

Female family physicians and the first 5 years

In pursuit of gender equity, work-life integration, and wellness

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We have still not shattered that highest and hardest glass ceiling.

Hillary Rodham Clinton

The feminization of family medicine in Canada has seen the representation of women tripling to 45% in the past 4 decades.¹ With this shift, we see numerous benefits to our health care system, patient care, and medical education. Female family physicians employ more patient-centred communication, spend more time with patients,² and address a greater number of issues per visit³ than their male colleagues do. They spend more time on preventive and psychosocial aspects of patient care,⁴ and display higher levels of empathy, which are factors associated with higher patient adherence and greater patient satisfaction.⁵

The increasing proportion of women in family medicine is often viewed as a success for feminism, the diversity of the profession, and overall population health.⁶ Yet many female physicians are faced with gender-based obstacles to professional and academic success, resulting in disproportionate rates of burnout and negative effects on their career trajectories.⁷ It is disheartening that in 2019 women still face overt and hidden barriers to full inclusion and equity. Female family physicians just starting their practices might be especially susceptible to these challenges, with female sex, younger age, and early career status being independent risk factors for burnout.⁸⁻¹² The 2017 Canadian Medical Association National Physician Health Survey⁸ supported previous research findings demonstrating that considerably more female physicians reported lower resilience and higher levels of burnout, depression, and suicidal thoughts than their male counterparts did.¹³⁻¹⁵

While the pursuit of gender equity in medicine is being explored in other jurisdictions and disciplines, the unique challenges for early career Canadian family physicians have not been comprehensively considered. As 3 female academic family physicians coming to the end of our first 5 years in practice, we reflect on our own challenges and the challenges of those who have come before us, and propose solutions that we hope will pave the way for a national dialogue to better empower and support our early career female colleagues.

Challenges

Early career female family physicians face unique systemic and individual challenges (Box 1).

Box 1. Challenges among early career female family physicians

Systemic

- Implicit gender biases
- Overt harassment
- Gender-based pay inequities
- Lack of women in leadership positions and support through career transitions and advancement
- Lack of comprehensive family-, caregiving-, and medical-leave policies

Individual

- Balance of home, child care, and caregiving responsibilities with professional responsibilities
- Imposter syndrome, which is most prevalent in women and early career physicians
- Intersecting forms of social positions

Systemic challenges. Inherent systemic issues make it challenging for female family physicians to be professionally and financially supported as they begin their careers. Compared with their male counterparts, female physicians are often confronted with implicit gender biases held by their patients, learners, and colleagues, making them more likely to receive lower evaluation scores, be deemed less capable by medical students,^{16,17} and be less often introduced as *Doctor*.¹⁶⁻¹⁸

Dr Bogler shares the following personal experience:

In my first year as a staff family doctor, I entered the elevator in my scrubs after delivering a baby, where a gentleman asked me, “How does it feel to be a nurse?” I smiled politely, but this was neither the first nor the last time I have been asked this question. I have been mistaken for a nurse many times, even while standing next to my husband who is a physician of the same age and year of medical training—both of us were wearing stethoscopes. The only difference is that he was assumed to be a doctor and I was not.

More explicitly, sexual harassment toward women continues to pervade medicine despite efforts to improve gender equity, and increased awareness from movements such as #MeToo.¹⁹ Professional support is also lacking, as women are underrepresented in leadership positions in medical institutions and academic departments, and generally face greater obstacles to career advancement.²⁰ A lack of supportive and comprehensive parental-, caregiver-, and medical-leave policies, often

disproportionately affecting those in early career, further adds to these challenges.

Pay inequities for women continue to exist across most industries, and medicine is no different. Female physicians make less than their male colleagues do even after controlling for age, specialty, practice characteristics, and number of hours worked.²⁰⁻²² Multiple factors might contribute to these inequities including payment models that compensate volume over quality, the need to balance work and family responsibilities, and seeing fewer patients in favour of more time with each.²³

Individual challenges. Restrictive gender norms also disproportionately affect female family physicians early in their careers because of the challenges involved in integrating work and life responsibilities. Female physicians spend more time than male physicians do on domestic and home responsibilities and subsequently contribute fewer hours at work.^{19,24} Women leave academic medicine at a higher rate than men do, while bearing more family responsibilities; this is particularly evident in early career physicians returning to work after parental leaves.^{25,26} Compared with their male counterparts, female family physicians generally experience an inverted career pyramid.⁶

Another challenge disproportionately affecting female physicians is the “imposter syndrome”—an inability to believe that one’s success is deserved or has been legitimately achieved as a result of one’s own efforts or skills.²⁷ Imposter syndrome might be heightened in the early years of a physician’s career and amplified for women with intersecting forms of social positions such as race and sexual orientation. As Dr Rambihar explains:

Throughout my first 5 years in academic family practice, I have often been introduced or referenced without the title *Doctor* by trainees and patients, in written communications, and on panels where colleagues have been introduced with their full titles. Several of my mentors with similar past experiences suggested this might propagate feelings of imposter syndrome, encouraged me to ask to be referenced as my colleagues were, and suggested I question whether on a professional scale this was related to gender, seniority, or other types of implicit bias.

Solutions

Here we propose several solutions to help achieve gender equity, work-life integration, and wellness (**Box 2**).

Systemic solutions. Systemic solutions to address these challenges should be undertaken by family medicine organizations and departments, and be better incorporated into existing educational structures and compensation models. We encourage implicit bias and sexual harassment training for all levels of training, career

Box 2. Practical strategies to improve gender equity, work-life integration, and wellness for early career female family physicians

Systemic and institutional strategies

- Mandatory implicit bias training
- Flexible work policies and scheduling
- Financial advisors specialized in supporting women around early career planning
- Development of comprehensive family-, caregiving-, and medical-leave policies
- Effective mentorship and career advancement support
- Research on the reasons for increased burnout among vulnerable groups (eg, residents, women, early career) and best practices to minimize these risk factors

Individual adaptive strategies

- Peer-to-peer support (eg, Balint groups, PBSG support, social media forums), which can help connect women, as well as target imposter syndrome and burnout
- Open communication with colleagues and leaders on career goals
- Effective time management, proactive scheduling, and outsourcing of domestic tasks
- Setting boundaries, being comfortable saying no, and managing the 24 hours a day, 7 days a week nature of the EMR

EMR—electronic medical record, PBSG—practice-based small group.

seniority, and genders, which can be delivered through multidisciplinary rounds and workshops. Flexibility in scheduling and expectations for early career female family physicians can improve their sense of career control, satisfaction, and likely longevity. Scheduling of meetings and extracurricular commitments, specifically in early morning and evening, should respect work and life responsibilities, and team-based care with a collaborative approach to cross-covering patients can further support flexibility needed for parental or sick leave or caregiving responsibilities.

The physician gender wage gap should be addressed with further research on the causal factors and effects on physicians, patients, and the health care system. In family medicine, research on which payment models widen or lessen this gap is also recommended. We advocate for systems that adequately compensate for time spent with patients and complexity of care, especially in family medicine, which faces increasingly socially and medically complex patients. Caring for many such patients can take a toll on a physician and the physician’s practice, as described by Dr Lazare while reflecting on a female colleague’s difficult predicament:

In a casual conversation about practice management with colleagues, an older male colleague remarked that he has his practice “well trained”—patients come to see him infrequently, and mostly for medical issues rather than psychosocial ones. A female colleague

shared that, in contrast, she seemed to attract more psychosocially complex patients whom she had to spend more time with at each visit, which she finds very stressful. It requires her to maintain a smaller practice size to adequately meet their needs.

Financial advising, with a focus on practice management for women, should be more readily available. Family medicine organizations and departments should be transparent in their payment models and adequately invest in comprehensive parental-, caregiver-, and medical-leave policies. This is essential, as many of these female physicians taking leaves are in the process of building their practices and are often still carrying large debts from their medical training.

Formalized mentorship is also essential to support women as they start their medical practices and begin to advance in their careers. We recommend leveraging existing forums for early career physicians (eg, First Five Years in Family Practice Committee). The existing academic advancement model also does not recognize parental leave as a period where academic growth is difficult to sustain. We need to recognize that women take unique pathways toward promotion and career advancement, and productivity and professional reviews should be carefully and uniquely assessed for these women.

Finally, more research needs to be done within our family medicine organizations, departments, and educational programs to identify the reasons for, and the effect of, increased burnout in early career female family physicians.

Individual solutions. We encourage peer-to-peer support through Balint groups, practice-based small groups, and social media networks, such as the Canadian Physician Moms Group on Facebook. These forums allow female physicians to connect and share strategies around managing work-life balance, practice and billing, child care, and domestic tasks, as well as deconstructing imposter syndrome. Early career female physicians should be encouraged to have open communication with colleagues, leaders, and family members about personal career goals. To help minimize work-life conflict, solutions include practising effective time management, establishing proactive scheduling, and, for those who have the option, outsourcing child care and home responsibilities. Furthermore, setting boundaries is crucial for personal and professional growth, particularly in the era of electronic medical records where family physicians are often universally available.

Conclusion

It has been nearly 140 years since Dr Emily Stowe became the first female licensed physician in Canada only a short time after being denied entry to medical school on the basis of her sex.²⁸ Despite the notable

gains that women have realized in our profession, there is much more work to be done. It is disappointing that in 2019 female physicians are paid less than their male counterparts and that the medical profession and academic institutions still do not fully accommodate the unequal challenges women face in integrating work and life responsibilities. These challenges are very relevant to our discipline of family medicine, especially within the first 5 years of practice, where female physicians achieve less academic advancement, are underrepresented in leadership positions, and experience disproportionately higher rates of burnout. As we have detailed, several tangible and scalable solutions exist to disrupt gender inequities in the profession and to ensure that all physicians can have better work-life integration and overall wellness. 🌿

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Competing interests

None declared

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