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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. 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. 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. By the 1920s, however, new conceptions of biomedical science, of therapeutics, and of medical professionalism 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.

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. Moreover, the dominant structures of career opportunity in the first three-quarters of the 20th century were not
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 Taylor-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. 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.

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 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.

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,
lethargic parental leave, on-site child care, 
career driven, and married to a “support-
mant model of the past century: male, “leaders” will always resemble the domi-
need to overturn traditional presump-
Another more intractable challenge is the 
for childbearing and child rearing.
tenure clock and the “biological” clock 
obstacles still obstruct their progress. One 
women who do pursue careers in acade-
professional odyssey should also make 
of the day.
compete for the few hours left at the end 
of the day.
An account of women physicians’ 
journey should also make clear that, for the sizeable minority of 
who do pursue careers in academ-
ric research or administration, significant 
obstacles still obstruct their progress. One 
is the well-known conflict between the 
and the “biological” clock for childbearing and child rearing.
Another more intractable challenge is the 
need to overturn traditional presump-
tions that presume that professional 
“leaders” will always resemble the domi-
nant model of the past century: male, career driven, and married to a “support-
ive” wife. Mentoring programs, unpro-
lomatic parental leave, on-site child care, 
meetings that end by 5 PM, and adminis-
trations that openly support gender fair-
ness—these are some of the measures 
that can help academic women physi-
cians 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 
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 underrepresen-
tation. Several medical textbooks on 
woman’s health have also appeared, 
complementing early efforts to establish 
medical school curricula in this field. 
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 
tended) 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.

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). 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 back-
ground 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, 

We hypothesized that the career goals 
and life plans of African-American and 
non-African-American women physi-
cians—defined as specialty choice, prac-
tice 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 prefer-
ence 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.

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. 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. The same seems to be true for the percentage of full-time medical school faculty who are women. 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.

References