Womens Doctors: Comparing Medical Practice in Different Countries

The Italian "scenario"

Antonella Vezzani, Ornella Cappelli
AIDM – Associazione Italiana Donne Medico

Entry to medical school

In Italy, as in the rest of Europe, a considerable demographic shift has occurred since 1970 and continues to occur in medicine as older physicians retire and a greater proportion of women enter the profession. More than half of all new medical students are female. Women account for 33% of all doctors: only 15% are over 60 while 66% are under 35.
We need to understand the organizational and economic implication of the increasing share of medical women in the profession. There are many differences between women and men in medical practice.

Pregnancy

First of all women need balancing career and family. The timing for starting a family is a critical decision for women in medicine. The most opportune biological time for a woman to have a child coincides with the phase of life when the career demands are most intense, making the balancing of career and family particularly difficult for women during their 20s and 30s. This period in a woman's life coincides with medical school, residency and fellowships training when work demand are high and finance are strained. Most doctors postpone pregnancy until after the completion of training when they have a regular, well paid job, but the risk of infertility and congenital abnormalities increases. In Italy, in the next 10 years, most female doctors employed in the National Health System will between 30s and 40s and at least half of them will leave work for maternity. The replacement of pregnant women will require major economic and organizational efforts.
Italian Policy on maternity and parental leave sets five months of paid absence from work (two months before and three months after bearing) and up to two years of not paid temporary retire. Many physicians, nevertheless, do not take the entire period of maternity. This may be due to concern about colleagues attitudes towards their staying home with their infant as well as their own feelings of guilt about being away from their patients and work. The temporary replacement staff for physicians on maternity leave may be a potential solution to this problem but women still think that pregnancy and maternity leave would receive silent disapproval from most of their colleagues.
For 1 year, the current economic crisis makes not possible in Italy replace pregnant women. The result is that in Italy more than 44% of female doctors under 35s are single (while only a insignificant proportion of men), the 73% have at lest one child (against 90,5% of male doctors) but only the 45% have 2 children (against 73,6% of male doctors).

Choice of specialty

Medicine is distinctive among the professions in its rich variety of career choices. Different specialties attract individuals with different attitudes and abilities, demand different working practices and offer different forms of professional fulfilment. More women are advancing through each specialty. However, women, far more than men, consider the balancing of family, parental and occupational roles when making career decision. Moreover women have a relatively greater orientation towards interaction with people while men have a greater orientation towards thecnology. When specialty choices are examined, women are proportionately overrepresented in the primary care fields and psychiatry that offer a relatively plannable workload and a relatively strong emphasis on interaction with people. Women are overrepresented also in pediatrics and in

obstetrics/ gynecology despite the intense and unpredictable character of the field because a strong emphasis on interaction with people.
By contrast, women are under represented in surgery and orthopedics where workload is relatively unpredictable and radiology where workload is plannable but more thecnology oriented.

Medical career

While the number of female doctor in the hospital sector is increasing, (female doctors are 37,1%), the career progression and destination for women do not progress as far and as fast as men. In 2007 only 12,3% of clinical directors and 17,6% of professors on university contract were women.
This may be due in part to the traditionally gender difference in the average responses about work – family priorities and aspiration, but also a rigid work organization may impede progression of women that wish to reach leadership positions. In addition, promotion is still biased in favour of men due to the male oriented career framework in medicine which emphasizes single-minded focus on research and career. Moreover the leadership position requires a heavy out of hours investment in extra activities (attending meeting, preparing and making speeches, finding time to do research). Leadership capacity is hard to achieve even with full time working and still more for those on less than full time contracts.

The future of medical practice is changing.
Medical practice is changing for all physicians. All generations bring their generational traits to the medical profession. The “baby boomers” have traditionally worked longer hours and seen medicine as a tireless vocation. This has made them the workhorses of the profession.
When compared with boomers, “generation X” is more savvy with technology, more independent, less loyal to the institution, and seeks balance between work and lifestyle. Reasonable work hours, shared patient responsibilities, achieving personal and professional balance are the new target of medical practice both for men and women.
The organizational implications of changing workforce patterns and preferences with respect to working hours and speciality choices should be examined and their economics effects evaluated. Moreover the labour market for doctors looks set to become harsher; the worst public sector finances may reduce employment opportunities.
Success will depend on the recognizing the legitimate needs of medical workforce and on doctors individually and collectively taking realistic and evidence based views of their careers.