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History in Progress

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American Women Physicians in 2000: A History in Progress

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This article surveys major trends in the history of women physicians in American medicine during the 20th century, noting especially factors that have elicited renewed and increasingly public attention during the past two decades. These include the challenges of achieving greater professional visibility while also balancing family and career, of sustaining women physicians' legacy of commitment to women's health and primary care medicine without reinforcing the traditional stereotype that these are the specialties "best suited" to women doctors, and of addressing the need for more ethnic and racial diversity in the medical profession. Other recent developments include the leveling off of the number of women entering medical school and the increasing tendency of both men and women physicians to practice as employees.

In May 1999, the *Chicago Sun-Times* ran a story about women physicians' growing dominance in the field of obstetrics/gynecology. The male chair of the obstetrics/gynecology department at Rush-Presbyterian-St. Luke's Medical Center commented, "Women objected to the good old boys club. Now they have a good old gals club. History repeats itself" (*Chicago Sun-Times*, May 7, 1999:1). But does it, really? In 1990, in honor of AMWA's 75th anniversary, *JAMWA* published a history of the association.¹ A decade later, as we move into the 21st century, *JAMWA's* editors have asked that we look back at the careers of

American women physicians during this century and consider more recent, significant changes in their demographic profile and career prospects—changes that have become apparent only during recent decades.² In short, the following discussion will ask: How has the world changed for the woman physician, and how has she herself responded to the changing conditions of the profession? This article will particularly stress three factors that dominate the professional landscape for women physicians today: the continuing challenge of achieving professional visibility while maintaining some balance between family and career, sustaining women physicians' legacy of commitment to women's health and primary care medicine without reinforcing the stereotype that these are the specialties "best suited" to women doctors, and achieving greater ethnic and racial diversity in the profession.

What did the future of women physicians seem to hold in 1915, the year of AMWA's founding? Medical feminism—AMWA's original *raison d'être*—commanded the loyalty of relatively few women physicians. When AMWA was formed, in fact, most currents in the culture of medicine were flowing away from sex-specific health care institutions. Women's medical schools were almost all defunct, for example, with the Woman's Medical College of Pennsylvania the sole exception. A majority of women medical students had been choosing coeducational schools for 20 years. Women's hospitals and clinics were also beginning to decline. Granted, for much of the second half of the 19th century, society at large and many women physicians themselves believed in the necessity, or even the desirability, of concentrating women physicians' practices in a feminine sphere bounded by women's health, pediatrics, and the social-housekeeping aspects of public health.^{3,4} By the 1920s, however, new conceptions of biomedical science, of therapeutics, and of medical profes-

sionalism were ascendant. This perspective de-emphasized the individualized psychosocial and environmental dimensions of illness in favor of generalizable and measurable markers of disease. In the eyes of leading medical figures, professional authority would be reinforced by the laboratory, not by a well-informed relationship with patients and their families. (Not that a good surgeon, for example, should not have known whether the patient could afford the many weeks of bed rest then thought essential to a full recovery. But such information—at least in theory—was to have been provided by the new, largely feminine field of medical social work.) Medical education and practice thus redefined the "scientific" approach to diagnosis and treatment as one that could transcend such particularities as a patient's social class, race, or sex. By 1920 few women physicians would have wanted it any other way—even though their own practices remained, by and large, in an implicitly feminized domain. In this context, sex-specific health care and all-women's professional societies seemed irrelevant, old-fashioned, or even harmful to the progress of women in medicine.²

Certainly this characterization is less a description than a caricature of actual practice in the first third of the 20th century. Yet as an *ideal*, it did undermine the rationale for women's medical institutions and, indeed, the need to educate women doctors. Constituting less than 1% of the profession in 1870, women accounted for 5% of practicing physicians by 1920 and 4% of medical graduates. But, primarily because of the restructuring of the profession and continuing discrimination, these figures barely improved over the course of the next half-century. By 1960 women made up only 6.8% of practitioners and 5.7% of medical graduates.² (Tables 4.2, 8.1, 8.2) Moreover, the dominant structures of career opportunity in the first three-quarters of the 20th century were *not*

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gender neutral. They made no allowance for marriage, for family, or for the debilitating effects of sex discrimination in the profession. As AMWA's Committee on Career Opportunities for Women quickly discovered, internships and, by the 1930s, residencies in the better hospital programs were almost never awarded to women medical graduates. To a significant degree, this resulted in women's rates of formal specialization—and, thence, research opportunities, academic careers, and specialty society memberships—trailing even their modest proportion of the physician population and holding back their overall progress for decades.

AMWA's early leaders, particularly Bertha Van Hoosen, MD, Louise Tayler-Jones, MD, Martha Tracy, MD, and Kate Hurd-Mead, MD, attempted to circumvent these obstacles by promoting a model of female professionalism that would integrate women into the scientific and professional mainstream, and, at the same time, in Dr. Tracy's words, support "special work for women and children" by women physicians. They expected AMWA to help shape a workable model of female professionalism that would serve the needs of both women and medicine.^{1 (p165)} Thus AMWA and many of its individual members actively participated in the campaign to send women doctors overseas during World War I, helped enact the Shepard-Towner Act to establish maternal and child health clinics, were active in the medical work of the United States Children's Bureau, and worked closely with the health committees of local laywomen's groups. These seemed to be the avenues of advancement for women physicians during the early decades of this century.

With the exception of AMWA's successful campaign to gain women's admission to the Army Medical Reserves during World War II, however, its leaders—like most women practitioners—soon lost interest in directly challenging the gender norms governing American society and the medical profession. Only in the late 1950s did AMWA's original commitment to medical feminism begin to revive. Shortly thereafter, spurred by the civil rights movement and sustained by the rebirth of modern feminism, a combination of federal legislation and

executive orders between 1964 and 1974 barred discrimination in education and employment on account of race or sex. The number of women applicants rose and, under threat of lawsuits, medical schools across the country began to increase the number of women admitted to their entering classes. The number of women graduating from American medical schools reached unprecedented levels. By 1990, women made up 33.9% of the graduating classes of American medical schools and 16.9% of practicing physicians.^{2 (Tables 8.2, 8.3), 5-7} Women's place in the profession seemed on the brink of a dramatic—and permanent—reconfiguration.

How has the history of women physicians in the past two decades complicated this seemingly straightforward narrative of success? Slower progress, linked to continued obstacles to balancing personal and professional life, a painfully slow increase in the level of racial/ethnic diversity, and an unanticipated continuity of interest in primary care and women's health—these themes characterize the most striking aspects of American women physicians' contemporary history. We'll begin with the issue of women's progress in the profession and its link to the issue of balancing family and career. Measured quantitatively, the past three decades have produced remarkable gains for women physicians, largely as a result of federal equal opportunity legislation from the 1970s coupled with the impact of the feminist movement on women themselves. As of 1997 women made up 40% of medical graduates and 21.3% of all practitioners, compared with 8.4% and 7.6%, respectively, in 1970. Women physicians accounted for approximately 24% of full-time academic faculty. Significantly, however, according to the Association of American Medical Colleges, these increases have leveled off during the past two years. Moreover, even accounting for women physicians' younger age and fewer years in practice (in the aggregate), they are proceeding more slowly than their male colleagues into the upper ranks of the profession. In 1995, for example, they constituted 25% of all full-time medical faculty, but only about 11% of full professors; similarly, women made up only about 10%

of hospital chief executive officers in 1995.^{2 (Tables 8.2, 8.3), 8}

Do these figures demonstrate the continued existence of gender discrimination, or do they suggest a more complex reality? The experiences of neurosurgeon Frances Conley, MD, and others should caution us against rejecting the possibility that discrimination against women in medicine persists. Yet over the past decade, it has become clear that a more nuanced understanding will serve better to explain the actual obstacles faced by women physicians and to account for their own values and choices in constructing medical careers. Any such account must acknowledge that women physicians choose primary care specialties and non-tenure or employee status in great numbers—choices that, given inflexible professional institutions, often presage successful but less powerful careers. On the other hand, many women make these choices purposefully—to accommodate a life plan that gives importance, even centrality, to balancing obligations to profession and family.

Research during the 1990s has examined whether women physicians' practice styles, particularly in primary care, differ substantively from men's. As Judith Lorber, PhD, and many others suggest, women physicians face strong social expectations to be empathic. Women physicians have been shown to spend slightly more time with each patient and to engage in more supportive verbal and nonverbal communication (such as reinforcing patient narratives with "uh huhs," smiles, nods).⁹⁻¹¹ Hall et al,¹⁰ however, found that women physicians' advantage is more apparent with women patients. Physicians in general are better received by patients when they master these skills and, of course, many male physicians also are renowned for their capacity to communicate empathy.^{11,12} Yet on balance, women doctors do seem to excel at doctor-patient communication, a central skill of clinical medicine.

Paradoxically, they are today being asked both to communicate well and to be mindful of "physician productivity." This potential double bind, whose recent history has intimate links to the rise of managed care organizations, affects men as well as women in medicine. Indeed,

one of the major trends of the past decade has been the increasing convergence of male and female physicians' practice patterns; both sexes increasingly work as employees rather than as self-employed practitioners.^{13,14} Women's increased presence in medicine thus coincides with a massive shift in structures of career advancement that were in place for three-quarters of a century. If doctors' professional legitimacy was defined by reference to research in 1950, it is defined as much today by the size and efficiency of their clinical enterprise. Health maintenance organizations and large group practices have discovered that significant numbers of patients prefer women physicians. Women's battle for *clinical* legitimacy has been won. In this environment of crammed patient panels and fixed practice hours, however, family and career advancement compete for the few hours left at the end of the day.

An account of women physicians' professional odyssey should also make clear that, for the sizeable minority of women who do pursue careers in academic research or administration, significant obstacles still obstruct their progress. One is the well-known conflict between the tenure clock and the "biological" clock for childbearing and child rearing. Another more intractable challenge is the need to overturn traditional presumptions that presume that professional "leaders" will always resemble the dominant model of the past century: male, career driven, and married to a "supportive" wife. Mentoring programs, unproblematic parental leave, on-site child care, meetings that end by 5 PM, and administrations that openly support gender fairness—these are some of the measures that can help academic women physicians maintain their career momentum without sacrificing their families.

Increasing women's health research and establishing a new specialty in women's health have been proposed as ways to finesse the double bind facing women who wish to become leaders in the medical profession without jettisoning their identities as women or their interest in the health needs of women patients. With support from Bernadine Healy, MD, then director of the National Institutes

of Health, Congress in 1991 authorized the NIH to found the Office of Research on Women's Health, headed by Vivian Pinn, MD. At about the same time, NIH guidelines began directing clinical researchers to either include proportional numbers of women as experimental subjects or to justify their underrepresentation. Several medical textbooks on women's health have also appeared, complementing early efforts to establish medical school curricula in this field.¹⁵⁻¹⁷ It is still too early to tell if women's health will become a board-certified specialty. If it does, will it reinforce the segregation and undervaluation of women's health in the medical curriculum, or (as is certainly intended) will it become a source of female professional authority by creating a formal institutional base for a female-friendly specialty? As one potential source of compromise, some medical schools are developing subspecialty tracks in women's health care within generalist specialties such as family medicine or general internal medicine.¹⁸

The effort to increase racial diversity is another facet of the recent history of the profession, one that is just beginning to receive scholarly attention. According to findings of the Women Physicians' Health Study, African Americans have increased their representation among the population of women doctors from an average of 1.7% during the 1950s to 5.3% during the 1980s; comparable figures for Hispanic/Latina women physicians are 4% (1950s) and 5.4% (1980s).¹⁹ Writing a decade ago, prior to this small but definite increase in the number of minority women physicians in the United States, it seemed quite appropriate to generalize about women physicians regardless of different racial/ethnic backgrounds. We now know that some generalizations based on gender are in order, but only those that have been subjected to deliberate investigational scrutiny.

For example, it has been suggested that differences in racial/ethnic background would significantly contribute to differences in the career goals and life plans of women physicians. To test the relative importance of race/ethnicity and gender in determining women physicians' career and lifestyle choices,

we surveyed a small sample of women physicians (109 African American and 109 non-African American) residing in the Houston-Galveston region of Texas during the fall of 1995. The overall response rate was 55.4%, 51% of African-American women physicians and 59.8% of non-African-American women physicians. The respondent group could be described as, on average, 42 years of age, 40.2% with at least one child, with 32.6% of African Americans currently single compared to 12.3% of other respondents. Both groups had similar years of experience, a mean of 9.4 years in practice. Since the characteristics of the universe of this population were not available, the sample's representativeness cannot be expressed with precision. Frequency distributions do not carry statistical significance, and thus the results can be reported only as observations and not as general conclusions concerning this population. This preliminary study merits follow-up with a larger, national sample (Greer MJ, Fields VW, More E, unpublished data, 1996).

We hypothesized that the career goals and life plans of African-American and non-African-American women physicians—defined as specialty choice, practice setting, community involvement, and family responsibilities—would demonstrate that gender was a more powerful predictor of career and life plans than race/ethnicity. That hypothesis appears to be only partially valid. Although the external characteristics of the careers of both groups of women were similar, their perceptions of their careers differed in important ways. (Major differences were defined as ranges of response that differed by 20% or more between cohorts or in overall differences of the priority rankings they assigned to items on the questionnaire.)

The two groups proved most similar in their choices of specialty and practice setting. For both groups, personal preference was the most common reason for choice of specialty, and the three most frequently selected specialties were internal medicine, pediatrics, and family practice. But when we analyzed the two cohorts separately, we found major differences between the African-American and non-African-American respondents in their

perceptions of major obstacles faced in medical school, residency/fellowship, and in establishing their practices, as well as in identifying those who provided them with encouragement and/or mentoring.

African-American women physicians selected racial discrimination as the primary obstacle encountered in medical school, residency/fellowship, and establishment of practice. Non-African-American women, on the other hand, reported that financial obligations were the major obstacle during medical school and residency/fellowship, and family responsibility to a spouse/partner was the greatest obstacle to establishing a practice. Both non-African-American and African-American women listed responsibilities for child rearing as their second major obstacle during establishment of practice.

The non-African-American cohort reported students and faculty as their chief sources of encouragement throughout their early careers. African-American women physicians reported receiving encouragement and/or mentoring from fellow students, but also from nurses and members of the clerical staff. Nurses, in fact, were cited as important sources of mentoring and encouragement throughout their careers.

African-American women physicians were more likely than their non-African-American counterparts (for up to 25% of their weekly allocation of discretionary time) to participate in church-related and community outreach work. African-American women physicians' perception of their "double jeopardy" status—minorities of race *and* sex—as well as the historic tradition of black community self-help may have contributed to the greater frequency with which they practice in communities of the underserved as well as to their greater allocation of time to community and church-related activities.²⁰

To conclude, the increasing number of women physicians seems to bode well for their future status in the profession. Sociologist Rosabeth Moss Kanter has demonstrated for women in corporations the near impossibility of achieving lasting influence or power under conditions of extreme underrepresentation. Kanter characterized any population that represents less than one-third of a group's

members as a "tilted" ratio. That is, as a minority within the larger group, it will have little power to affect group decisions.²¹ The same is true for women physicians, particularly in academic medicine. Even now, they represent less than one-fourth of practicing physicians. With a nearly ninefold increase in women medical graduates from 1970 to 1995 (when they accounted for 39.1% of graduates), their representation in the field grew from 7.6% to 20.7%. But, according to the Association of American Medical Colleges, the rapid growth of the 1970s and steady growth of the 1980s appears to have plateaued in the 1990s.^{8 (p1)} The same seems to be true for the percentage of full-time medical school faculty who are women.^{8 (p2)} If (for the sake of argument) we assume the persistence of the currently steady rate of 40% women medical graduates, it will take decades for women to reach even 40% of the profession, approximate parity with men according to Kanter's model. Viewed from the end of the 20th century, then, women physicians in America have made remarkable gains in a very short time. But the energy, vigilance, and commitment demonstrated by the generation of the 1970s—the first cohort to benefit from equal opportunity legislation and the rebirth of modern feminism—will still be necessary if women's newfound presence in the profession is to effectively represent women's interests both as patients and as physicians. ■

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