# *From The "Glass Ceiling" to Quicksand*

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### *Introduction*

The history of women in the labor force over the past 60 years has taken several important turns. During World War II women began to enter the labor force. Their employment in manufacturing and the service sector transformed the nature of the family in the United States. In the 1950's and 1960's a change in women's participation in college and graduate schools has now resulted in women making up majorities of the 2005 incoming class at Harvard and most law schools. The educational barriers that stopped women from progressing up the corporate and government ladders are being erased. With the advancements in education made by women, we are now at the point where women in many fields achieve greater educational successes than men. A key component of the "Glass Ceiling" that has prevented women from taking leadership positions in many fields is now being erased across the economic landscape of this country.

One might also find some reason for optimism that in general the barriers to women reaching the highest levels in the professional ranks are also coming down. More and more women are successfully entering medical school and becoming physicians. In some specialties such as dermatology and pediatrics over half the new specialists are female. Unfortunately, the good news stops there. This article will explore the new reasons why women are not progressing rapidly into the leadership ranks in the field of health care. In all likelihood, this analysis applies to law, engineering, government service and many other professions. The article focuses on health care since I have an excellent view of what is going on in health care today from my medical professional work in numerous leadership capacities.

### *Women in Medicine: The Facts*

The fact is that many women, having completed their specialty training, increasing numbers, are opting out of the climb up the professional ranks in the field of health care and choosing to take such a significant role in their family life and raising children that they do not have the full time and energy to rise up through the challenges and ladders that exist on the road to leadership positions in the health care field. The statistics will make this very clear.

Increasing numbers of women are becoming physicians. Before 1960 the number of women in medical schools was usually 5%, held down by informal quota systems, which actively restricted the number of women admitted to medical schools. Last year (2003) women were 49.7% of the entering class across the nation.[1[1]] Similarly, in 1970, 7.6% of the physician workforce was

[1[1]] Statistics provided by the Association of American Medical Colleges

female. Now women make up 25.2% of the physician workforce. [2[2]]As more women physicians enter the workforce, and older physicians retire this is more likely to approach 50%, reflecting the distribution of entering students.

Women enter medicine for many reasons, including the prestige of the profession, the high income potential, and more importantly the true desire to be in a helping profession. The high income and professional status are attractive to both smart young people, both women and men, who are contributing to the reversal of the trend of declining medical school admissions. The income supports a life style that is attractive and appealing, despite the long years of education necessary to become successful.

The increase in women physicians validates that women are smart and capable. It makes it easier for female patients to have female physicians, a preference expressed by many women. Many studies have shown that women physicians are more empathetic and spend more time with patients, with enhanced communication skills. The nurturing characteristics of women are an excellent fit with the characteristics that many patients desire. Almost every one agrees women do make good doctors.

With the increased access to medical school, the more favorable hours of training and the general acceptance on women in the medical workplace, the barriers to success during these early years have been reduced. Indeed young women physicians and medical students rarely perceived the hostility that older women physicians accepted during their training period. These young women are in large measure treated as equal to their male colleagues. Medical schools are working diligently to eliminate harassment and make the educational process more humanistic for male and female students alike. Younger female physicians at the conclusion of their training have personal and professional expectations of a life, with an ease that reflects the ease of their training experience.

This pool of young women physicians represents a special challenge to workforce management. Because women physicians typically work fewer hours (49 as opposed to 57 for men) and see fewer patients in a practice setting, more physicians are necessary to produce the same physician "work". Similarly women physicians tend to cluster in certain specialties, and like many young physicians are seeking controllable life styles. Both young men and young women place increasing emphasis on family life and are unwilling to make the commitments to total involvement that characterized the typical physician of the past.

### *The Quicksand Metaphor and The Quicksand Reality*

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[2[2]] Physician Characteristics and Distribution in the U.S., 2004 Edition and prior editions. American Medical Association, Chicago

Many young women who successfully complete medical school and specialty training become angry and frustrated when faced with the dual challenges of raising a family and continuing a career. Car pools play groups, and after school activities don't mesh well with full time medical practice. In contrast to men who continue to persevere, anecdotal stories abound of successful women physician who decide that the stress is overwhelming, and leave the workplace. For a woman, even a physician, to choose to be a stay at home mom is considered acceptable or even desirable in some circumstances. Alternatively, many women practice part-time, attempting to balance family responsibilities while dealing with the demands of a profession, which still considers part time as a failure or cop-out. Web sites like Mom MD, which provide practical advice on coping skills like hiring a nanny, are filled with stories about women who have opted out. Though many female physicians are married to physicians, mitigating the financial consequences of drop out, the high student debt does keep some unhappily in the workplace. In addition to the personal loss and sense of failure, the societal cost of training women physicians who do not practice is high.

Therefore, as women physicians begin to seek a balance between the hours it takes to deliver quality parental supervision to their children (and occasionally care needed for their parents or siblings), they can not keep up with the enormous hours and commitment that their male counterparts invest in reaching the highest levels of leadership in the medical field. I refer to this as the quicksand problem. The more a woman tries to do a great job in both her family and in her profession, the more frustrated and tired she gets, with the quality of her work (and/or her life) diminishing faster the harder she tries to do everything. This is like quicksand, the harder you struggle the quicker you die.

### *The Medical Profession – How it Should Respond*

One of the major trends in health care is the impending shortage of doctors and other health professionals. Long waits for physicians' visits, especially, specialists have led to the popular perception that there is a physician shortage. Many experts have confirmed the prediction, which is likely to especially focus on specialists, key to our current health care delivery system. The Council on Graduate Medical Education is about to issue a report predicting a physician shortage and suggesting that medical schools should increase enrollment. The Association of American Medical Colleges has recently reversed its previous position that there is likely to be physician excess, and numerous experts are predicting a physician shortage. In short, the medical profession cannot afford to have women physicians drop out of the medical field. And, more bluntly, the medical profession cannot afford to exclude 50% of its workforce (women) from leadership positions.

The medical profession must begin to deal now with putting a solid foundation under the women in the medical profession who want to stay in the field, raise their children, and, at the same time, also, rise to the important leadership

positions in the field. Thus, the overwhelming challenge is to keep female physicians who want to contribute to the early childhood success and well being of their children, involved in the workforce, remaining as productive members of the medical workforce and to find ways to groom them into becoming leaders in the health care field. There are many ways that this can be accomplished and one does not need a Ph.D. in Human Resource Management to figure them out. Alternatives can be developed which meet the needs of both women physicians employed in large group practice or HMO settings, or those who select the more entrepreneurial approach of private practice. Alternatives include job sharing, flexible schedules, intermittent employment, as well as part-time traditional practice. However, what is needed is a firm commitment by the current leaders in the health care field to achieving this goal of equal access to leadership positions for women who devote their lives jointly to the profession and their families. And, action is needed now to avoid the continuation of this huge human capital drain that the medical profession is forcing on itself by creating women physicians who are also primary caretakers of their families as persona non grata in the upper echelons and leadership positions of the field of health care.

Critical to success is an open discussion of the needs of both parties, the employer and the employee physician, as well as a willingness to remain flexible and renegotiate the job as the particular needs of the physician change. For instance, soccer season might mean that certain afternoons need to be kept free, whereas day camp might allow longer hours than the school year. The key is flexibility and adaptability and a willingness to create patient scheduling mechanisms that allow such flexibility. Indeed if patients are encouraged to call for appointments during the week in which they want to be seen and doctors schedules are set using this short term flexibility, the argument that schedules must be set 6 months in advance can be deflected. In order to deal with the nursing shortage, hospitals are allowing 9-month work schedules coincident with the school season, with pay spread over 12 months. Similar approaches by physician groups are not only possible, but will become necessary to recruit and retain these young physicians. By creating flexibility at the early stages of a career long-term loyalty can be developed. Financial incentives such as bonuses for long-term service must be structured to reward continued employment. Since medical school graduates have an average debt load over 100,000$, loan repayment coupled with flexible hours and long-term employment is likely to be a successful employment strategy.

### ***The Medical Profession is Failing***

Much of this is contrary to the established culture of American medicine. The idea that doctors are valuable only if they are working more than 40 hours a week must be discarded. The value of a physician must reflect the skill and expertise in patient care, and the organization must recognize the individual contribution regardless of the time commitment. For a woman with small children a 30-hour workweek usually represents a greater emotional commitment and

sacrifice than a 60-hour week of a 50-year-old male physician. These time sensitive commitments must be commended not just with a commonly seen acknowledgement that the physician is lucky that the organization was accommodating, but all the same rewards that other employees receive, though financial rewards may be appropriately scaled. Each of us, and especially working women who view themselves as making a sacrifice, want and need to be appreciate for their well-done work. Leaders of health care organizations must embrace flexibility and adaptability for their physician workforce in order to compete successfully in hiring these increasingly scare valuable individuals.

## *Conclusion*

Yes, women have successfully overcome the barriers to medical school entrance and specialty training. Now they face quicksand laid before them by the male dominated leadership of the medical profession. This quicksand must be replaced with a strong foundation for women physicians and such a strong foundation for them can only be built with a significant change the culture of the health care work place. Health care leadership, both physician and non-physician, must recognize that the coming health professional shortage will require a new mindset to keep women physicians engaged in their chosen careers. The time is now. Health care has enough problems without us killing off one of our most important assets in the industry – the growing number of women who are choosing to become physicians.

## *Biographical Information*

**Stephanie Pincus, M.D., M.B.A., most recently led the teaching mission of the Veterans Health Administration as the Chief Academic Affiliations Officer. She received her M.D. from Harvard Medical School and her M.B.A. from the J. L. Kellogg Graduate School of Management at Northwestern University. She is board-certified in Internal Medicine and Dermatology, and has held numerous leadership positions in academic medicine and medical organizations. Prior to her VA position she was Professor and Chair of the Department of Dermatology at the State University of New York at Buffalo in Buffalo, New York.**

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