Misogyny in medicine impacts us all

October 9 2023, by Ada Cheung

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Over the last week or so, there has been widespread condemnation of a letter to the editor penned by a retired British anesthetist and published in a U.K. newspaper.

In his letter, Dr. Peter Hilton described female doctors as a "snowflake generation" who need to "toughen up" in response to new research showing that 30% of female surgeons had been sexually assaulted by their male colleagues while at work.

> Sir, This "snowflake generation" of young doctors, largely female and selected on mainly academic excellence, clearly did not do their homework. Medical training and practice is brutal and demanding, with long hours, and bullying happens. Sexually inappropriate comments and actions do occur. It is stressful. All I can say is that if they want to make a success of this rewarding career then they should toughen up. Perhaps four A*s at A-level are not the answer to all the problems they will face.
> **Dr Peter Hilton**
> Consultant anaesthetist/intensivist 1986-2020; Haverfordwest

Dr Peter Hilton's letter sparked outrage. Picture: X

While his comments sparked outrage, he went on to defend his stance. "You will meet people who are bullies, you will meet people who are misogynistic and do inappropriate things but deal with it. I've sent the letter to colleagues I worked with and they agree wholeheartedly."

Sadly, he is correct about the fact that many of his colleagues agree. He is incorrect in saying female doctors should just "deal with it."

But opinions like Peter Hilton's are not isolated. They are widespread in our public hospitals.

I've seen it, heard it and lived it.

Misogyny in medicine in 2023

While female medical students at universities in Australia have outnumbered males since the mid-1980s, there remains significant underrepresentation of women in leadership across all medical and academic fields.

Especially in senior prestigious roles.

In my specialty of endocrinology, of the 11 teaching hospitals with Endocrine Departments in Victoria, only one is led by a female.

This is despite 78% of endocrinology trainees being female.

When raised, most men are shocked and oblivious to that dominance—a reflection of their unconscious bias and privilege.

But repairing broken systems becomes impossible when leaders view misogyny as a shocking anomaly instead of acknowledging it as an underlying structure.

Hospitals are hierarchical institutions built by men for men.

Whether it's the name of a lecture theater, a hospital wing or the portraits adorning the walls—the patriarchal culture is unmistakable. There are few spaces where women are represented and visible.

Outright discrimination is common, ranging from unconscious bias, repeated microaggressions, to harassment, bullying or sexual assault. Under-reporting of such behavior in Australian medicine is endemic.

The small microaggressions faced by female doctors occur daily; "are you a nurse?" or "you're so bossy" are common, being interrupted when speaking, or having ideas and suggestions ignored in meetings but then finding those same ideas appropriated by a male doctor who then receives credit.

Cumulatively, microaggressions like these have been clearly shown to negatively impact the physical and mental health of recipients.

Men hold most of the senior leadership roles within public hospitals, and as such, control performance reviews, references and the future careers of medical staff they supervise.

This power imbalance in hospital structures perpetuates inequity, with junior staff often gaslit or feeling unable to report inappropriate behavior for fear of reprisal.

As leaders, once appointed, often remain in their roles until they retire. Even when complaints about misconduct are raised, they can be ignored for years with little prospect of effecting change.

Hospital leadership structures need a radical review to enable psychological safety to speak up and ultimately, to nurture innovations most effectively in patient care.

Female doctors are quitting

Research has found that female doctors do more for our patients for less recognition. Salaries of female doctors are 12 to 25% lower than males across all specialties, even after accounting for hours worked.

There are less resources to support women—whether it's financial resources, support staff or disparities in mentoring and sponsorship.

On top of the gender pay gap is a workload gap. Female doctors undertake more mentoring of junior medical staff, accept more committee service, are more likely to answer patient queries and more accurately document in medical records.

All highly important but invisible work.

Outside of the hospital, inequity doesn't end. High achieving female physician scientists spend 8.5 hours more per week than their male counterparts on domestic activities like caring for children or family.

This disparity was magnified by the COVID-19 pandemic. During the pandemic, male medical researchers published more studies than women compared to pre-pandemic levels—which suggests that women are at far greater risk of falling behind their male colleagues during and beyond the COVID-19 pandemic.

Not surprisingly, the constant inequity and battles for recognition negatively impact physical and mental well-being.

When women don't feel heard, they disengage, don't turn up or they leave. Burnout, depression, inability to find professional fulfillment and realize career goals and amplified imposter syndrome are just some of the consequences.

Harm is magnified for women who are part of other underrepresented groups like women of color. Research shows that across every career stage, female doctors are leaving teaching hospitals, or are planning to withdraw, at a higher rate than male doctors.

All of this is happening at your local hospital.

Female doctors provide better patient care

Despite these workplace challenges, patients of female surgeons and physicians have better outcomes, unrelated to case complexity.

Doctors from diverse socio-educational backgrounds better serve the community, and there is clear evidence that patients are not only less likely to die, but have less surgical complications, hospital readmissions and even better control of their diabetes with female doctors.

The relative risk reduction of 4% seen by patients of female doctors compared to patients of male doctors is equivalent to the reduction in all-cause mortality seen over the last 10 years because of advances in medicine.

Many female doctors practice medicine differently to male doctors and research supports this.

They are more likely to provide preventative care, use patient-centered communication, provide more psychosocial counseling, take more time per patient, may be more deliberate in their approach to solving complex problems, are more likely to adhere to clinical guidelines, and spend more time documenting in medical records.

Who would you prefer to have treating you next time you arrive in the Emergency Department?

The inability to retain female doctors was already an issue prior to the COVID-19 pandemic, but staffing shortages have now reached crisis point and will only worsen.

If drastic changes don't occur to support and retain female doctors, we will face a hospital staffing crisis where critical health operations cannot be sustained.

Action is needed now to protect our community

Established in 2005 to encourage and recognize commitment to advancing the careers of women in science, technology, engineering, mathematics and medicine (STEMM), universities across the world have committed to the Athena SWAN Charter.

This is a framework designed to support and transform gender equality within higher education and research.

Nothing like this exists in our public hospitals or health care organizations.

There needs to be a commitment and mandate from Government, unions and hospital boards to urgently address misogyny in medicine and embed change in governance and accountability structures.

Hospital leaders need to:

1. Prioritize and appropriately resource gender equity, diversity and inclusion work
2. Undertake transparent, rigorous self-assessment to analyze existing culture and barriers to gender equity
3. Develop proactive plans to reduce identified barriers, increase the safety of all staff and enable system-wide cultural change. Some examples include the American Society of Clinical Oncology's practical steps for cultural change or Ruchika Tulshyan's ADAPT framework.

There is no reason why hospitals and health care organizations cannot commit to the Athena SWAN Charter or other similar frameworks like the National Academies of Medicine recommendations to address misogyny in medicine.

We have enough evidence. We already know enough to act.

Public hospitals use public funds to best serve the community. We can't hope to effectively improve the health of the wider community if we can't ensure that female staff in our health care and academic institutions are safe, healthy and well.

Provided by University of Melbourne