Women in Medicine: Celebration and Struggle

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In light of International Women's Day (celebrated annually on March 8), we have been reflecting on the history, present, and future of women in medicine in Canada. We are grateful, as women physicians, for those who came before us and paved the way. We value the contributions of women in medicine and need them to use their voices for change. Indeed, it was women who refused to be quiet who won the right to vote and to practice medicine to begin with. It was women who advocated for women to be included in health research, an ongoing process which is slowly improving gaps in health equity between women and men (Woodward, 2019).

Jennie Trout was the first female physician in Canada, licensed in Ontario in 1875, after fighting to be accepted to the Toronto School of Medicine, where women were not yet allowed to study. The first Black woman physician and first female surgeon, Jennie Smillie Robertson, began her practice in 1910, after needing to seek an internship and surgical training in the US as no hospital in Canada would accept her for postgraduate training. Upon starting practice, she faced further barriers - no hospital would allow her to perform surgery. Following these two trailblazers came many other firsts. Notably, Dr. Madeline Chung, the first female Obstetrician in BC, delivered thousands of babies, became known as one of the first physicians practicing culturally sensitive care and faced discrimination both for being a woman and for being a Chinese immigrant (Chung, 2021; Lee-Young, 2021). The first Indigenous female physicians came much later with Dr. Nel Wieman, the first Indigenous female psychiatrist in Canada finishing medical school at McMaster in 1993 and Dr. Nadine Caron in 1996 from UBC. Of more recent note, Dr. Bonnie Henry is the first woman in the role of BC's provincial health officer (Ministry of Health Communications, 2018) These women and their contemporaries fought to open doors to women across the country, as did many of those who followed. While we have come a long way towards gender equality in medicine since the early days of Drs. Trout, Robertson, and Chung, and from 1954 when there were only 2 women in UBC's first medical school graduating class, there are still many more firsts to come (Iles et al., 2016).

While we stand on the shoulders of those who came before us, we recognize that sometimes historical struggle can blind us to the present. We do recognize that our senior colleagues have often had to overcome obstacles that we will be fortunate never to have to know, or to have a clear remedy should they occur. However, we respectfully disagree with the suggestion that societal change takes time, and that the meritocracy will come through to grant equality. This presumes that those empowered to make changes recognize that there is a problem: imagining this from a clinical perspective, why would you embark upon a course of treatment if you had no diagnosis? We recall the Letter from Birmingham Jail, wherein Dr. Martin Luther King, Jr. disparages the support of the moderate, who prefers a negative peace (the absence of tension) to a positive peace (the presence of justice). While substantial progress has indeed been made, women continue to be underrepresented in research, leadership, and in higher-paying

specialties (Doolittle and Wang, 2022). Women with intersectional identities, including those who are BIPOC, 2SLBTQ+, and who have disabilities are affected even more so.

The gender pay gap has been well documented in other industries, and within healthcare in other areas of the world. A review of salary information from 24 American medical schools revealed lower mean salaries for women ($207K vs. $258K), with a smaller difference following adjustment for a number of factors ($228K vs. $248K) (Jena et al, 2016). We still have a paucity of data in the Canadian context, though a recent study in the fee for service model in Ontario showed that women make 24% less than their male colleagues, even within specialties, regions of practice and duration of practice (Merali et al., 2021). A similar study looking at fee for service-based surgeons in Ontario showed a similar wage gap-controlled for hours spent operating and suggested men have more opportunities to perform the most lucrative procedures (Dossa et al., 2019). Indeed, a study looking at referral patterns to surgeons in Ontario found exactly that: women received fewer overall referrals, and fewer procedural referrals compared to men (Dossa et al., 2022). We are beginning to see data that overall female physicians effect better health outcomes for their patients than their male counterparts, despite disparities in compensation (Greenwood et al., 2018; Dossa et al., 2022; Sergeant et al., 2021; Meier et al., 2019; Wallis et al., 2017; Dahrouge et al., 2016; Tsugawa et al, 2017).

Beyond pay disparity, women continue to experience multiple forms of harassment in the workplace (Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine | The National Academies Press, 2018). During our brief time in our roles, we have been disappointed to hear about overt discrimination against female residents, by male and female co-workers alike, especially in traditionally male-dominated spaces. Our hearts break to hear of residents reluctant to report sexual harassment owing to concerns about retribution. This is to say nothing of those discouraged from pursuing or excluded from their chosen specialties due to assumptions about their future plans. As well, while White, middle to upper class women have made considerable progress towards equity in medical school enrollment, systemic barriers continue to limit the numbers of Indigenous, Black and Women of Colour as physicians in this country, as well as those from lower income backgrounds.

While the task can seem daunting, there are several initiatives underway to gradually address these issues. UBC Medicine 's Office of Respectful Environments, Diversity, and Inclusion has been working to address many of these areas, such as developing anonymized processes for reporting mistreatment, and championing learning opportunities such as the Gender Bias in the Learning Environment Module. In our roles as the PGME AREDI co-leads, we have provided guidance to program directors as to how to make the resident selection process more equitable, including measures such as including a diverse group in interviews and selection committees, and anonymizing candidate applications. These are perhaps small steps on our path to equality, but with each of our colleagues making their own small steps, together we can achieve real systems change over time.

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