Women's contribution to general practice: Medusa or Mother Teresa?

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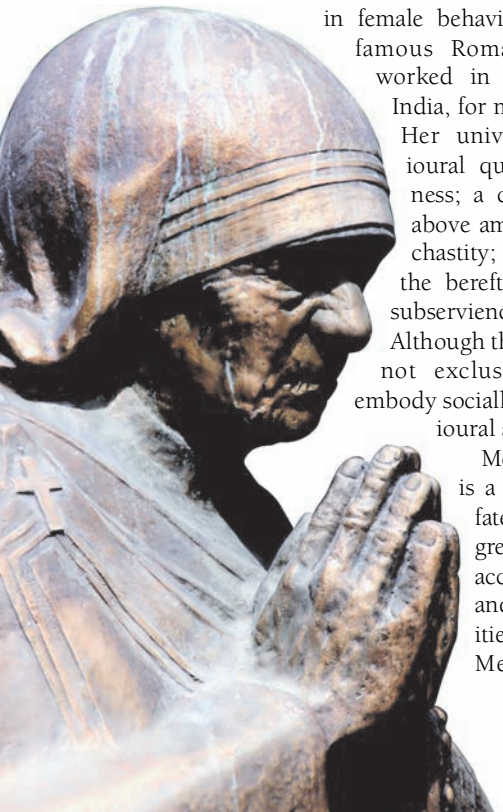
If the female perspective is missing, how can true feminisation of the medical workforce occur?

Much has been written about the feminisation of the medical workforce. However, this usually refers to the increasing numbers of women entering medicine, rather than to an adaptation of medical theories and practices to incorporate a female perspective. Women and men work differently, and these behavioural differences are attracting attention as the workforce debate brings women's contribution to medicine, and their place in general practice,[1] under an intense spotlight. A number of studies have demonstrated the gendered nature of communication and practice styles,[2-6] health care delivery[7] and patient care.[8] Some have raised the question of whether female work styles contribute to the workforce problem[9] — work styles that are often assumed to represent inherent female behavioural attributes.[10] The tension generated by increasing numbers of women within a predominantly male-driven medical ethos can be examined using two conceptual models — the "Medusa effect" and the "Mother Teresa effect". These are used to demonstrate how gender-based stereotyping, plus entrenched assumptions and concepts about gendered behaviour, may be affecting the interpretation of practice styles[11] and underpinning the workforce debate. We argue that there is an urgent need to re-think the gendered nature of medicine in order to allow us to explore innovative solutions to the problem of the current workforce shortage in general practice.

Exploring female attributes: what is acceptable behaviour?



The Mother Teresa effect exemplifies the virtuous in female behaviour. It is based on the famous Roman Catholic nun who worked in the slums of Calcutta, India, for much of the 20th century. Her universally admired behavioural qualities included selflessness; a commitment to vocation above ambition or a personal life; chastity; a willingness to care for the bereft and the destitute; and subservience to a greater authority. Although these behavioural traits are not exclusively female, they do embody socially accepted female behavioural attributes.

Medusa, on the other hand, is a mythical goddess whose fate is emblematic of transgressing the boundaries of acceptable female behaviour and highlights the complexities of gender relationships. Medusa emerges in the dawn of history, in many guises and in many civilisations. Her name means sovereign female wisdom, and she possessed powers of foresight, but Medusa paid a gruesome price for her wisdom and her power. Mythology has it that Medusa, a beautiful maiden, so enraged Athena after coupling with Poseidon in Athena's temple that Athena turned Medusa into a hideous sight, and then assisted the hero Perseus to pursue the pregnant Medusa and behead her. The symbolism of Medusa hints at retribution if female knowledge, wisdom, sexuality and independence overpower the more acceptable female virtues of nurturing and caring.

Female behaviour, women doctors and general practice

An interplay between the Mother Teresa effect and the Medusa effect echoes the complexity of the female presence in medicine across several professional domains, including the doctor–patient relationship (and local care), the societal delivery of health care, and the medical profession itself.[12]

The doctor–patient relationship

Women's presence in medicine has been good for patient care. Studies from Western countries about gender differences in the consultation have produced similar findings — women have an inclusive and democratic style of communication[13] that helps foster "collaborative relationships" with patients.[12] Women tend to be "information giving", use a more participatory decision-making model[14] and appear less motivated by financial rewards.[15] They deal with more complaints, are more patient-centred in their approach, and provide more preventive health care.[2,16] These attributes, which could be grouped or labelled as consistent with the Mother Teresa effect, are valued by patients, appear to produce good patient outcomes,[17] and have helped shift medical teaching away from a doctor-centred agenda to a patient-centred one.[18]

On the other hand, in relation to health care delivery, women's work patterns are seen by some to limit patients' access to medical services as well as being a contributory cause of workforce shortages. Although acknowledging that "empathy and communication are important",[1] quantitative studies also demonstrate that women work about 13.8 hours less per week than men, tend to work part-time, have longer consultations, and provide less institutional care, emergency services or procedural services.[10]

However, simply assuming that quantitative studies are evidence of female doctors' inefficiency or "inability to live with risk",[1] or are a consequence of female doctors preferred working styles[7] may confuse cause and effect. Numbers merely describe gendered work patterns — they do not and cannot explain them. Seeking such an explanation may help clarify solutions for some of our workforce problems. Attributing the cause to "women's behaviour" and in doing so ignoring any other possible factors could reflect an underlying attitude related to the Medusa effect.

Placing gendered workplace solutions on the agenda — some suggestions

Medical education

- All students applying for medicine should be able to attend information sessions about the personal and social expectations of being a doctor.
- Medical students need to understand how sex socialisation and sexual stereotyping can affect self-expectations, patient expectations and society's expectations of being a doctor.
- Vocational educational perspectives could address how the gender of the doctor (and the gender of the patient) can sculpt clinical practice.

Clinical practice

- Alternative models of health care delivery could be explored, such as including childcare subsidies in practice incentive payments. This could, for example, help support practices to provide childcare facilities on site to enable doctors to have access to their children, while their patients have access to the doctors.
- Job-sharing rosters could address peak times for both practice and families; split (rather than continuous) shifts may help to better match supply and demand.
- Enhanced electronic communication could ensure appropriate patient handover and follow up.

Health care policy

- There should be a decreased reliance on "proxy" workforce measures such as consultation times (if not controlled for patient gender, conditions managed, and health promotion).
- Patient health outcomes should be included in workforce modelling.
- The new opportunity provided by the GP Super Clinics could be used to trial gender-friendly workplace models of health care. ◆

The importance of these other factors, such as the patient's gender, the sex match of the doctor–patient duo or the patient's prior health status,[5,19] was highlighted in an Australian study by Britt and colleagues, who established that some of the associations attributed to gendered work styles disappeared after controlling for the influence of age, experience, other practitioners' characteristics, and patient mix.[20] Similarly, a cross-sectional European study into consultation length found that 55% of the variance was due to factors at the patient level and that "the age and sex of the doctor had no impact on the duration of the consultation".[21]

Societal delivery of health care

The missing ingredient in contemporary discussions of the effect of women in medicine is the role of sex socialisation, a powerful force for both women and men. The traditions of Western medicine have been forged in a male-centric work model. In this model, vocational commitment is demonstrated by long hours of work and dedication to the profession.[18] This could be seen as the male version of the Mother Teresa effect, except that it is predicated on a personal life that is provided by a full-time "invisible" other. That invisible other is traditionally female.

It would seem that little has changed. Many female medical students still see their gender as a disadvantage for their careers and expect that they will be required to sacrifice their professional lives to have a personal life, even if they are in a dual career relationship.[22] This persistence of "gendered schemas" within the medical profession means that "men are consistently over-rated and women under-rated" in relation to competence and performance.[23] Invisible barriers such as the classic glass ceiling[24,25] — or other hidden forms of the Medusa effect — may often stymie women's attempts at assertiveness or leadership.

Overcoming the constraints of such a "discriminatory environment"[18] may be having an adverse effect on female doctors' health and wellbeing,[26] especially if the effects of gendered behavioural expectations are not given a place at the "workforce patterns" discussion table.

In any debate that draws on quantitative data, women are likely to "fall foul" for biological reasons. In a male-centric environment, periods of peak career building coincide with the time of establishing a family. Both are time hungry, and gendered socialising still sees women expected to take the prime responsibility for both children and domestic requirements.[27] Gjerberg, from the Norway Work Research Institute, has pointed out that any discussion of medical workforce patterns that does not factor this expectation in ignores the fact that, while women work shorter hours in paid work, compared with their male colleagues, they work longer hours in total.[28]

The medical profession

Women are here to stay, and we believe that trying to dance to the Henry Higgins refrain of "why can't a woman be more like a man?" will not help us find workable and practical solutions to help shape the profession's future. Women now account for about 37% of the Australian general practice workforce overall and half the workforce among general practitioners younger than 45 years. These trends appear set to continue, as two-thirds of all GP registrars younger than 35 years are female.[29]

As the medical workforce races toward a gender balance, to what extent is the female perspective influencing major decision making within the profession? Evidence suggests this is limited, as gender still appears to have a filtering effect in terms of leadership roles, choice of specialty, and academic advancement for women within the profession.[30]

Embracing gendered health care

If the female perspective is absent from medical decision making, how is it possible for true *feminisation* of the medical workforce to occur? Real feminisation implies an adaptation of medicine's epistemology to include a female perspective and female ways of knowing, which are then expressed ontologically through its work-

force. If the female voice is missing, so is the female perspective.

As the number of female doctors continues to grow, their perspective is vital for finding workable and realistic solutions that meet society's needs and expectations for adequate health care. An obsessive focus on women's behaviour, whether it be on the Mother Teresa or the Medusa traits, in a gender "blame game" is unlikely to accomplish this perspective. As Australian researchers Joyce and colleagues have said, it is indeed "time for a new approach to workforce planning".[31]

Are we mature enough then, as a profession, to explore assumptions about gendered social and professional roles and responsibilities? In laying these bare, are we ready to truly "feminise" the medical workforce and embrace new possibilities in workplace patterns that do not sacrifice ourselves, our children, our personal relationships or our responsibilities to our community to provide medical care? The implications for medical education, clinical practice and health care policy will be considerable (for some examples, see Box). A tall order certainly, but in the spirit of the recent Australia 2020 Summit, a think tank is urgently needed that has the gendered basis of medicine firmly at its centre, with a vision focused on the need for medical theory and practice to be inclusive of all the factors that are currently moulding medical workforce styles and health care delivery.

Competing interests

None identified.

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