The X-factor

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Now you're a married woman, aren't you?" That was the common introductory question from my women patients in northern Newfoundland, before they would feel free to go ahead and confide their various troubles. I was one of those "lady doctors," a young one, of course, so probably not too wise in the ways of the world. But definitely a doctor of the right sex with whom a married woman could talk about her gynecologic or marital problems.

It has been many years since Dr Emily Stowe became the first woman physician to practise in this country; in 1870, her classmate Dr Jenny Trout was the first woman licensed to practise medicine in Canada. Dr Stowe's daughter, Dr Augusta Stowe-Gullen, was the first woman to graduate from a Canadian medical school in 1883.

My own medical school class was 20% women—enough that we were not anomalies, but in the overall practice population of physicians, our presence was still somewhat of a novelty. As we 1976 graduates moved ahead in our careers, we were often not the first women to have achieved what we did. When I became Head of the Department of Family Medicine at Queen's University in Kingston, Ont, I had the honour of succeeding Dr Janet Sorbie. The College of Family Physicians of Canada had its first woman president, Dr Joan Bain, in 1987, and I am proud to be the fifth woman president of our organization.

Now, in 2008, 55% of the respondents to the 2007 National Physician Survey (**www.nationalphysiciansurvey.ca**) under the age of 35 were women. Almost half (47%) of College members are female, and women are in the clear majority of those members under the age of 45.

Equal numbers is not equality

Increasingly, data are showing that women work at their profession fewer hours than men. Regardless of age, the 2007 National Physician Survey shows that women physicians report spending 47.5 hours per week at work versus 53.8 hours for men. This gap widens by almost 13 hours per week for women who have children under 5 years old at home; the gap narrows to a difference of only 1.3 hours per week once children are grown, particularly if there are no dependants. In fact, both men and women younger than my baby-boomer age group work fewer hours. They are seeking—and achieving—a different balance between professional and personal lives than did my generation. (Although we often talk about work–life balance, we are fortunate in having a satisfying, remunerative, absorbing profession—surely our work as physicians is part of our life.)

Reports of this trend in medicine have occasionally tended to blame women physicians for the shortage of physicians overall. When there is a shortage of family physicians, it is easy for some to suggest that fewer women in medicine would solve the problem.

At the other end of the spectrum, some reports describe women's practice patterns in a way that suggests women have a monopoly on caring. Women do, on average, spend slightly longer on each patient encounter and engage in more preventive maneuvers.[1] However, men who choose family medicine, in my experience, are also making a choice of career where patient-physician relationships are central; they themselves are often the epitome of caring communicators.

Then there are those who controversially denounce the increasing participation of women in the profession by suggesting that the profession itself has consequently become devalued—whatever women do, goes this line of thinking, is less valued by society. Women are doing family medicine, so it must be less valued in our society.

Pushing forward

So, what are we to make of these trends? Both women and men have a great deal to offer the practice of medicine, and family medicine in particular. Family medicine challenges our technical abilities, our gifts as listeners and teachers, our physical stamina, and our emotional and spiritual breadth. It is an all-consuming, tireless job, and all those willing to engage in it are needed. Certainly our health human resource planning (such as it is) needs to take into account generational and sex differences in practice patterns. And our practice models need to be family-friendly to both men and women physicians in their child-rearing years. As to the status of family medicine, whether its physicians are men or women (let alone whether they are married or single), I have no worries. It will always be highly regarded wherever attentive, personal, and skilled medical care is valued.

Cet article se trouve aussi en français à la **page 654.**

Reference

1. Contandriopulos AP, Fournier MA. *Féminisation de la profession médicale et transformation de la pratique au Québec.* Montreal, QC: Quebec Medical Association; 2007. Available from: **www.amq.ca/fra/PDF/feminisation_final.pdf**. Accessed 2008 Jan 23.