Equality for Women In Respiratory And Sleep Medicine in the Asia-Pacific Region: Opportunities For Change

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Globally women have been practicing as qualified doctors for two hundred and sixty-five years. While the Asia pacific region can proudly claim some of the first women medical graduates, disappointingly discrimination and a substantial gender gap in pay and career opportunities remain prevalent issues worldwide. Furthermore, serious discrimination against women continues to make news headlines worldwide. Recent examples include the alleged widespread sexual harassment of female surgical trainees in Australia, and one of Japan’s medical schools admitting deliberately altering entrance scores for more than a decade to ensure more men became doctors than women. It is timely for respiratory physicians in our region to consider the issues women face and embrace opportunities for societal and health system change to facilitate equality in medicine.

We can learn much from the trail blazing first women doctors, who fought for the right to receive a medical education and serve their communities. Legends from antiquity tell of Agnodike (4th century BCE) as the first woman physician, who worked disguised as a man in Athens, as the laws of the time prevented women from practicing medicine. Approximately 2150 years later Dr Dorothea Erxleban obtained a medical degree from the University of Halle in Germany in 1754, after she campaigned for her right to become a doctor. Disappointingly, nearly another one hundred years passed before other determined, highly educated women, such as Dr Elizabeth Blackwell (qualified 1849 - USA), were able to enter medical schools and join the profession. Notably, some of the earliest female medical graduates globally were in the Asia pacific region.
These women include: Dr Emma Constance Stone (awarded her MD in Canada in 1888 and returned to Australia to practice), Dr Anandibai Gopalrao Joshi (graduated in the USA in 1886, returning to India to work), Dr Kadambini Ganguly (graduated in India in 1886) and Dr Emily Siedeberg (graduated in New Zealand in 1896).

Many of the first women doctors shared similar experiences around the world, including being barred from completing medical degrees in their home countries, thus needing to travel overseas to obtain their qualifications. Many experienced discrimination that prevented them obtaining medical appointments in hospitals. Consequently, these women often founded and ran new hospitals and medical training colleges for women. Many highlighted the need for women doctors, as they were best able to understand and care for female patients. Similarly, these first women doctors often undertook less prestigious work (often unpaid) caring for poor women and children and those living in slums. Sadly, some of the first women doctors died from illnesses (tuberculosis or influenza) contracted in their poor working conditions. These extraordinary women also worked tirelessly to promote women’s rights, support other women doctors, improve healthcare, and often held multiple leadership positions, in addition to being wives and mothers with several children of their own. Importantly we must acknowledge the support provide by enlightened families and spouses that enabled these women to challenge the social norms of the time.

In the 1800s it was often stated that women were neither adequately intelligent nor resilient enough to become doctors. However, there is increasing evidence that women doctors achieve patient outcomes that are as good or better than those of their male counterparts. In a recent cross sectional study, Tsugawa et al found that patients treated by women doctors had statistically significant, lower mortality rates, as well as lower readmission rates than patients treated by male
doctors\textsuperscript{5}. Wallis et al similarly found that patients of female surgeons had statistically significant lower rates of 30-day mortality than patients of male surgeons\textsuperscript{6}. Possible explanations include different practice patterns, as it is recognised that women doctors are more likely to adhere to clinical guidelines, use more patient-centred communication, spend more time with patients, engage family members more and provide more frequent preventative care than their male counterparts\textsuperscript{5-7}.

Since its inception in 1986, the Asian Pacific Society of Respirology (APSR) has had fourteen presidents, of which three (21\%) have been women. Three of 17 people listed on the APSR honour roll are women (Dr Eden Chua, Dr Teresita de Guia and Dr Mary Ip)\textsuperscript{8}. Each comes from a different part of the region and exemplifies that women respiratory physicians are capable of achieving at the highest level. The three APSR women presidents: Prof Wan-Cheng Tan, Prof Ann Woolcock (died 2001) and Prof Mary Sau-Man Ip also have much in common. They are all world leading, clinician researchers with hundreds of publications, have held multiple leadership positions, served on national and international committees as well as multiple editorial boards, and each has received several prestigious awards. In an interview in 2000, Prof Ann Woolcock acknowledged that her career path (attending medical school aged sixteen, graduating aged 21, and by age 30 having had her first child as well as completed a MD thesis, authored over 30 papers, obtained fellowship of the Royal Australasian College of Physicians having done only a few years of clinical medicine) would not be possible today. She noted that things were becoming harder due to the formal requirements physicians had to complete, and that the support of her husband for her academic career had contributed to her success\textsuperscript{9}.  

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While the women presidents of the APSR are shining lights to all of us (irrespective of gender), many women face barriers that prevent career progression. Importantly, despite substantial participation in all areas of medicine, women doctors are less visible and more likely to be overlooked. This problem is not unique to medicine, being equally recognised as a significant issue in science generally. Our own research has demonstrated that women are significantly less likely to be an invited speaker or chair of conference sessions at international meetings, despite evidence of women participating vigorously in respiratory research and academic medicine. Similarly, women are significantly less likely than men to author invited commentaries in scientific journals despite equivalent expertise, seniority and publication metrics. Additionally, many medical schools have had equal numbers of men and women enrolled for some years, and the USA now has more women than men enrolled in medicine. Nevertheless, women are under-represented in faculty and leadership positions at American medical schools, with only 16% of departmental chairs held by women in 2015. The gender inequality in leadership roles, positions and titles, progress in academic medicine, gaps in salaries and gender parity in specialties has been labeled the “glass ceiling”.

On a smaller scale, women may take on or be allocated less visible roles within medical departments. For example, some women may select clinic consultations in preference to ward service, assuming that the hours may be more predictable and contained thereby facilitating family commitments. However, by taking on such roles they have less opportunity to demonstrate their skills to other members of their department. Furthermore, women doctors are also more likely than their male colleagues to be referred to by just their first name, instead of by their title and surname when introduced at academic presentations, and less likely to be recognised as doctors by patients, their families and other hospital staff than their male peers. Additionally,
women physicians in the USA are paid twenty-six percent less on average than their male peers. These biases, while often unconscious, are pervasive and undermine women’s role, expertise and leadership in medicine.

Some of the obstacles faced by women can be attributed to “timing”. Many pivotal career steps such as completion of specialist training, overseas fellowships, completion of research higher degrees and first appointments as consultants occur at the same time as childbearing. Women generally take on the majority of child rearing responsibilities, leading to significant career disruptions. However, many key networking opportunities or research meetings often occur at the same time as family commitments. The conflict between wanting to participate in committee meetings or research teleconferences at the start or end of the day and needing to drop off or collect children from school or childcare is a real issue. Furthermore, sometimes there are just not enough hours in the week, with Nobel Prize winner Donna Strickland explaining that she never applied for a full professorship as “filling out the paperwork...wasn’t worth doing”.

Importantly, sometimes there is no “right” approach for women. The reduced representation in leadership roles and gap in salary have been attributed to women being less assertive in negotiations. However, assertiveness in women is often viewed negatively with assertive women (including Hilary Clinton) described by male colleagues as “nasty”, “bossy or “upset”. Therefore, criticism occurs whichever option is taken. Importantly, patients and their families expect women doctors to be empathic, kind and patient, which often leads to longer consultations. Furthermore, women doctors may be less comfortable delegating tasks to other (often female) members of the healthcare team. These practices may make a woman doctor appear less efficient to senior colleagues than her male counterparts.

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Inspiring senior women and mentors clearly make a difference. This was most succinctly described by Marian Wright Edelman, American civil rights activist as: "You can’t be what you can’t see". However, the role of a sponsor may be more pivotal; a sponsor is someone who directly suggests your next career move, promotes you to others and personally advocates for you. There is often some hesitation to promote women due to well-meaning but misguided assumptions; colleagues may think a woman wants more time with her family or believe she may find a certain role too stressful. The best way to circumvent this issue is to simply ask the woman what she might wish rather than assuming. Furthermore, everyone benefits from leadership training, yet this is conspicuously absent from undergraduate and postgraduate training curricula. Encouraging and facilitating all physicians to engage in formal leadership training and mentoring programs are simple solutions.

New media excitingly allow flexible engagement in the clinical and academic sphere. University and research websites, citation managers and internet-based social networks allow women to keep their research profile up to date at a time that suits. However, there is evidence that women may not be as successfully engaged in digital platforms, with one study demonstrating that in some areas of health research women’s voices didn’t have the same magnitude of influence on Twitter. Virtual interfaces such as Skype or videoconferencing allow women to contribute at times when they are unable to have a physical presence. However, the digital age brings challenges for anyone trying to balance work and family life, conveniences such as the ability to dictate clinic letters on a mobile phone results in more work being shifted out of the workplace and out of paid hours. Internet based teleconferencing avoids face-to-face and commuting time
but may result in scheduling at critical family times and a resultant sense that even if one is *working and remunerated* part-time, one should be *available* full-time.

Recognition of and payment for administrative and non-clinical activities encompassed by a medical career are important. Whilst time and resources for these activities are often factored into a job description for a full-time role, they are often absent from part-time positions. Offering administrative support and protected non-clinical time to male and female part-time physicians on a *pro rata* basis is only fair and equitable.

Finally, the importance of raising the issues women face through invited articles like this and regularly at dedicated conference symposia at national and international conferences (Thoracic Society of Australia and New Zealand and Chest conferences) cannot be underestimated. Recognising, admitting and openly discussing significant gender inequality issues are the first steps in finding solutions. There is not only one correct approach to overcoming these issues, however, involvement of the entire medical community will facilitate the pivotal changes required.

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