**1237**	**100.0%**
University of BC	520	52.6%	469	47.4%	**989**	**100.0%**
Total	**5486**	**53.6%**	**4748**	**46.4%**	**10234**	**100.0%**

From Caper (Canadian Post MD Education Registry) we see that 49-62% of graduates entering specialty training in Canadian schools today are women. (see Figure 2) Most are choosing non-surgical specialties. We also know that 64% of those entering training in family medicine (2008/09) were women while only 45% of those entering surgical training (2008/09) were women. Some of the surgical specialties attract a greater share of these women (87% of OB/Gyn trainees are women vs. 23% heading into orthopaedics). Overall, only 37% of doctors entering practice in any surgical field are women (2008). We have to ask ourselves why women do not fully access careers across the full spectrum of medical specialties. Given that the majority of graduating MDs are now women, and given that health human resources are so precious at this time, we need to ensure that women's talents and skills are available to every discipline.

What are the factors at play in influencing women's choice of specialty as well as the factors that influence all aspects of her medical career –her satisfaction, her advancement within that career, and her productivity? Are her career decisions unencumbered? We will present discussion on a few of these factors. Women may be choosing their career path based on a number of internal as well as societal influences.

1. A given specialty may be considered more or less "plannable" and more or less " people oriented", both factors felt to be of importance to women.

2. Women at the time of making this career choice are seeking to start families and have the major responsibility in their households for caregiving.

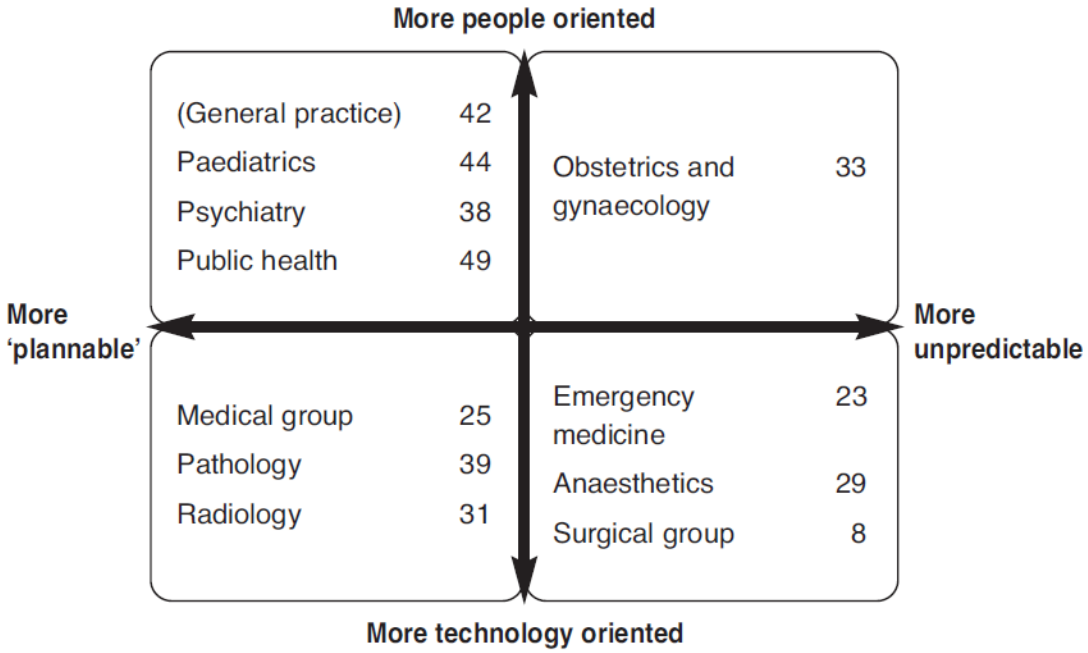
3. Attitudes and policies in medicine support a strong work ethic where dedication traditionally meant uninterrupted time spent at work. Work hours have traditionally been long. The double bind of having to choose either family OR career is often described. Those seeking a less traditional path experience barriers to their progress.

4. New generations of doctors, both men and women, are seeking a better balance of work and life. Both men and women deserve the respect of their peers when family responsibilities dictate a need for flexible workplaces

5. Role models have not existed in non-traditional choice specialties. Similarly, role models are still absent at multiple levels within the leadership in medicine, within local university, hospital and governing body associations.

We can see that women make these choices, at least in part, because of the nature of the resulting practice when we look at the report of the College of Physicians (UK) 2009. (see figure 3) Their analysis of the numbers showed that women chose more "people oriented" and/or more "plannable" specialties. While we have the statistics being discussed today, no such analysis is available for Canadians. In fact, most of the discussion examining women in medicine comes from the UK and the USA. They are well ahead of us in looking at this critical situation. If we look at the statistics from Caper and in particular, the first year post-MD trainees, our numbers come very close to mirroring the UK distribution, so perhaps we can extrapolate that their conclusions apply here.

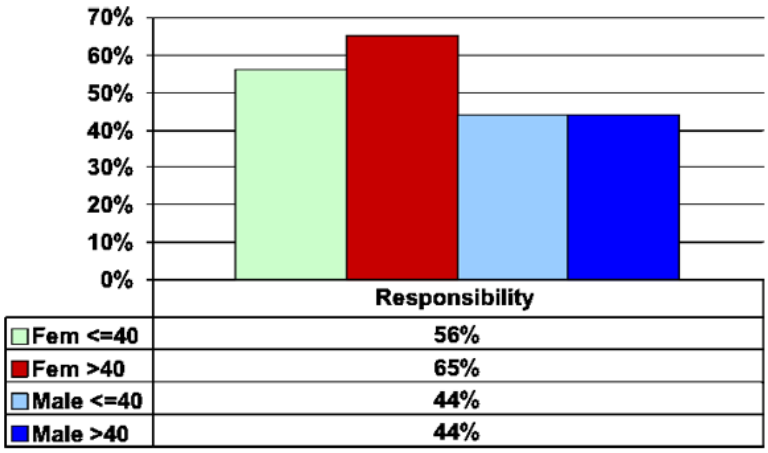
Figure 3: Female share (%) of all consultants (and GPs) by specialty (2007) (source: main report pg 46)



2009 report of the Royal College of Physicians (UK) "Women and Medicine the Future"

The "plannable" aspect of medical practice appears to be the dominant factor and that is not surprising. Women (in or out of medicine) shoulder more responsibilities related to their family/personal lives than their male colleagues. This must (and does) affect their career choices. Women physicians are the primary caregivers for family members. (see figure 4). This is not only true of the younger women. We see 65% of women over 40 taking major responsibility for dependents. Work climates must support not only those 65% of women over age 40, but also the 44% of men in all age categories who are caregivers for family members. The future will also require men to be equally supported and expected to care for their children.

Figure 4:
Major responsibility for children & other dependants (from the National Physician Survey 2007



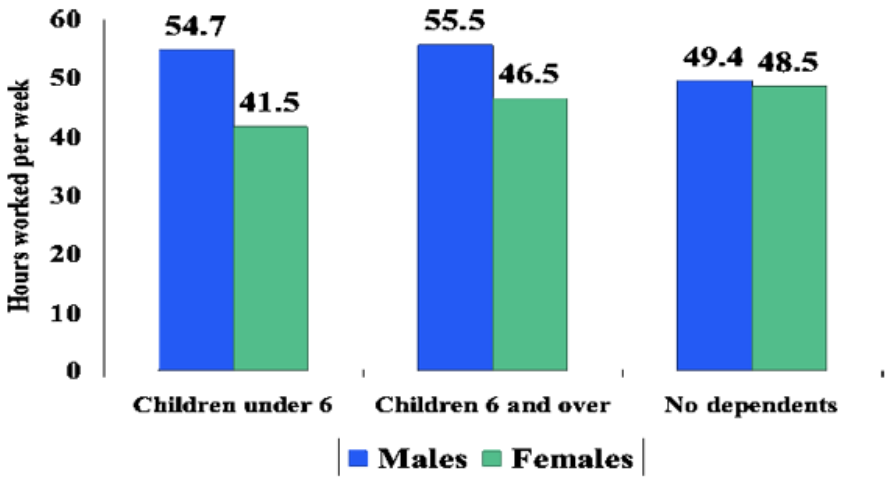
Medical practice traditionally involves long hours at work. Women physicians in Canada work an average of 47 hrs per week vs. 52 for men when looked at overall. However, when it is broken down by dependents, men with school-aged children actually work the most, 55.5 hrs compared to their spouses at 46.5. (Figure 5) It is the presence of dependants that influences work hour decisions for men and women in opposite directions!

Interestingly, there is no significant difference in work hours for male vs. female doctors without dependants. And at 49 hrs per week, these doctors work far less than the 52 hr national averages for men overall. So at 52 hrs per week overall for male physicians, are we honouring overwork as a model of good or appropriate behavior? Are women who on average work 47 hrs per week not contributing their appropriate share? Does the satisfaction or the wellness of a doctor's patients count? Clearly physician productivity will need to be measured in terms other than hours worked.

Indeed, what is appropriate work? When does excessive work actually risk dangerous outcomes? There is a new literature addressing safety concerns when physicians are overtired. Error outcomes are found to be similar to other industries which have taken the lead on this topic, such as pilots or truck drivers. In this case Canada has not yet followed some of the European Union's attitude-shifting work hour philosophies which limit maximum workweek time to 46 hrs. In JAMA's recent 2010 report by Staiger et al., the authors show that both men and women physicians in the US have decreased their work hours each by about 5%. In the last decade, this has brought physician hours closer to, but still above the normal average hours for other professionals such as lawyers or nurses.

Figure 5:

Hours worked per week by type of dependants (excluding on-call), from NPS 2007



Academic medicine is still wasting a great deal of the intellectual capital of its faculty women: many choose to "opt out" rather than navigate what is described as the chilly climate. The climate shift is occurring at different rates in different fields of medicine. To navigate it as individuals, each physician has had to face the systemic reasons why women do not advance at the same rate as men. Leadership gaps have still been demonstrated, despite systematic efforts at promotion, which has improved by over 60% in the last 10 years in Canada. The AFMC (Association of Faculties of Medicine in Canada) keep data that shows that within Universities, women comprise only18% of full professors of medicine and within hospitals, they comprise only 13% of department chairs. And while leadership of provincial and national medical organizations has shown increases, gaps remain.

What is it that women need or want that will allow them a freer and fuller choice of medical careers? It is important that from the start of post secondary education, to the completion of medical specialty training, qualification takes a minimum of 10 years and often longer. This time frame usually overlaps the period in their lives when women are establishing families. The UK Royal College report helps here once again, and on a smaller scale, so does the Needs Assessment done by the FMWC (Federation of Medical Women of Canada) on its members in 2008.

Students tell us they need:

- improved opportunities for different styles of education (part time training, job sharing, exit/reentry strategies)
- improved availability/cost of childcare for "students"
- improved availability/cost of financial support for "students"
- a family-friendly culture & elimination of the stigmas attached to availing the benefits of work-life policies (professional organizations for students and residents exist in each province)
- more role models / mentors, particularly focusing on those from non-traditional (surgical) specialties.

Once these women get out into practice, many of the same issues exist. Given the cost of their education, and the needs of our healthcare services, retention becomes a significant issue. Young physicians entering practice need:

- increased flexibility in the workplace (more opportunities for job sharing and part time work)
- developed exit/reentry strategies for physicians who need/want to leave practice for a definable length of time
- increased physician resources in Canada, and elimination of the idea that women are the cause of human health resource problems
- a family-friendly culture & elimination of the stigmas attached to benefiting from work-life policies (Mat/Pat leaves according to professional associations/legislation)

We must not forget the impact of aging in Canada. Women often find themselves increasingly responsible for aging parents as their young children mature and require less time. Not uncommonly, the two overlap, placing these women in the well-known "sandwich" generation. These women need:

- flexibility in the workplace (job sharing / less than full time work)
- socially supported leaves of absence for care-giving
- family friendly culture that includes positive attitudes towards care-giving

For women to be comfortable or indeed to thrive in any non-traditional role for physicians- from surgical practice to subspecialty, or to leadership roles in any field, a cultural shift is essential. On a very basic level, women need to be confident that they can contribute in a meaningful way by providing quality care while retaining the respect and goodwill of their colleagues. Policies and practice on the ground need to support them. This is no different for men. "Women's issues" are no longer relevant only to women. Since Generation X came on stream, we have seen both men and women place a much higher value on family life and personal time. Neither sex of this generation is willing to sacrifice these values for career achievements (prestige or money). This means that the issues on women's agendas related to the practice of medicine are now on *everyone's* agenda. The response to this will require system and policy changes so that each individual no longer has to navigate this path on their own.