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Invited Editorial

Women in medicine: It is not only necessary but also essential for the next generation

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1. What Do We Know About Women in Medicine?

Globally, women account for almost 50% of the population [1]. Therefore, it is not surprising that just over 57% of all women participated in the labor force in 2019, and it should not be surprising that many seek higher education, including careers in medicine [1]. Women now comprise 50% of matriculants to medical school and now account for close to 30% of the physician workforce in the US [1]. This brings the necessity of the changing landscape to support the needs of this student body and workforce.

Unfortunately, the increase of women in medicine is associated with many challenges, with women physician retention and academic promotion less than their male counterparts. Challenges exist in both professional and personal spheres. Supportive structures for pregnancy, lactation, family expansion, and child raising do not really exist in the medical profession in general but have long been shouldered more in some families by women. During the pandemic, women physicians who could not work from home and had children who were learning remotely faced monumental decisions of how to juggle this newfound problem, as childcare was not always readily available. Professionally, women persist in small numbers in positions of leadership, especially at the executive or dean level, with only 16% representation [2]. This unbalanced hierarchy in leadership requires intentional interventions where needed, especially in academic institutions where these structures tend to perpetuate themselves despite the change in the population landscape with the increased number of female medical students [2].

The hierarchical imbalance in medicine is even more magnified for physicians of color and underrepresented in medicine (URM), where, according to the American Association of Medical Colleges (AAMC), 9% of physicians identify as Black, American Indian, Alaska Native, and Latino [3]. The intersectionality of gender and ethnicity always presents additional challenges. An important change in our world's population is the increase in racial diversity, with a significant proportion of people in the US identifying as multiracial. Gender and ethnic diversity are important when addressing healthcare disparities and improved health outcomes.

Gender is one source of systematic variation in medical encounters, where women and men differ in the way they communicate with their patients [4]. Gender is "linked to fundamental processes of interpersonal communication" and will have an impact on medical interactions, where effective communication is so critical [4]. In addition, women healthcare clinicians have improved ability over men to better conduct consultations and engage in partnership building, and this is likely related to styles of communication, both verbal and non-verbal [4]. The baby boomers, our largest generation, are all over 60 years and aging with many more healthcare needs. Fifty-eight percent of them are women and their healthcare needs have changed over the last decades as we see women are living longer. They are an important group, who, in the US, make approximately 80% of the healthcare decisions for their families [5].

2. Workforce Diversity

Additionally, there is a gender gap in the workforce for members of minority racial and ethnic groups, such that 52% of younger physicians are women compared with men. Finally, URM faculty represent only 4% of the faculty members in medical schools in the US [3].

Although this commentary is focused on women in medicine, the problem is compounded when race and ethnicity are added. Increasing the pool of women physicians alone is not enough and increasing the pool of women leaders and mentors is a vital factor and can only be intentionally addressed across the healthcare field. This will only happen when institutions become accountable and improve efforts to recruit and retain a diverse healthcare workforce, including those from underrepresented populations.

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3. Conclusion

According to the AAMC, pre-COVID pandemic, 40% of women scale back their practice or leave the workforce altogether. Innovation occurs out of necessity and it is necessary that we are intentional and innovative as we think about our changing physician workforce on many levels, including and not limited to the needs of women physicians, a workforce that expresses more of a desire for work-life balance without sacrificing leadership and academic promotion. Creation and innovation are required in the healthcare system, as is a willingness to accept new models that will allow for this progress. As we seek to improve healthcare outcomes and reduce healthcare disparities, it becomes clearly necessary that gender and ethnic diversity are reflected in the physician workforce, and this needs to be addressed early in our educational structure, from matriculants and continued to leadership within the upper ranks of healthcare organizations.

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