Sexism in obstetrics and gynecology: not just a "women's issue"

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THE PROBLEM: ••••.

A SOLUTION: ••••.

Women have made significant progress in medicine. Since 1970, women have entered medical school in ever increasing numbers; in 2017 for the first time, more than one-half of medical students were women.[1,2] No other subspecialty in medicine has seen such a dramatic shift in gender dynamics as has obstetrics and gynecology. Over 80% of residents matching in obstetrics and gynecology are women. In 2012, women comprised >50% of Fellows and Junior Fellows in the American College of Obstetricians and Gynecologists. Today, nearly 60% of practitioners in obstetrics and gynecology are women, far exceeding any other surgical specialty. Further, obstetrics and gynecology has the highest proportion of underrepresented minorities, specifically black and Hispanic physicians, when compared with any other specialty,[3] which demonstrates another positive trend for diversity and inclusion in our field.

Core recommendation

Progress, however, is not success. In medicine as a whole, by almost any metric, the gender gap persists. In academic medicine, women are paid less from the start of their first faculty appointment; they are promoted less often and at slower rates.[4] In the late 1980s, the median annual earnings for women physicians, adjusted for age, sex, race, hours worked, and state, was 20% less than that of physicians who are men; 20 years later, the gap actually had increased to 25.3%.[5] Additionally, startup funding for basic science researchers in medicine is significantly lower for junior faculty who are women,[6] although some would attribute these findings to ascertainment bias.[7] In a Swedish study, applicants who are women needed to have publication impact scores 2.5 times that of applicants who are men to be deemed equally qualified.[8] National Institutes of Health grant reviewers also show bias in evaluative judgments that act against applicants who are women who apply for independent funding, particularly for women who apply for grant renewals.[9] A female sounding name on an application can alone decrease the chance for success.[10] Not surprisingly, across all specialties in medicine, the percentage of women in senior faculty and leadership positions remains low.[11] Although not the focus of this discussion, these same markers are even more troubling for underrepresented minorities.[12,13] Although these disparities may not be a result of explicit prejudices, evidence suggests that healthcare providers harbor the same levels of implicit or unconscious biases as the general population,[14] which may contribute to career barriers for women (and minorities) in our talent pool.

One might expect that a discipline dedicated to the promotion of women's health and well-being would offer greater parity for physicians who are women. However, this is not the case. In academic Departments of Obstetrics and Gynecology, physicians who are men earn approximately $36,000 more per year than their counterparts who are women after correcting for the usual variables cited for pay discrepancies.[15,16] Although factors that contribute to compensation are difficult to assess comprehensively, based on this study, an under payment of well >1.2 million dollars without inflation is estimated over a woman's career. Obstetrics and gynecology does have the largest percentage of women in leadership positions, defined as chair, vice chair, division director, or residency program director. In 2013−2014, 22% of Obstetrics and Gynecology Department Chair positions were held by women, compared with 20% in pediatrics, 18% in radiology, and 1% in general surgery.[17] However, men in obstetrics and gynecology are still more likely to advance to senior positions, compared with women, based on the representation ratios, which take into account the gender make up of earlier residency cohorts. Despite the flood of women to obstetrics and gynecology, the bottleneck for women's advancement is proportional to that seen in general surgery and internal medicine.[18] This challenges the common belief that lack of women in leadership is a pipeline issue and that, with time, the growing numbers of women will result naturally in the symmetrical representation of men and women at the highest levels.

Recommendation 1. The status of women in obstetrics and gynecology

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TABLE
Sexism in obstetrics/gynecology: what can be done?

Learn about the problems of unconscious bias and gender disparity and examine how you participate in it.
Create open forums to listen to others' perspectives on issues of disparity.
Encourage mentorship of women and advocate to increase their visibility in the broader work community sponsorship.
Provide financial transparency to encourage parity.

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likely reflects the society in which we live. Part of the reason for the observed gender gap may relate to sexism and sexist views that are held by both men and women. Sexism may be described as prejudice or discrimination based on sex and can include behavior and/or attitudes that endorse stereotypical roles based on sex. Implicit or unconscious bias are unintentional cognitive shortcuts that allow us to make rapid judgements about people based on our social experiences. Implicit gender bias is a form of sexism. Sexism towards women has been described in 2 forms: hostile and benevolent.[19] Hostile sexism is the more traditional, overt form based on the belief that women are inferior. It can manifest with the underlying assumption that women are incompetent or less competent in work that involves traditionally masculine skills and, in particular, leadership roles. An example in medicine would be cases in which female physicians are passed over for leadership roles because they may not be seen having leadership (ie, masculine) qualities and therefore are not the right "fit" for the position.

Recommendation 2. Benevolent sexism is more insidious and based on the belief that women should be protected and revered. The premise of benevolent sexism is that women should be cared for because they are weak and that men are strong. It is the foundation for male protectiveness, such that men should physically protect women, provide for them, pay for meals, open doors, etc.[19] As an example, well-intentioned male physicians may try to protect their female colleagues from the stress of a difficult case, or supervisors may not want to burden faculty members who are women from extra projects or committees that require time away from family. In these examples, women inadvertently are denied professional growth experiences and the opportunities to demonstrate competence.

In addition, women are rewarded socially if they restrict their behavior to conform to traditional gender roles and likewise punished for lack of conformity. For instance, women who demonstrate agentic qualities may not be perceived as a strong leader, rather as someone who is difficult to work with or who is less likeable.[20] The idealization of motherhood is another area where a woman's behavior is highly regulated by self and others. Mothers are expected to be self-sacrificing with primary responsibility for the physical and psychologic well-being of children. Women who comply with this modern ideal are extolled for prioritizing the care of the family above all else.[21] "Bad" mothers, however, are sharply criticized and stigmatized.[22,23] Benevolent sexism undermines the status of women by rewarding subservience and the voluntary servitude that comes with motherhood.[24] In addition, by promoting women's internal conflicts surrounding family-work balance, society encourages women to "opt-out." Although individual women will have specific reasons for making career choices, motivation and drive must be understood within the context of social factors that systematically reward some choices and discourage others.

Recommendation 3. Sexist views also have negative effects for the men in obstetrics and gynecology. The vast majority of obstetrician-gynecologists who are men support gender equality. However, as well-meaning as men in obstetrics and gynecology may be, the societal standards for masculinity may contribute to patient preferences for physicians who are women.[25] The social ideal of masculinity includes being strong, rational, emotionless, dominant, and, even at times, violent. Some women may hold the belief that men, physicians included, are inclined biologically to objectify or sexualize women, to be uncaring, and to behave more aggressively toward women as a result. These views may make it more difficult for female patients to see male physicians, particularly obstetrician-gynecologists as allies. Additionally, because of societal valuation of masculine traits over feminine qualities, men who demonstrate "feminine" traits are penalized. The same learned qualities that may make male physicians seem competent may in turn make it more difficult for them to be, or be seen as, nurturing and to establish trust with female patients.[26]

Recent progress

We are currently at pivotal point in the evolution of obstetrics and gynecology. In the era of #metoo and #timesup, women are rebelling against the constraints of the traditional patriarchal structure of society. At the same time, some men in obstetrics and gynecology are lamenting the loss of the profession as they once knew it and are asking "Are men still welcome in the field"?[27] We would argue that gender equity is not about whether or not physicians are overtly or unconsciously sexist. We are all a little bit sexist (readers can check their own biases at Harvard's website for implicit bias testing at https://implicit.harvard.edu/implicit/takeatest.html). Physicians are social creatures raised in a society with historic roots founded on patriarchy and a system in which men, particularly white men, have disproportionate power. People living today did not create this system, but all of us