

How will the new wave of women graduates change the medical profession?

CHARLOTTE GRAY

Dr. Emily Stowe was the indomitable suffragette who gained the first foothold for women in the medical profession in Canada. Her battle for entry into a recognized Ontario medical college lasted 20 years. On one occasion in the late 1860s, when she received yet another refusal from the University of Toronto, she is said to have declared fearlessly, "The day will come when these doors will swing wide open to every female who chooses to apply".

Maybe she exaggerated. But Emily Stowe, who was finally licensed to practice exactly 100 years ago, would undoubtedly be surprised by her own prescience. Last year women constituted 25% of the University of Toronto's 252 first year medical students. This was well below the national average, which for the academic year 1979-80 was 37%. At McMaster more than half the first year medics were female. Women are now applying, and being admitted, to medical school in steadily increasing numbers.

"The proportion has been rising steadily since the late 1960s", comments Eva Ryten research associate at the Association of Canadian Medical Colleges (ACMC). "By 1990 we can expect 45% of our graduating physicians to be women. We used to assume that this would be the crest of the wave, but med-

ical statisticians in Britain now suggests that the proportion there could go to 50%. Maybe that will happen here. We no longer know where to draw the line."

And as Dr. Douglas Waugh, executive director of ACMC, points out, "We are still talking about the high proportion of women in training; the great majority of practising physicians are male. The wave of women hasn't crashed on the beach yet; we will only feel the impact a few years down the road".

Womenpower planning

But an impact there will be — on manpower planning, on society and on the profession. We have come a long way since Dr. Emily Stowe was complaining that "the education of girls just about stops where boys begin to grapple with the abstruser difficulties".

One of the problems bedevilling those responsible for medical manpower planning is that they know very little about practice patterns generally and even less about those of women in particular. No one collects detailed data at present; nobody is quite sure how many of Canada's 43 192 active physicians (including interns and residents) are women or how many of them are in full or part-time practice. The best estimate that Ryten can come up with is that about 15% of the manpower pool is made up of women — which would mean Canada has 6478 female physicians — and that the proportion of women to men is increasing by 1% a year.



(Photo courtesy of Patricia Emily Stowe)

Dr. Emily Stowe: these doors will swing wide open.

She adds, however, "We can't be sure because we don't know how many of the doctors who trained abroad, who constitute about a quarter of the pool, are women. Many of our doctors come from countries like India and the UK which traditionally have trained a higher proportion of women physicians than has Canada."

Such information as there is on women doctors comes mainly from three sources: studies in countries like Sweden, the UK and the US which are experiencing the same increase; Canadian studies that are based on very small samples; and information about the intentions of

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today's medical students collected by Ryten in the course of regular statistical surveys of medical education.

The picture which emerges suggests that the impact will be profound. As Dr. Arnold Relman wrote in the *New England Journal of Medicine* editorial headed, "Here come the women" last May, "I have the distinct sense that we are turning a corner, that major transformations in professional attitudes and styles of medical practice are in the offing, and that young women physicians will have an important role in bringing them about".

Myth of the drop-out

Two assumptions dog discussions about women physicians. The first is that women have a higher drop-out rate and the second is that they work fewer hours during the week and fewer years during a lifetime. On the basis of these assumptions the suggestion is sometimes made that educating women doctors is not as good an investment as educating men doctors.

Closer examination of the facts reveals that although there is limited support for the assumptions, the patterns of male and female productivity are converging rapidly and the pattern of female practice is changing.

For instance, a 1976 study of 155 women physicians who graduated from the University of Western Ontario showed that those who graduated between 1961 and 1970 were far less likely to stop working than those who graduated between 1924 and 1958. More of them were in part-time practice than their older colleagues, but more of them were in their peak child-bearing years. And only 17% of married women in the 1961-70 cohort stopped working outside the home during child-rearing years compared to 33% in the 1924-58 cohort.

Dr. Elizabeth Pollonetsky, the retiring president of the Federation of Medical Women of Canada, argues, "Wastage does *not* differ markedly by sex. I prefer to call the pattern of women curtailing practice when their children are small "stop-outs", because if the condi-

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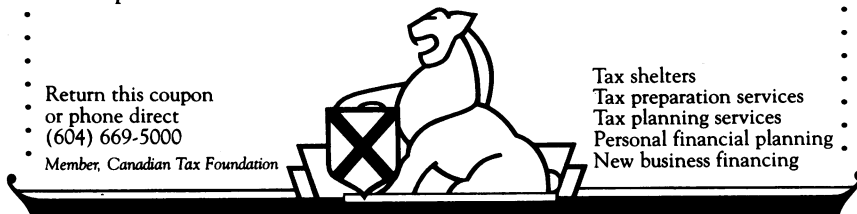
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tions are right they will always return. And men don't always stay in the profession; many switch to politics or business. Look at Dr. Morton Shulman and Dr. Steven Smith."

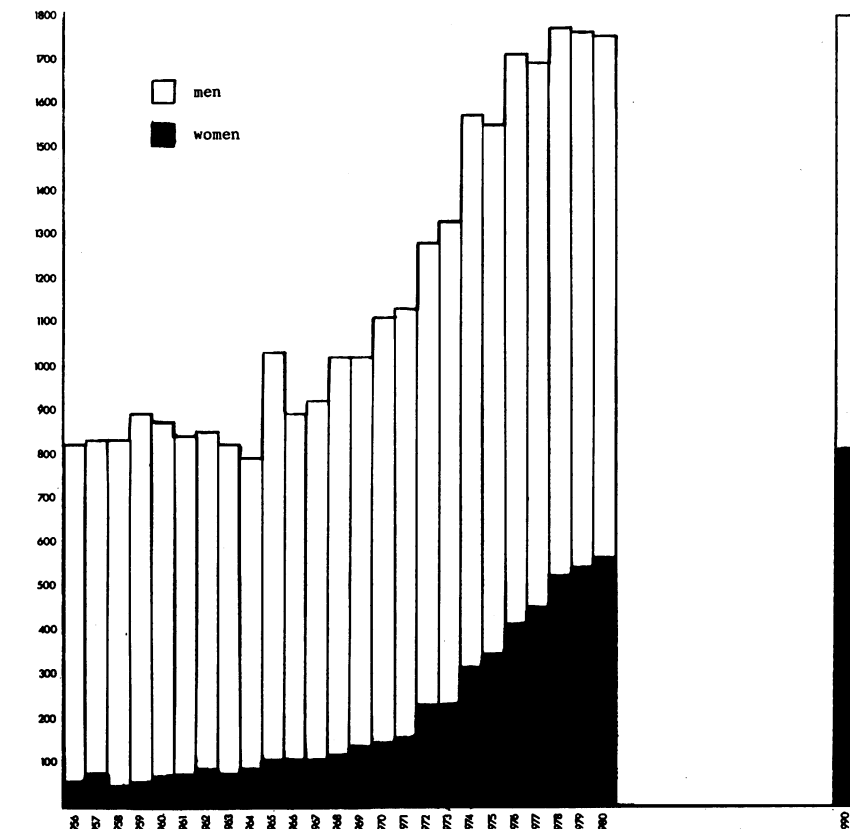
And, one could add, Dr. Charles Allard, the Edmonton ex-surgeon who has just sold his financial empire for \$127 million. Or Dr. George Repin, secretary-general of the Australian Medical Association, who spent 15 years in the catering business.

Longer working hours

Studies conducted in the United States show that the percentage of full-time practitioners among women physicians has increased by 25 to 30% in the last two decades. Not only are they practising for more years; they also work longer hours. Women graduates from the 1930s and 40s practice an average of 33 hours per week; those who graduated in the 1950s, 35 hours per week; and those from the 1960s 44 hours per week.

While the women's weekly hours of work have increased, those of men have declined. The average US internist practised 56 hours in 1966, but only 50 hours in 1974. As Canadian interns and residents demonstrated this year in their negotiations with paying agencies, an increasing number of male physicians are no longer apologetic about limiting their professional commitments so they have more time for outside interests. Values and priorities in the larger society are changing; any picture of today's conditions could look like a faded snapshot within just a few years, as traditional roles and expectations dissolve.

In which specialties are women concentrated? Evidence from Sweden and the US show that, until now, women went into family practice and pediatrics and avoided surgical specialties. The same pattern is quite obvious in Canada. A study conducted in 1975 in Quebec, where there has always been a higher proportion of women doctors than in other provinces, revealed that 28.4% of the women surveyed were general practitioners, 9%



MD degrees awarded by Canadian medical schools by sex, 1956-80

(Courtesy E. Ryten, ACME, Ottawa 1980)

were pediatricians, and 12.8% were anesthesiologists. The latter is popular with women because they don't have to work long hours or buy a lot of equipment.

According to Eva Ryten, these choices will probably remain the popular ones. In the fall of 1978 Ryten conducted a survey of the entire medical student population of Canada to ascertain career intentions; 6292 medics — 86 percent of the total student population — replied.

Motherhood v. the specialties

Ryten wanted to find out how many of these students were considering research as a career. She discovered that twice as many men (5.7% to 2.9%) intended to do research; nearly half the women, as opposed to 38% of the men, were committed to careers in general practice. It is likely that women avoid research or esoteric specialties because they don't want several more years of study. A greater number of women than men (39% to 29%) are younger or older than

the average, which suggests that they are more interested in committing, or have already committed, to motherhood the years which would otherwise be spent in further training.

This will have a big impact on the profession. Surgical specialties are already moving into shortage; if women shy away from the knife, the shortfall will be exacerbated. The popularity of pediatrics, on the other hand, clashes with the decline in the birth rate; fewer pediatricians will be required. Elizabeth Pollonetsky points out that we will, however, need more geriatricians: "I like to feel that women doctors, who shine as pediatricians because of the motherly qualities required, will also shine as health care providers for our increasing population of old people."

In recent years, medical schools have put a strong emphasis on primary care, and this is the most popular career choice for today's women medical students. One can speculate that in future years it is going to be as hard in some regions to find a male GP as it is nowadays

to find a female gynecologist. How the public will react to this is anybody's guess — although it is worth remembering that a person looking for a male lawyer might run into the same problem.

A further insight revealed by Ryten's study is that the female students differed from their male classmates in attitudes to the profession. Ryten says, "I read through hundreds and hundreds of comments about why students did not intend to go into research and found that, proportionately, far more women said they were less concerned with the financial rewards of medicine and more concerned with face-to-face relationships with patients. The men were concerned too, but were also prepared to admit to financial ambition."

Perhaps the women were merely hesitant to discuss money; but, whatever their motivation, they were being realistic, since women doctors earn less than men. A Statistics Canada survey of graduates' annual incomes in 1973 showed that women physicians, who then constituted only 11% of the physician pool, were earning only 56% as much as their male colleagues. A US study of doctors in the mid-west found that women earned only 60% as much as their male colleagues. The Quebec insurance board has reported that women doctors in Quebec tend toward lower earnings. Women physicians are less interested in income — and they get less.

Two-career women

Any working woman is faced with the continual dilemma of balancing the responsibilities of job and home. For a physician, whose work expands to fill the available hours plus several unavailable ones, this can be a nightmare juggling act. Studies in different countries all indicate that women doctors tend to work fixed hours, on salary, in urban rather than rural areas, and if possible in a team within an institutional setting.

According to a 1978 study conducted among interns and residents in two Montreal hospitals for instance, 45% of the women compared to 29% of the men, said

that hours and conditions of work were big factors in their choice of career. The possibility of working on a team was rated important by 25% of the women and 14.5% of the men.

A structured worklife, in cities where childcare facilities are available, is obviously a big advantage to a professional woman with young children and a home to run. But as more doctors choose these conditions, it could have an interesting effect on the profession. In his *NEJM* editorial Arnold Relman speculated, "There may well be a softening of the profession's traditional resistance to experimentation with different economic arrangements for medical practice". Will physicians become more amenable to salaried jobs and less wedded to the idea of professional independence? Will there be a greater willingness to enter contractual arrangements with governments in exchange for guaranteed incomes?

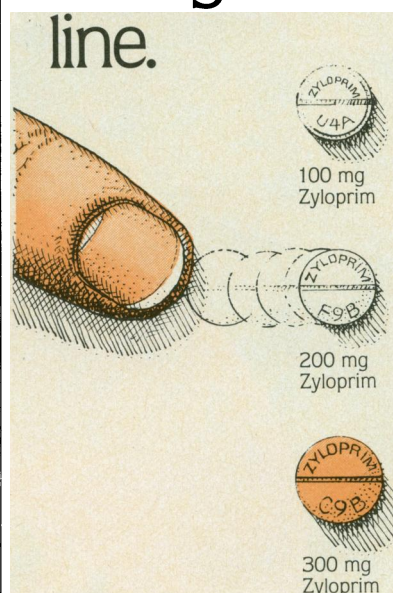
Declining prestige?

And lastly, is the increase in the number of women doctors going to affect the prestige of the profession? Traditionally, medicine has always been at the top of the greasy pole of prestigious jobs. Male-dominated and well-paid, it consistently ranks number one in public respect.

However, in countries where most of the doctors are women — such as Latvia, with only 15% of its doctors male, or the Soviet Union generally, where women make up 65% of the doctors — the profession is considerably less well-paid and less prestigious. One can argue that this is because general practice there, in which women congregate, requires less training than in Canada. Nevertheless, Canadian studies of professional prestige rankings always show male-dominated occupations higher than female-dominated ones even when years of training are similar. Even within the same profession — as we have seen for medicine — women with the same educational qualifications as men don't earn the same.

It is already evident that fewer men are applying to the 16 Cana-

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dian medical schools. In a study of applications between 1973 and 1979, Ryten discovered "a truly startling change". While applications from women had increased over the 6 years by 23%, applications from men had dropped by 26%. Even allowing for a predictable decline from the peak year of 1973-74, "it is difficult to suggest plausible reasons why there should have been such a drop in demand . . . amongst Canadian males". Fewer men than before,

apparently, consider careers in medicine attractive.

It seems that Dr. Relman's feeling that "major transformation in professional attitudes and styles of practice are in the offing" applies equally to Canada and to the United States. What's more, these transformations will probably happen in Canada first, because the concentration of women physicians in our manpower pool is rising even faster. Apart from the greater proportion of graduating physicians

emerging here, medical statisticians also suspect that the majority of physicians drifting to greener pastures and warmer climes further south are men. Dr. Waugh of the APMC recently suggested to Dr. Relman, "If you want to assess the impact of this change, you need only look north of the border, since the wave of women medical students will break first on these shores."

How Dr. Emily Stowe would have rejoiced! ■

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